G.N. 5152

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF THE MEDICAL COUNCIL OF HONG KONG

DR KWAN HAU CHI VANESSA (REGISTRATION NO.: M15484)

It is hereby notified that after due inquiry held on 30 August 2022 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong ('Inquiry Panel') found Dr KWAN Hau Chi Vanessa (Registration No.: M15484) guilty of the following disciplinary charges:—

'That she, being a registered medical practitioner:—

(a) was convicted at the High Court on 23 August 2021 of the offence of manslaughter, which is offence punishable with imprisonment, contrary to section 7 of the Offences against the Persons Ordinance, Chapter 212, Laws of Hong Kong; and

(b) has been guilty of misconduct in a professional respect that she failed to report to the Medical Council the conviction mentioned in paragraph (a) above within 28 days of the conviction, contrary to section 29.1 of the Code of Professional Conduct published in January 2016.'

Dr KWAN's name has been included in the General Register from 17 July 2007 to the present and her name has never been included in the Specialist Register.

By a statutory declaration dated 12 October 2015, Madam Wong, mother of the late xxx, complained to the Medical Council against Dr KWAN in relation to the death of xxx following liposuction performed by Dr KWAN on 26 June 2014.

By a memo dated 26 May 2017, the Director of Health also brought to the attention of the Medical Council about the fatal case involving xxx and possible professional misconduct of Dr KWAN.

Dr KWAN was prosecuted and tried in the High Court with a jury of one count of manslaughter in Case No. HCCC 200/2018. After 27 days of trial, on 23 August 2021, Dr KWAN was convicted of manslaughter. On 4 October 2021, Dr KWAN was sentenced to six years' imprisonment.

By a letter dated 28 January 2022, Dr KWAN informed the Preliminary Investigation Committee of the Medical Council *inter alia* that she was sent to custody immediately after the criminal conviction and she was not aware of the need to notify the Medical Council of her conviction within 28 days.

There was no dispute that Dr KWAN had not reported her conviction to the Medical Council within the prescribed time limit of 28 days under section 29.1 of the Code of Professional Conduct published in January 2016 (the 'Code').

The Notice of Inquiry dated 15 July 2022 was successfully sent to Dr KWAN by registered post at her last known address at Lo Wu Correctional Institution.

By a reply letter dated 25 July 2022, Dr KWAN applied for an adjournment of the scheduled inquiry.

By a letter dated 8 August 2022, the Medical Council informed Dr KWAN that her application for adjournment of scheduled inquiry was rejected. Dr KWAN was told that the inquiry would be held as scheduled and she might wish to send in her written submission, if any, for consideration by the Inquiry Panel as soon as practicable.

By a letter dated 11 August 2022, the Medical Council informed Dr KWAN that she could furnish copies of all documents upon which she intended to rely at the hearing of the inquiry.

Up to the inquiry held on 30 August 2022, Dr KWAN did not submit any written submission for consideration by the Inquiry Panel.

There is no dispute that the offence of manslaughter was and still is punishable with imprisonment. By virtue of section 21(1) of the Medical Registration Ordinance ('MRO'), Chapter 161, Laws of Hong Kong, the disciplinary powers of the Inquiry Panel against the Defendant is engaged.

Section 21(3) of the MRO expressly provides that *'Nothing in this section shall be deemed to require an inquiry panel to inquire into the question whether the registered medical practitioner was properly convicted but the panel may consider any record of the case in which such conviction was recorded and any other evidence which may be available and is relevant as showing the nature and gravity of the offence.'*

The Inquiry Panel also noted from reading the Reasons for Sentence in HCCC 200/2018 ('Reasons for Sentence') by the trial judge that:—

'…

Overview

2. On 26 June 2014 xxx died following a procedure of liposuction performed by the defendant, a registered medical practitioner … xxx's death led to the prosecution of the defendant and subsequent conviction for gross negligence manslaughter.

The prosecution case

3. The prosecution's case was that the defendant as xxx's doctor owed a duty of care to xxx who was her patient. She was responsible for xxx's wellbeing, safety and life before, during and after the liposuction procedure. The prosecution alleged that the defendant breached her duty of care. Her failure in her duty of care amounted to gross negligence which substantially caused the death of xxx.

…

The defendant's breach of duty of care as framed in the indictment

6. There were five main particulars of breach as pleaded in the indictment

(ii) In breach of that duty of care, (the defendant) failed to take reasonable care for the safety of the said xxx, by:—

(a) Failing to ensure the presence of a properly qualified person to administer and monitor sedation when the said liposuction procedure was performed to the said xxx;

(b) Failing to ensure sufficient oxygen supply to the said xxx, during sedation;

(c) Failing to follow the paragraphs 3.3.1 to 3.3.3, 3.3.7, 3.4, 4, 5.1 to 5.3, 5.4.1.4 to 5.4.1.8, 7.3, 7.5, 10 and 11.2 of the "Guidelines on Procedural Sedation" of the Hong Kong Academy of Medicine endorsed by the Hong Kong Academy of Medicine Council on 22 December 2009 when she was responsible for conducting the liposuction procedure for the said xxx;

(d) Failing to provide the said xxx, with proper and sufficient monitoring after the liposuction procedure; and

(e) Failing to provide adequate timely resuscitation to the said xxx;

7. From the jury's verdict and the evidence at trial I shall sentence the defendant on the basis that the defendant had breached all the above five particulars and upon the fact that xxx was under deep sedation after the defendant administered her with a combination of sedative drugs save for a very short period when she came out of deep sedation during the procedure.

8. Apparent from the jury's verdict was that the defendant's failures fell far below the standard of a competent doctor. The inactions and actions of the defendant substantially caused the death of xxx. A reasonably competent doctor would have foreseen that the breach of her duties gave rise to a serious and obvious risk of death and her breach was so truly exceptionally bad and so reprehensible.

…

The defendant's culpability

58. In sentencing the defendant it is necessary for me to have regard to the defendant's culpability. The facts of this case are so serious as to warrant an immediate custodial sentence.

59. The prosecution experts, Dr Mainland, the anaesthesiologist, and Dr Chan Yu-wai, a specialist surgeon in plastic and reconstructive surgery expressed the view that the breach of duty in this case constituted a very serious departure from normal professional standards. These included amongst others, factors such as:—

(i) *no pre-surgery assessment of xxx's medical condition (such as a full work up of comorbidity associated with obesity given her weight) such assessment would have shown if xxx had an increased risk of cardiorespiratory compromise.*

(ii) *Lack of documentation and/or lack of records of necessary information. There was no record of a peri-operative interview with xxx regarding the nature of the surgery, the potential risk associated with the procedure.*

(iii) *The anaesthetic drug record was skeletal. There was an absence of detailed written records of the dosages of drugs, the time of administration or the route of administration.*

(iv) *There was no written record of the monitored variables (vital signs) from the Mindray monitor during or in the recovery phase of the procedure.*

(v) *There were no written records of the operation which should include the name of the person performing the operation, the site on the body where the surgery is being performed, the posture of xxx nor the amount of fat aspirated during the liposuction and how the wounds were sutured.*

(vi) *No supplemental oxygen was given despite the combination of sedative drugs administered, particularly the drug propofol.*

(vii) *There was no post-operative monitoring whatsoever. Once xxx was sutured the Mindray machine was detached whilst xxx was still under sedation and unconscious.*

(viii) *The defendant left xxx in the operating room with medically untrained assistants whilst xxx was still sedated and unconscious in a prone position after a procedure that lasted about 3 hours.*

60. I consider the following to be aggravating factors. Before the commencement of the surgery the defendant anticipated that xxx's respiratory condition could be compromised. At the beginning of the surgery at 1109 hours the defendant said:—

> *'Get the airway out just in case… She's the kind who can't breathe. I'm worried she will get tired when she's asleep.'*

Despite her expectation, the defendant did not ensure optimisation of xxx's airway or provide her with oxygen during the procedure. xxx's airway and oxygenation were not established or maintained. The airway was not used and no supplementary oxygen was administered.

61. The defendant understood that death was a risk of the procedure. She told that to xxx at the time xxx signed the consent form. Despite the acknowledgement of the risk of death, the defendant failed to monitor or assess xxx's vital signs during and after the procedure.

62. The defendant displayed a blatant and serious disregard to the wellbeing of xxx and to the valuable warning that xxx's life was at risk and in jeopardy. The Mindray machine was alarming throughout the procedure. The alarm was a crucial alert giving a clear and emphatic warning to the defendant that something was wrong with xxx. Even if the defendant believed the machine was 'too sensitive', she should have reset the machine or checked the reason why it was alarming. Her actions of silencing the alarm and ignoring it was shocking.

63. Appallingly, the defendant left xxx in the hands of medically untrained assistants when she knew that xxx was sedated and not awake or conscious. I would be so bold as to suggest that no patient would have opted for this surgery if they were told by their doctor prior to the surgery, 'after the operation I will leave you in the care of my medically untrained assistants who are beauticians and receptionists whilst you are still sedated and unconscious.' No doctor let alone a person in their right mind would have expected a doctor to leave xxx when she was not awake. Obviously the defendant should have waited until xxx was completely awake from her sedation and stable before departing. It remains a mystery as to what the defendant's engagement was. The defendant's conduct in leaving when she did can only be catergorised as deplorable.

64. Mr Leung's submission that defendant was likely under a false sense of security that no adverse events would arise given the previous uneventful liposuction, using similar sedative medication performed on xxx is unsound. If on the previous occasion what the defendant did was the same or similar to this occasion it was perhaps purely fortuitous that a fatal or serious outcome did not follow. The fact that something is done erroneously previously and nothing adverse happened does not make it right.

65. The defendant was the only medically trained person in the operation room. The surgical procedure lasted for about 3 hours. As Dr Chan stated the defendant's concentration would be on the surgery as the surgeon, she would therefore be unable to properly monitor xxx's vital signs.

The defendant had lost all rational verbal communication and response with xxx as she was deeply sedated. With no other properly qualified person to administer and monitor xxx's sedation, this was a risky situation that should never have arisen. Although I assume, the defendant may have tried to have kept the costs of the procedure down for xxx this was done wholly to the detriment of xxx.

66. Taking all the above considerations I have mentioned into account, I consider these were immense failings in the defendant's duty commencing at the outset until the tragic end. The whole scenario from beginning to end was a dangerous one. The defendant's conduct in carrying out this procedure as found by the jury fell far below the standard of care incumbent on her and was so truly exceptionally bad. The jury found that the defendant's breach of her duties gave rise to a serious and obvious risk of death and that they substantially caused the death of xxx.

67. xxx placed her life into the defendant's hands. The defendant turned a blind eye to the hazards of the situation. She disregarded the need to attend to xxx's airway and provide her with supplementary oxygen when she administered the combination of sedative drugs. She ignored and silenced the alarm on the Mindray. Critically the defendant left xxx in the hands of assistants who were not trained in resuscitation nor were they able to recognise any deterioration in xxx's condition.

68. xxx was a vulnerable patient because of her obesity and the nature of her surgery whilst lying prone. xxx understandably trusted and relied on the expertise and competence of her friend, the defendant who failed her miserably. The defendant displayed a casual, carefree approach to this invasive procedure performed under deep sedation.

69. The defendant's conduct fell so far short of what could reasonably have been expected of her that such conduct was so exceptionally bad such that the jury found her conduct required criminal punishment. This was an abysmal failure of her duty of care incumbent on her and showed such high disregard to the life and safety of xxx.

…'

The Inquiry Panel was entitled in law to treat the aforesaid conviction as conclusively proven against Dr KWAN. Accordingly, the Inquiry Panel found Dr KWAN guilty of the disciplinary charge (a).

There was no dispute that Dr KWAN failed to report to the Medical Council her conviction within the prescribed time limit of 28 days, contrary to section 29.1 of the 'Code'. Failure to report within the specified time by itself is a ground for disciplinary action.

The Inquiry Panel found it inexcusable for Dr KWAN not to report her conviction to the Medical Council within the prescribed time limit of 28 days. In the view of the Inquiry Panel, Dr KWAN's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr KWAN guilty of the disciplinary charge (b).

The Inquiry Panel emphasized that the primary purpose of a disciplinary order is not to punish Dr KWAN for the criminal offence for a second time but to protect the public from persons who are unfit to practice medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation. In the view of the Inquiry Panel, the breach of duty in that case constituted a very serious departure from normal professional standards. The Inquiry Panel opined that Dr KWAN was not only grossly negligent and there was an abysmal failure of her duty of care, but also unethical in all respects.

Manslaughter is no doubt one of the most serious crimes and Dr KWAN had brought the medical profession into disrepute. It is essential in the view of the Inquiry Panel to maintain amongst members of the public a well-founded confidence that any registered medical practitioner whom they consult will be a person of unquestionable integrity, probity and trustworthiness. Any person who lacks any of these essential attributes can hardly be a fit and proper person to practice medicine. There is no doubt in the mind of the Inquiry Panel that Dr KWAN is unfit to be a member of the medical profession.

Taking into consideration the nature and gravity of the case and the mitigation advanced before the trial judge in the Reasons for Sentence, the Inquiry Panel ordered in respect of charge (a) that Dr KWAN's name be removed from the General Register indefinitely and the operation of the removal order would take immediate effect upon publication in the *Gazette* pursuant to section 21(1)(iva) of the Medical Registration Ordinance. In respect of charge (b), the Inquiry Panel further ordered that a warning letter be issued to Dr KWAN.

Pursuant to the Inquiry Panel's orders, Dr KWAN's name has been removed from the General Register on 16 September 2022.

The orders are published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Inquiry Panel of the Medical Council is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*