



Cosmetic surgeon – discipline

Charges

A Complaints Assessment Committee (CAC) laid eight charges based on individual complaints against Dr Chan. The charges were laid at the level of disgraceful conduct in a professional respect (Lisa Clement, Ms A, Ms B, Ms C and Mr D), professional misconduct (Ms E) and conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine (Miss F and Ms G). The CAC laid a ninth charge against Dr Chan which was a composite charge. The particulars of the composite charge related to individual complaints by Lisa Clement, Ms A, Ms B, Ms C, Ms E, Miss F and Ms G. This charge was laid at the level of disgraceful conduct in a professional respect.

Finding – eight individual charges

In all eight charges Dr Chan was charged with failing to convey the fact that he was not vocationally registered as a plastic surgeon in New Zealand. The Tribunal considered, in relation to all eight complainants, while it was clear that Dr Chan did not convey that he was not vocationally registered as a plastic surgeon in New Zealand, this was not a disciplinary matter. It was clear that Dr Chan pointed out particular certificates that he had received in respect of cosmetic surgery, but he did not appear at any stage to have indicated that he had qualifications which he did not hold. It was also noted that in a number of instances, the complainants contacted Dr Chan's practice as a result of perusing the Yellow Pages. Dr Chan's practice was listed under cosmetic surgeons and it may well be that a number of the complainants did not distinguish between a cosmetic surgeon and a plastic surgeon.

Lisa Clement

Charge: The particulars were as follows:

1. Dr Chan failed to carry out an adequate pre-operative patient assessment and clinical examination.
2. Dr Chan failed to adequately inform Lisa Clement of the anaesthesia process, and surgical procedure and the risks and complications associated with that procedure and the operation thereby he failed to:
 - (a) obtain Ms Clement's informed consent of the proposed anaesthesia process and surgical procedure; and/or
 - (b) obtain Ms Clement's informed consent to the procedure at the time of surgery.
3. There were serious deficiencies in Dr Chan's anaesthetic practice, namely:
 - (a) He failed to provide adequate information to Ms Clement about the nature or effects of the anaesthetic that she was to receive; and/or

- (b) He failed to obtain an adequate pre-operative medical history from Ms Clement and to ascertain the correct name of the medication she was taking, hence could not have been aware of potential drug interactions; and/or
 - (c) He failed to notate or document the amount of local anaesthetic used in this procedure thus compromising patient safety.
 - (d) He failed to adequately monitor Ms Clement's condition during the surgical procedure; and/or
 - (e) He failed to monitor Ms Clement's condition adequately post-operatively; and/or
 - (f) He failed to ensure that the normal discharge criteria had been met prior to Ms Clement's discharge after surgery, thereby potentially compromising patient safety.
4. Dr Chan failed to convey to Ms Clement that he was not vocationally registered as a plastic surgeon in New Zealand.

Background: Lisa Clement had a breast augmentation carried out by Dr Chan in October 2000. Ms Clement was assessed by a nurse and she did not meet Dr Chan until the morning of the proposed surgery. She had sent photos to Dr Chan to assist with choosing the implant.

Finding: The Tribunal found Dr Chan guilty of conduct unbecoming a medical practitioner which reflects adversely on his fitness to practise medicine.

The Tribunal was satisfied Particular 1 was established and it was concerned by the inadequacy of pre-operative assessment and clinical examination of Ms Clement.

When considering the issue of informed consent (Particulars 2, 3(a) and 3(b)) the Tribunal found that as there was such a short period of interaction between Ms Clement and Dr Chan it was unlikely that Ms Clement received the information necessary for her to be able to give informed consent to the process and procedures.

The Tribunal was satisfied Particular 3(c) was not established. Dr Chan did keep notes for the amount of local anaesthetic although the infiltration rates were not noted. The Tribunal considered that the keeping of infiltration rates is good practice, but on this occasion the failure to do so was not a safety issue.

The Tribunal was satisfied on the facts that 3(d) and 3 (f) were not established. However, it was satisfied that Particular 3(e) was established as the records showed only one recording taken 20 minutes after the operation.

The Tribunal was satisfied that Particular 4 was not a disciplinary matter.

Ms A

Charge: The particulars were as follows:

1. Dr Chan neglected to carry out an adequate pre-operative patient assessment and clinical examination.
2. Dr Chan failed to inform Ms A fully of the risks and benefits of the procedure and further failed to advise her whether liposculpture was likely to produce the results

Ms A wanted and failed to make her aware that liposculpture is not a treatment for obesity.

3. Dr Chan failed to provide Ms A with the opportunity to meet with him prior to the day of surgery and failed to adequately inform her of the anaesthesia process, the surgical procedure and the risks associated with that procedure and possible side effects of surgery and the post-operative care that was required, thereby failing to:
 - (a) obtain Ms A's informed consent to his proposed treatment, including the anaesthesia and surgical procedure; and/or
 - (b) obtain Ms A's informed consent to the procedure at the time of surgery.
4. Dr Chan failed to inform the patient that he was not a vocationally registered plastic surgeon in New Zealand.
5. There were serious deficiencies in Dr Chan's anaesthetic practice, namely:
 - (a) He failed to provide adequate information to Ms A about the nature or effects of the anaesthetic that she was to receive; and/or
 - (b) He failed to carry out an adequate or proper anaesthetic assessment of Ms A prior to surgery including taking a satisfactory history of her asthma; and/or
 - (c) He failed to record the amount of local anaesthetic used thus compromising patient safety; and/or
 - (d) Dr Chan failed to monitor Ms A's condition adequately during the surgical procedure; and/or
6. Dr Chan failed to monitor Ms A adequately post-operatively, including:
 - (a) monitoring her fluid balance;
 - (b) responding appropriately to her concerns about her condition after the operation;
 - (c) being aware of the possibility that Ms A's post-operative symptoms may be due to the large amount of fluid removed in the operation and thus very serious.
 - (d) refusing to see her (to assess her condition) when she asked him to do so, thus compromising her safety.
7. Dr Chan discharged Ms A without any of the usual discharge criteria being met, thereby compromising patient safety.

Background: Ms A had liposuction carried out by Dr Chan on 13 June 2000. On the day of the procedure Ms A signed the consent for the operation in front of the receptionist. Ms A said she filled in her medical check list at the time including the fact that she was asthmatic and that she had had a previous bad reaction to Hypnovel. Photos were then taken of Ms A and she was given a sedative pill. Ms A then saw Dr Chan for the first time when he drew circles on her body.

Ms A recalled waking during the procedure to find another doctor working on her thigh. She stated that she woke because she had sharp stabbing pains that increased as the liposuction probe was advanced. She recalls crying and did not see Dr Chan but tried to gain the attention of the other doctor.

Ms A left the Australasia Cosmetic Surgery Clinic without a follow-up appointment despite the fact that there was a clear leakage of blood. Ms A was feeling very unwell and returned to a friend's place where she continued to bleed. Her friend rang the Australasia Clinic and was told that that was normal and when asked to see Dr Chan the following day, was told that everything was okay. Ms A's friend rang a plastic surgeon in Auckland who spoke to her friend over the telephone and arranged antibiotics for Ms A, but was unable to see her before Ms A left Auckland. Ms A said that she was very uncomfortable for a further two and a half weeks on her return home.

Finding: The Tribunal found Dr Chan guilty of professional misconduct. The Tribunal was concerned at the inadequacy of the pre-operative patient assessment and clinical examination of Ms A and was satisfied Particular 1 was established. Ms A was an asthmatic and had advised of a previous allergic reaction to Hypnovel. There was no reference or indication that there was any concern regarding this reaction.

The Tribunal was satisfied that Ms A did not give her informed consent to the procedure and therefore it considered that the first part of Particular 2 and all of Particular 3 were established. While Ms A received a pamphlet put out by Dr Chan concerning liposuction, that pamphlet did not inform fully of the risks and benefits of the procedure. The pamphlet essentially was an advertisement for liposculpture. The Tribunal did not consider that the second half of Particular 2 was established. One of the few matters that the pamphlet did specifically address was that liposculpture is not a treatment for obesity.

The Tribunal considered Particular 4 was not a disciplinary matter.

The Tribunal was satisfied Particular 5(b) was established. However, it did not consider 5(a), (c) and (d) were established as Ms A had received the information about the anaesthesia process and it was clear that from the patient records that notes of the amount of local anaesthetic were kept.

When considering Particular 6 the Tribunal was very concerned at the post-operative care Ms A received. In terms of monitoring her fluid balance, this fell short of accepted standards. A bleeding problem was identified. Ms A, through her friend, raised this issue and nothing appeared to have been done. There was no appropriate response to Ms A's concerns about her condition after the operation. The lack of adequate monitoring of her fluid balance post-operatively put Ms A's renal function at significant risk.

Particular 6(d) was not established as Ms A was unsure as to whether Dr Chan knew she was there when she returned to the clinic the following day.

The Tribunal found Particular 7 was established. The Tribunal considered Dr Chan was responsible for all the staff he employed at his clinic and in this instance Ms A was bleeding and was discharged with no further instructions as to what to do if the bleeding continued.

Ms B

Charge: The particulars were as follows:

1. There were serious deficiencies in Dr Chan's anaesthetic practice, namely:

- (a) He failed to provide information to Ms B about the nature or effects of the anaesthetic that she was to receive; and/or
 - (b) He failed to carry out an adequate or proper anaesthetic assessment of Ms B prior to surgery; and/or
 - (c) He failed to carry out a proper pre-operative history and assessment particularly with respect to her stated history of smoking and asthma; and/or
 - (d) He failed to record in the patient records the details of the amount of local anaesthetic used, thus compromising patient safety; and/or
 - (e) A drug (Maxolon) was administered despite documentation of Maxolon allergy, thereby placing Ms B at serious risk; and/or
 - (f) He failed to monitor Ms B's condition adequately during the operation and post-operatively;
2. Dr Chan failed to adequately inform Ms B of the anaesthesia process, the surgical procedure and the risks and complications associated with that procedure and the post-operative care that was required, thereby failing to obtain Ms B's informed consent to his proposed treatment, including the anaesthesia and surgical procedure.
 3. Dr Chan failed to inform the patient he was not vocationally registered as a plastic surgeon in New Zealand. The literature provided to the patient was misleading in this regard.
 4. Dr Chan discharged Ms B without any of the usual discharge criteria being met, thereby potentially compromising her safety.

Background: Ms B had a mastopexy carried out by Dr Chan on 5 March 2001. She understood that she would have dissolvable stitches. Ms B told the nurse that she was allergic to Maxolon. Ms B also suffered from asthma and was a smoker. It would appear that initially her operation sheet stated that she had no allergies and that had been changed, most likely on the day of the operation. The references on the operation sheet to allergies and current medications appeared to be in Ms B's handwriting. It was not clear whether the decision to use Maxolon on this occasion was made with any awareness of her previous reaction or any idea of preventing a recurrence.

Finding: The Tribunal found Dr Chan guilty of professional misconduct.

When considering Particular 1(a), (b) and (c), the Tribunal was satisfied some information was given to Ms B and she had signed the form saying that she understood the issues relating to the anaesthetic. However, it considered Dr Chan failed to carry out an adequate or proper anaesthetic assessment prior to surgery. Dr Chan did not listen to Ms B's chest or ask any questions at all about her asthma which in the Tribunal's view fell well short of a proper anaesthetic assessment.

When considering Particular 1(d) the Tribunal was satisfied that although the amount of local anaesthetic was not recorded, it was not a matter that warranted disciplinary action.

The Tribunal found Particular 1(e) was established. There was a failure to document the recognition of the allergy, the reasons for using the drug and the methods for combating the allergy. In the absence of any such reference, it appeared that further

information was not obtained in respect of the allergy and that it was merely fortuitous that Ms B did not experience an adverse reaction. The Tribunal considered it notable that Ms B was not asked at all about the type of reaction she had had to Maxolon.

Ms B suffered a severe post-operative infection. However, the post-operative infection was not an infrequent complication and changes were made to her antibiotics in an attempt to deal with the infection. Therefore Particular 1(f) was not established.

The Tribunal did not consider Particular 3 was a disciplinary matter.

Ms C

Charge: The particulars were as follows:

1. Dr Chan failed to inform the patient he was not registered as a plastic surgeon in New Zealand.
2. Dr Chan failed to carry out an adequate pre-operative assessment and clinical examination of Ms C prior to surgery.
3. Dr Chan failed to adequately inform Ms C of the risks and possible side effects of the surgery, nor was she made aware that the outcome of the procedure may not meet her expectations and therefore Dr Chan failed to obtain Ms C's informed consent to the procedure.
4. There were serious deficiencies in Dr Chan's anaesthetic practice, namely:
 - (a) Dr Chan misled and/or failed to provide adequate information to Ms C about his anaesthetic management.
 - (b) Dr Chan failed to provide adequate anaesthesia during the procedure, resulting in Ms C suffering severe pain during surgery.
 - (c) Dr Chan operated without an anaesthetist present during the procedure and drugs were administered by him contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists.
5. Dr Chan discharged Ms C without any of the usual discharge criteria being met, thereby compromising her safety.

Background: Ms C had liposuction performed by Dr Chan in March 1998. During the operation Ms C experienced intense pain and asked Dr Chan to stop the process. Her arms were held down and she was told to lie back down and to calm down. She visited another plastic surgeon four months later and had further surgery done under general anaesthetic as she was dissatisfied with the results from the surgery by Dr Chan.

Finding: The Tribunal found Dr Chan guilty of conduct unbecoming a medical practitioner and that conduct reflected adversely on his fitness to practise medicine.

The Tribunal considered Particular 1 was not a disciplinary matter.

The Tribunal was satisfied Particulars 2, 3 and 4(a) were established. The Tribunal considered that Dr Chan did fail to carry out an adequate pre-operative assessment and clinical examination prior to surgery. He had one brief appointment prior to the

surgery with the patient who did not seem to have any further contact with Dr Chan until just before the operation. Ms C confirmed that Dr Chan did not listen to her chest or listen with a stethoscope or take blood pressure. The Tribunal was satisfied Dr Chan failed to inform Ms C about the risks and possible side effects and outcomes, therefore affecting her ability to give informed consent.

The Tribunal was satisfied Particular 4(b) was established. Ms C had awoken during the surgery. The Tribunal considered adequate anaesthesia was not provided.

The Tribunal was not satisfied that Particular 5 was established.

Mr D

Charge: The particulars were as follows:

1. Dr Chan performed a rhinoplasty procedure on Mr D while suspended from practising medicine.
2. Dr Chan failed to ensure that the patient was aware of the risks and side effects of rhinoplasty, and of the anaesthetic and the operation, and thus failed to get informed consent to the procedure.
3. Dr Chan failed to inform the patient that he was not vocationally registered as a plastic surgeon in New Zealand.
4. Dr Chan failed to provide the patient with a satisfactory result from the rhinoplasty procedure.

Background: Mr D had a rhinoplasty procedure carried out on the 3 July 2001 at a time when Dr Chan was suspended from practising. At the first consultation Dr Chan had explained the procedure and on the day of the surgery, Mr D was seen by a nurse and was taken into a room and given pre-operative medication. Mr D saw Dr Chan one week later and the plaster was taken off his nose. Mr D was clearly unhappy with the results of the surgery.

Finding: The Tribunal dismissed the charge against Dr Chan in respect of the treatment of Mr D.

The Tribunal was satisfied at the time of Mr D's operation, Dr Chan was suspended from practice as a result of an order of the Tribunal. The CAC asked the Tribunal to determine that the fact that Dr Chan should not have been practising medicine at this stage was in itself disgraceful conduct in a professional respect. The Tribunal was satisfied that such an argument may have gained some support if section 109(1)(g) relating to the breach of an order of the Tribunal did not exist. The Tribunal considered this was a matter that could have been the subject of a charge under section 109(1)(g) of the Act or section 9 of the Act. A charge under section 109(1)(g) or prosecution with regard to section 9 of the Act were not brought in respect of Dr Chan practising while suspended, and therefore the Tribunal was unable to deal further with the matter. It was this Tribunal's view that practising while suspended does not amount to disgraceful conduct in terms of section 109(1)(a) as a matter of law, and therefore Particular 1 was not established.

The Tribunal was satisfied Particular 2 was not established. Mr D had the benefit of being accompanied by a partner with a nursing background. She acknowledged in her

evidence that she had asked Dr Chan about the complications and there had been discussion of them.

The Tribunal was satisfied Particular 3 was not a disciplinary issue. It considered Particular 4 related to a subjective cosmetic issue and did not warrant a disciplinary finding.

Ms E

Charge: The particulars were as follows:

1. Dr Chan failed to ensure that the patient was aware of the risks, side effects and possible poor outcome of the rhinoplasty surgery, and thus failed to obtain informed consent.
2. Dr Chan failed to inform the patient he was not a vocationally trained plastic surgeon.
3. The surgical procedure carried out by Dr Chan was not carried out with the due skill and care expected of a competent medical practitioner working in the area of rhinoplasty procedure.
4. Dr Chan failed to obtain informed consent to the procedure by:
 - (a) giving the consent form for surgery to the patient to sign after Ms E had been given her pre-operative sedation.
 - (b) using foreign implants in the procedure despite his assurance prior to surgery that no foreign implants would be used.
5. There were serious deficiencies in Dr Chan's anaesthetic practice namely the immediate post-operative care was unacceptable and unsafe. The guidelines from ANZCA state that even with 'conscious sedation' the patient must be chaperoned afterwards.

Background: Ms E had a rhinoplasty procedure done during 1995, Dr Chan was to operate by using cartilage from behind Ms E's ear. Ms E had stated she did not want a silicon implant and she was told that the operation would be done with cartilage from behind her ear. Five years after the operation, Ms E had a boil on her nose and it was found that it had been caused by a silicon implant protruding through the skin which had to be removed.

Finding: The Tribunal found Dr Chan guilty of professional misconduct.

The Tribunal was satisfied Particular 4(b) was established. The Tribunal considered it a matter of grave concern that Dr Chan felt he was able to undertake a procedure so clearly against the wishes of the patient. The Tribunal found in all other respects the remaining particulars were either not relevant or not proven.

Miss F

Charge: The particulars were as follows:

1. Dr Chan failed to adequately inform Miss F of the anaesthesia process, the surgical procedure and the risks associated with that procedure including the possibility of a less than satisfactory outcome for her, thereby failing to obtain

Miss F's informed consent to the proposed anaesthesia process and surgical procedure.

2. There were serious deficiencies in Dr Chan's anaesthetic practice, namely:
 - (a) He failed to provide adequate information to Miss F about the nature or effects of the anaesthetic that she was to receive; and/or
 - (b) He failed to undertake a pre-operative clinical examination of Miss F; and/or
 - (c) He failed to obtain an adequate pre-operative medical history from Miss F;
 - (d) The method of sedation he used was inappropriate for the procedure, resulting in more pain than necessary for Miss F and in any event the method of local anaesthetic used was administered contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists.
3. He failed to perform the operation to a reasonable competent standard in that the breast reduction did not lead to any real reduction in her breast size.
4. He failed to inform her that he was not a vocationally registered plastic surgeon.

Background: Miss F had a breast reduction performed by Dr Chan on 15 June 2000. She had the surgery undertaken under local anaesthetic and was told that she would feel no pain but she awoke several times during the surgery due to the pain she felt. She was not satisfied with the results which were supposed to move her to a C cup sized bra. She is still wearing E cup sized bras.

Finding: The Tribunal found Dr Chan guilty of conduct unbecoming a medical practitioner which reflected adversely on his fitness to practise medicine.

The Tribunal was satisfied Particular 1 was established as although Miss F had at least two consultation visits with Dr Chan it was clear that some risks and complications were not explained.

The Tribunal was satisfied Particular 2 was established. Miss F suffered from asthma and there was no reference of discussion relating to the asthma and no examination of the chest in terms of the asthma.

The Tribunal was concerned that the method of sedation was inappropriate for the surgery. It was clear from the expert evidence submitted to the Tribunal that those undertaking that surgery consider that it is a matter best done under general anaesthetic. The Tribunal found there has been a failure to perform this surgery to a reasonably competent standard, and therefore Particular 3 was established.

The Tribunal did not consider Particular 4 was a disciplinary matter.

Ms G

Charge: The particulars were as follows:

1. Dr Chan failed to adequately inform Ms G of the anaesthesia process, the surgical procedure and the risks associated with that procedure including the possibility of a poor outcome for the patient thereby failing to:
 - (a) obtain Ms G's informed consent for the proposed anaesthesia process and surgical procedure.

- (b) obtain Ms G's informed consent to the procedure at the time of surgery.
2. There were serious deficiencies in Dr Chan's anaesthetic practice, in that he failed to provide adequate information to Ms G about the nature or affects of the anaesthetic that she was to receive.
 3. He failed to record in the patient records the amount of local anaesthetic used thus compromising patient safety.
 4. Dr Chan failed to appropriately manage Ms G's condition post-operatively.
 5. Dr Chan failed to advise Ms G that he was not a vocationally registered plastic surgeon.

Background: Ms G had liposculpture performed by Dr Chan in August 1994. Ms G had a very brief consultation with Dr Chan and was reassured that she would feel no pain. The pain that she suffered both during and following the surgery was intense and was not her expectation in respect of the surgery. Following the surgery, Ms G contacted the Australasia Cosmetic Surgery Clinic and was told to take Panadol. She then approached her general practitioner and was given a prescription for a stronger pain killer. Ms G was bedridden for about three weeks and was off work for about six weeks.

Finding: The Tribunal found Dr Chan guilty of conduct unbecoming a medical practitioner which reflected adversely on his fitness to practise medicine.

The Tribunal was satisfied Particular 1 was not established as this was a matter prior to the Medical Practitioners Act 1995 and prior to the Health and Disability Commissioners Act 1994. It considered the issues about informed consent were within a different context.

The Tribunal was satisfied Particulars 2 and 4 were established. There were serious deficiencies in his anaesthetic practice given the pain experienced by Ms G. It was also concerned at the poor post-operative care given to Ms G.

As the patient notes were not available the Tribunal could not find Particular 3 proven and it considered Particular 5 was not a disciplinary matter.

Composite Charge

Charge: The particulars were as follows:

1. He advertised his surgical services to the complainants in a way that did not make it clear that he was not vocationally registered as a plastic surgeon and provided promotional material that was misleading in this respect.
2. He failed to adequately explain fully the benefits and risks of the surgical procedure that was to be undertaken, and to advise patients as to whether the procedure sought was appropriate for them, thus failing to obtain informed consent to the procedures.
3. He failed to adequately assess the complainants before the operation in order to assess their physical and mental wellbeing, the suitability of the person for the operation and to ensure that they were fully and adequately informed of the procedure that they wished to undertake, and the nature of the anaesthetic to be

used, its benefits and risks, including the possibility that there may be some pain and discomfort experienced under local anaesthetic.

4. He failed to adequately record in the patients' notes (or at all) the amount of local anaesthetic used thus compromising patient safety.
5. He carried out the operations with lack of due skill and care.
6. Following the completion of the operation, he discharged the complainants without proper assessment of their post-operative wellbeing.
7. Following the completion of the operation, he failed to respond to the post-operative concerns of the complainants including failing to see the patients when requested, and failing to act promptly to concerns expressed by them, thus compromising patient safety.
8. The particulars of the composite charge relate to the individual complaints by F, B, Lisa Clement, A, E, G and C.

Finding: The Tribunal dismissed the charge.

This charge was laid as an additional charge not an alternative charge. The Tribunal was concerned that what was proposed by the CAC was essentially charging Dr Chan twice in respect of the same incident. The Tribunal considered that *Duncan v MPDC* [1996] NZLR 513 did not provide that charges can be assessed on an individual basis and then again on a cumulative basis.

Penalty: The Tribunal ordered:

- Dr Chan be censured in relation to each of the seven guilty charges, fined \$15,000 and suspended for a total of 36 months being 12 months on each of the three professional misconduct charges. Each 12-month period to be served consecutively;
- following the 36-month suspension, Dr Chan practise medicine for the following three years only in accordance with the conditions below;
- that Dr Chan has a fully qualified anaesthetist present when he undertakes any surgical procedure;
- that Dr Chan is required to attend medical education courses on consent and patient and practice management at the direction of the Medical Council;
- Dr Chan pay 45% of the costs of investigation, prosecution and hearing of the charges;
- a report of the Tribunal's decisions on the charges be published in the New Zealand Medical Journal.

The full decisions relating to the case can be found on the Tribunal web site at www.mpdt.org.nz Reference No: 01/88C.