PROFESSIONAL STANDARDS COMMITTEE INQUIRY

Constituted under Part 8 of *the Health Practitioner Regulation National Law (NSW)*
to hold an Inquiry into a Complaint in relation to:

Dr Christopher Tien Yen Chee
MED0001191463

Date/s of Inquiry:	12 & 13 October 2017
Committee members:	Ms Diane Robinson, Chairperson Dr Celalettin Varol Dr Mauro Vicaretti Ms Jennifer Houen
Appearance for Health Care Complaints Commission:	Ms Emma Bayley
Appearance for Dr Christopher Tien Yen Chee:	Ms Christine Melis, instructed by Ms Louise Watson from Meridian Lawyers
Date of decision:	4 December 2017
Decision	The Committee finds Dr Christopher Chee guilty of unsatisfactory professional conduct and determines to reprimand him and impose conditions on his registration
Publication of decision:	Refer to paragraph 112 of this decision for details of non-publication directions

REASONS FOR DECISION

THE COMPLAINT

1. Dr Chee is a specialist urologist practising in Port Macquarie. In November 2013 he performed a radical left nephrectomy on a 69 year old woman which resulted not only in the removal of her left kidney, but also in the occlusion of her right renal artery and consequent loss of function in her right kidney.

2. On 24 June 2014 Dr Chee notified the Australian Health Practitioner Regulation Agency (AHPRA) that Port Macquarie Private Hospital had restricted his ability to perform nephrectomies and that Port Macquarie Base Hospital had arranged for a review of his laparoscopic nephrectomy cases.

3. That notification was forwarded to the Health Care Complaints Commission (the Commission) and the Medical Council of New South Wales (the Council).

4. On 24 March 2017 a Complaint was made by the Commission, alleging that Dr Chee was guilty of unsatisfactory professional conduct. That Complaint is now being prosecuted before this Professional Standards Committee.

5. In summary, the Complaint alleges that Dr Chee, in performing a left nephrectomy, incorrectly clipped the right renal artery and failed to recognise the damage caused to the right renal artery. It is also alleges that after he converted from a laparoscopic to an open procedure, as a result of continued heavy bleeding, he failed to check the patient's vascular anatomy, failed to consider the possibility of a vascular disaster or call for assistance from a vascular surgeon.

6. The Complaint contains 4 Particulars and is set out in full in Annexure A to this decision.

LEGISLATIVE PROVISIONS

7. Unsatisfactory professional conduct is defined in section 139B of the *Health Practitioner Regulation National Law NSW* (National Law (NSW)), as, amongst other things, conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

8. Section 139B of the National Law (NSW) and other relevant legislative provisions are set out in Annexure B to this decision.

STANDARD OF PROOF

9. The Commission bears the onus of establishing that Dr Chee is guilty of unsatisfactory professional conduct.

10. The standard of proof required to establish the Complaint is the civil standard so the Committee must be reasonably satisfied on the balance of probabilities of the matters alleged against Dr Chee. Given the seriousness of the allegations and the nature of their consequences, the Committee needs to be comfortably satisfied that the Complaints have been established on the Briginshaw principles (see *Briginshaw v Briginshaw* (1938) 60 CLR 336).

PRELIMINARY MATTERS

Documents

11. The Committee has considered the documents provided by the parties.

12. The Commission provided two volumes of documents tabbed 1 to 51. The Commission also provided a chronology for the assistance of the Committee. Dr Chee provided a statement dated 7 September 2017 and his Curriculum Vitae. At the commencement of the proceedings he also provided two references.

Admissions

13. Dr Chee denied that he is guilty of unsatisfactory professional conduct but made some admissions in relation to the factual aspects of the Complaint.

Non-publication orders

14. A non-publication direction, in relation to the patient referred to as Patient A in the Complaint, was made preventing the publication of the name, address and any information which might identify Patient A.

Witnesses

15. The following people gave evidence to the Committee:
    - Dr Chee, the Respondent
    - Dr Hayden, urologist and expert witness for the Commission.

Disclosure

16. On the second day of the hearing the Committee disclosed that one of its members had had a brief, private conversation that morning with a medical practitioner who is the author of a document in evidence before the Committee. A hypothetical scenario similar to the Complaint concerning Dr Chee was discussed. The substance of this conversation was disclosed, as were details of the professional relationship between the Committee member and the medical practitioner.

    The Committee gave the parties time to consider these disclosures,

take instructions and make any applications considered appropriate. The Committee also made a formal direction that any information disclosed by the Committee member would not be regarded as part of the evidence or taken into account in the Committee's deliberations.

No formal applications were made concerning this issue.

ISSUES

17. The issues to be determined by this Committee are:

    a. Which, if any, of the Particulars of the Complaints are proven to the comfortable satisfaction of the Committee.

    b. Whether the proven conduct overall amounts to unsatisfactory professional conduct. The Committee can look at all the conduct found proven either separately or cumulatively when making a determination as to whether the conduct amounts to unsatisfactory professional conduct (*Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 at 545, 546 and 547).

    c. If such a finding is made the Committee must decide whether orders or directions made pursuant to Part 8 Division 3 Sub-division 3 of the National Law are appropriate.

BACKGROUND

Dr Chee

18. Dr Chee graduated MB BS from the University of Nottingham in 1990 and between 1990 and 1991 worked in hospitals in Nottingham and Mansfield in the United Kingdom. He then worked in Singapore as a medical officer for the military (1992-1993), a surgery Resident (1994-1997), a urology Registrar (1997- 2001) and Associate Consultant (2001- 2002).

19. Dr Chee had a postgraduate urology fellowship at Westmead Hospital, Sydney between May 2002 and June 2003, after which he again worked in urology in Singapore and also Malaysia.

20. He moved to Australia in 2006 and practised as Senior Staff Specialist at Dubbo Base Hospital until 2009 when he took up his current position as a VMO at Port Macquarie Base Hospital. He also works at Port Macquarie Private Hospital, Kempsey District Hospital and Wagga Wagga. He has private consulting rooms in Port Macquarie.

21. Dr Chee obtained a Fellowship of the Royal College of Surgeons (Edinburgh) in 1996 and became a Fellow of the Royal Australasian College of Surgery (Urology) in 2007. He was first registered to practice medicine in NSW on 22 April 2002 and he is currently

registered as a specialist urologist, without conditions on his registration.

Patient A

22. Patient A was referred to Dr Chee by her gynaecologist, who in managing a pelvic organ prolapse made an incidental finding of a solid left kidney lesion on pelvic ultrasound.

23. Patient A consulted Dr Chee in October 2013 for management of the suspicious left kidney lesion. Her right kidney appeared normal and it was thought that she likely had a left renal cell carcinoma. Dr Chee recommended that Patient A undergo a laparoscopic radical left nephrectomy and she was admitted to Port Macquarie Private Hospital to undergo this procedure on 19 November 2013.

24. During the laparoscopic procedure the patient experienced excessive bleeding. She lost 7.6 litres of blood. The laparoscopic procedure was converted to an open procedure. The left kidney was removed and Patient A was transferred to a high dependency unit.

25. Post-operatively an occlusion to Patient A's right kidney renal artery was discovered. Attempts were made to manage the right kidney occlusion in Port Macquarie and in Sydney but without success. Patient A now requires permanent haemodialysis.

EVIDENCE

26. The Committee heard evidence from Dr Chee and from Dr Hayden, a specialist urologist and past President of the Urological Society of Australia and New Zealand.

27. The Committee will deal with the evidence relating to the Particulars as they reflect the chronology of the surgery and then with the additional evidence provided by Dr Chee.

Particular 3

During the procedure, the practitioner incorrectly clipped the right renal artery instead of the left renal artery because he:

a. *did not do an appropriate anatomical dissection to identify the left renal artery as he did not fully dissect the colon off the kidney and push the colon, pancreas and duodenum medially; and*

b. *dissected the left kidney superiorly by tracing the gonadal vein to the left renal vein which resulted in the incorrect artery being identified as the aorta was more towards the left than usual.*

28. Dr Chee accepts he did incorrectly clip the right renal artery. In his written statement he says,

"*I did consider at the time that the operative field exposure had been extensive and adequate. However, despite the full exposure as per training and normal urological laparoscopic method, the incorrect artery was clipped and I have acknowledged from the outset that this was an error on my part."*

29. Dr Chee disagrees with the reasons put forward in Particular 3. In his oral evidence he gave a detailed description of his technique during the surgery. Dr Chee says he did dissect the colon off the kidney and push the colon and pancreas medially. He says that the renal vein is the landmark to find the renal artery and that he used the gonadal vein to locate the renal vein. He found the junction of the gonadal vein and renal vein and behind that junction is the renal artery.

30. It is alleged that he identified the wrong artery, as the aorta was more towards the left than usual, however Dr Chee says at the time of the surgery he was not aware of the unusual position of the aorta. In his oral evidence Dr Chee said that on reflection he considered that the patient's age and the bend in her spine caused by scoliosis may have resulted in the aorta being pushed to the left. So despite using standard techniques, an error occurred because of the patient's anatomy. Dr Chee's position is that this was an accident that could happen to anyone.

31. Dr Hayden states,

> *"It is hard to understand how an operation to remove a left kidney could have resulted in ligation of the artery to the right kidney…… my conclusion is that he did not adequately expose the anatomy and did not recognise where the vessels were at that time of the procedure. As such I disagree with his conclusion that this is something which could have occurred even in the most experienced hands."*

32. In his supplementary report dated 3 October 2017, Dr Hayden considers that an unusual gap between the aorta and the inferior vena cava may have led Dr Chee to more easily find an artery. However, he continues.

> *"Having identified an artery was only the first step. It was absolutely mandatory that the identity of the artery be completely identified and there are a number of dissection techniques available to confirm the correct anatomy and that must always be done before any irreversible step such as applying clips are attempted…….. once Dr Chee had exposed an artery which he assumed was the left renal artery he did not take the appropriate and absolutely necessary steps to determine its exact nature…."*

33. Dr Hayden said that at this early stage of the procedure there were no complications, such as excessive bleeding and Dr Chee had time to do a complete dissection. He considers that Dr Chee was obligated to understand and confirm the nature and origin of the artery he was clipping regardless of issues with the individual patient's anatomy.

34. His view is that Dr Chee's dissection was not appropriate or adequate. Dr Chee found an artery but failed to trace it to its origin, to the junction with the aorta, so failed to identify it as the right renal artery.

35. Dr Chee disagrees with Dr Hayden's view that the artery must be traced to its origin at the aorta, but says he accepts Dr Hayden's advice about the need for further dissection and will follow this advice in the future.

Particular 2

The practitioner failed to consider that the extensive bleeding could have been a result of a possible vascular disaster and failed to call a vascular surgeon to come into the operating theatre.

36. Dr Chee denies Particular 2.

37. In his letter to Dr King dated 24 January 2014 and his letter to the Commission dated 28 September 2017, Dr Chee acknowledged that he could not achieve control of the operative bleeding laparoscopically, and he was concerned about the possibility of cardiac arrest if the bleeding was not promptly controlled. Patient A required blood transfusion. *"Intra-operative blood loss required 10 unit PCT transfusion (8 units of packed cells and 2 units fresh frozen plasma), with platelets (1 unit.)"*

38. Dr Chee's written statement, dated 7 September 2017, does not directly address the question of whether he considered the extensive bleeding to represent a possible vascular disaster. Dr Chee told the Committee that he did not think the clips had caused the bleeding. He considered the possibility of a tear to a lumbar vein but he could not identify the actual source of the bleeding. He does acknowledge there was an urgent need to stabilise the patient, her blood pressure was low and she required fast fluid resuscitation by the anaesthetist. He also believed it was appropriate to take immediate steps to control the bleeding, which he did by converting to an open procedure.

39. In questioning Dr Hayden, counsel for Dr Chee suggested that there is a distinction between a vascular disaster and a massive bleed, based on the nature of the bleeding. Dr Hayden agreed, although he also stated that the volume of blood loss is a factor. Dr Chee questions whether there was a vascular disaster as he was able to control Patient A's bleeding.

40. Although Dr Chee denies Particular 2, he does not assert that he did in fact call a vascular surgeon.

41. Dr Chee states that it would not have been correct to hold back on any urgent steps to wait for a vascular surgeon to arrive, particularly as there was no certainty that one would be available. He says he did turn his mind to the availability of a vascular surgeon, but knew there was no vascular surgeon in the private hospital and *"the two vascular surgeons in Port Macquarie might have been either in their rooms, or operating across town in the Base Hospital."*

42. As to the need for a vascular surgeon, Dr Hayden initially gave evidence that there was extensive bleeding and the origins of that bleeding remained unknown. He considered that with unexplained and uncontrolled bleeding a vascular surgeon is needed to assess the situation. He did not consider that a general abdominal surgeon would be as well qualified as a vascular surgeon to do this.

43. In cross-examination Dr Hayden conceded that as the bleeding was controlled, a vascular surgeon may not have been required in the early stages of the operation. However, he believes that a vascular surgeon was needed later in the procedure when the possibility of damage to the right renal artery was raised by the absence of clips in the kidney specimen. He said a vascular surgeon is the best person to deal with any occlusion or need for revascularisation.

44. Dr Chee said that at the time he decided to convert from a laparoscopic to an open procedure he called for assistance from Dr Peck, a senior general abdominal surgeon, who was in an adjacent operating theatre. In his oral evidence Dr Chee said that Dr Peck arrived about 15 to 20 minutes after he was called. However, he also said that when Dr Peck attended the bleeding had been controlled, the left kidney removed and Dr Peck inspected the anatomy of the retroperitoneum and was satisfied nothing more needed to be done. He did not scrub in but observed the final stage of the procedure.

Particular 1

After the practitioner converted to open surgery and stopped the bleeding, the practitioner failed to appropriately check the vascular anatomy, particularly the left renal artery, in that he failed to expose the aorta in more detail in circumstances where he was aware of the anatomical abnormality relating to the right kidney.

45. In his statement dated 7 September 2017, Dr Chee says:

> *"After I had converted to the open surgery and stopped the bleeding, I inspected the renal bed and isolated and oversewed the left renal artery. There are risks associated with exposing the aorta and it is not, in practice, usually done. At the time, I*

considered I had appropriately identified the left renal artery and was not aware of any anatomical abnormality."

Was Dr Chee aware of an anatomical abnormality relating to the right kidney?

46. Dr Chee's letter to Dr Michael King dated 24 January 2014 and his letter to the Commission via DibbsBarker, solicitors, dated 28 September 2015 both state,

> *"Dr Chee met with Dr Nolan to discuss the CT findings. Dr Nolan thought the left renal tumour exhibited deep extension near the upper and mid pole calyxes. No clear margin of the tumour could be found. The left kidney was also supplied by a single renal artery. Dr Nolan also considered that the right kidney and aorta were a little more to the left of the body, with vessels splaying out. Dr Chee was conscious that these organs and vessels may come into the field of surgical dissection for the left kidney, and that this may cause difficulty in isolating vessels intra-operatively."*

47. The Commission's documents contain a file note, dated 20 July 2016, which records a telephone conversation between Ms Geraldine Holmes of the Commission and Dr Nolan. Dr Nolan advised he had no recollection of the matter concerning Dr Chee and Patient A. Ms Holmes informed Dr Nolan of Dr Chee's correspondence with the Commission, including his assertion that "*Dr Nolan also considered that the right kidney and aorta were a little more to the left of the body, with vessels splaying out".*

48. Dr Nolan's response was recorded as follows:

> *"Dr Nolan advised that this is quite significant information and that if this was his opinion it would have been noted in his addendum dated 22 October 2013. Dr Nolan further advised that if he had determined that the 'vessels were splaying out' as Dr Chee had stated, it would have been written in different terminology as he did not report using this type of language.*
>
> *Dr Nolan …….was very confident that had he found abnormalities during his assessment of a patient such as this, it would most certainly have been contained in the addendum to the radiology report."*

49. As noted above, in his written statement dated 7 September 2017, Dr Chee states,

> *"On reflection I do not think that I was aware of any anatomical abnormality prior to the surgery."*

50. When asked about this change in his evidence, Dr Chee said that the anatomical abnormality was something he reflected on after the event rather than something Dr Nolan told him about. He said he spent a lot of time, after the operation, thinking about what happened and he confused his post-operative reflection with his preoperative discussion with Dr Nolan. Dr Chee stated that he went into the surgery without knowledge of any aberrant vascular anatomy. He said he thought the aorta was in the usual position and if he had been aware that the vessels were splaying out he would have performed a wider dissection.

Did Dr Chee fail to appropriately check the vascular anatomy?

51. Dr Hayden says after the bleeding had been stopped there was an opportunity for further dissection and, whether or not Dr Chee was aware of any anatomical abnormality, the key thing was to identify the artery carefully and correctly. This was not possible when the bleeding was extensive, but after he converted to an open procedure, he could do so. If he had found the left renal artery or the aorta he would have had the opportunity to save the right kidney.

52. When asked about the need to dissect to the origin of the artery and expose the aorta, Dr Chee said that this was a technique known to him and he had used it on some occasions, however he generally follows the approach he learnt from Professor Lau, which is based on identifying various anatomical landmarks. He said that once the landmarks are located then tracing to the origin of the aorta is not required. However in cross-examination he acknowledged that there can always be anatomical aberrations, given the individual differences between patients and taking the additional step of tracking the aorta can be useful.

53. In cross-examination Dr Chee also explained that there is a change in the view of anatomy when a laparoscopic procedure is converted to an open procedure and while he did not consider that there might be a problem with the right renal artery, he conceded that additional surgical exploration would have allowed him to eliminate such a possibility.

Particular 4

The practitioner failed to recognise and/or consider the damage caused to the right renal artery in that he did not contemplate that the right renal artery had been obstructed by the surgical procedure and presumed the extensive bleeding was related to damage to the left renal artery or nearby vessels.

54. In his written statement, in response to this Particular, Dr Chee addressed his conduct in assessing Patient A post-operatively. He acknowledged there was a delay in the discovery of damage to her right renal artery and outlined the steps he took to consider and investigate that possibility.

55. At the commencement of the proceedings it was clarified between the parties that the Complaint in relation to Dr Chee, including Particular 4, relates to his conduct during the surgery. In his oral evidence Dr Chee acknowledged that during the surgery he was not aware that he had clipped the right renal artery. He said he did not contemplate damage to the right renal artery. He did not think of it, as in his mind he was operating on the left side.

56. Dr Hayden stated that when Dr Chee removed the left kidney and found no clips, he should have put his mind to the question of a possible error. Dr Hayden said that checking the specimen would have been a quick and easy thing to do and failing to find the clips in the specimen would have prompted Dr Chee to investigate further.

57. Dr Chee acknowledged that after he removed the left kidney he did not check it for clips. He assumed the clips were in the specimen, but he did not check to confirm. He told the delegates he did not turn his mind to this issue.

Dr Chee's evidence

Current practice

58. Dr Chee said he works with two other urologists in Port Macquarie, Dr Rashid and Dr Awad. Dr Chee initially told the delegates that he worked in the same clinic as Dr Rashid and Dr Awad, however later in his evidence he stated that in January 2017 he moved into his own rooms opposite the Private Hospital. He said that a fourth urologist has recently come to Port Macquarie. Dr Rashid owns his consulting rooms and wishes to guide the new doctor so the new urologist has moved into the premises with Dr Rashid and Dr Awad and Dr Chee has moved out. Dr Chee is now in solo practice. He says he does see colleagues at hospital meetings and there is also telephone contact.

59. Dr Chee told the delegates that he has a general urological practice. Dr Chee sees patients, referred by general practitioners or other specialists, who have kidney stones, prostate enlargement, bladder control issues and malignancy. He operates on Monday and Thursdays at the Base Hospital, on Tuesdays at Port Macquarie Private Hospital and on some Fridays he has a list at Kempsey or Wagga Wagga. He consults on Monday afternoons, Wednesdays and some Friday mornings. He also teaches medical students on Friday afternoons.

60. Despite no longer having restrictions on his scope of practice Dr Chee has not performed any unsupervised nephrectomies since treating Patient A. He stated he made the decision not to undertake those surgeries until these proceedings are finalised.

61. Dr Chee said he has good collegiate relationships with other doctors in Port Macquarie and is able to ask for assistance when needed. He does not consider himself to be professionally isolated. At the Base

Hospital he is involved in regular multidisciplinary team meetings, once a fortnight, and intra-departmental X-ray meetings, once a fortnight. He now also attends Mortality and Morbidity meetings once every three months.

Review and supervised training

62. After the procedure concerning Patient A Dr Chee ceased performing nephrectomies at Port Macquarie Private Hospital and agreed to undergo supervision of his laparoscopic nephrectomy technique. In addition Port Macquarie Base Hospital arranged for a review of his previous laparoscopic nephrectomy cases and Dr Chee voluntarily agreed not to perform laparoscopic nephrectomies at the Base Hospital.

63. The Director of Medical Services with the Mid North Coast Local Health District arranged, through the Urological Society of Australia and New Zealand, for two urologists to perform a clinical review of Dr Chee's surgical practice and provide recommendations as to his scope of practice, with particular reference to laparoscopic nephrectomy.

64. The relevant recommendations from this review are as follows:
    - "*Dr Chee to immediately commence an audit of all his surgical activities*
    - *Laparoscopic partial nephrectomy - we would recommend that he not be credentialed to do this operation at the stage*
    - *Laparoscopic nephrectomy - our recommendations would be that his privileges continue to be withdrawn for this operation until he has successfully completed mentorship training*"

65. In relation to the last recommendation it was proposed that a minimum of 10 cases be performed by Dr Chee and be observed by an experienced laparoscopic surgeon.

66. Dr Chee undertook some training with Professor Howard Lau in February 2016. He provided a report from Professor Lau confirming that he had completed a period of observation and supervision of laparoscopic renal surgery. Professor Lau's letter stated that Dr Chee has visited Professor Lau's unit and observed a number of laparoscopic renal surgeries.

67. Dr Chee told the delegates that he had assisted Professor Lau in five cases - two radical nephrectomies and three partial nephrectomies. On 8 January 2016 Professor Lau observed Dr Chee performing one procedure - a laparoscopic nephroureterectomy at Port Macquarie Base Hospital. Professor Lau's letter stated that he believes Dr Chee can perform this operation safely.

68. Dr Chee said that although it had been proposed that he perform a minimum of 10 cases while observed by an experienced mentor, after

discussion with the hospital the number of such cases was to be left to the mentor to decide.

69. By April 2016, on the basis of Professor Lau's recommendations, Dr Chee's scope of practice was no longer restricted at either Port Macquarie Private Hospital or the Base Hospital.

Future plans

70. Dr Chee told the Committee that he felt shocked and remorseful when he heard about Patient A's devastating injury. He said Patient A is still his patient and he has assisted her with support and coordinating dialysis.

71. Dr Chee said his confidence had been negatively affected after the surgery on Patient A. In addition he has not performed any laparoscopic nephrectomies since that time. Dr Chee told delegates that since commencing work at Port Macquarie in 2009 he has performed approximately 14 laparoscopic nephrectomies and prior to that maybe 5 or 6 while working in Dubbo. He also believes that referrals for laparoscopic nephrectomy are declining.

72. Dr Chee acknowledged that the number of nephrectomies he has performed is low, and he stated that he did not feel confident about performing a laparoscopic nephrectomy at this time. However, he would like to maintain his skills and ability to perform laparoscopic nephrectomy in the future. He believes to regain and then maintain his skills he should perform at least one surgery per month with the assistance of a senior laparoscopic surgeon. He felt that having a formal mentoring arrangement would be helpful to him.

References

73. The delegates note that Dr Chee provided two references. One is from Dr Bruce Hodge, a colorectal surgeon in Port Macquarie and the other is from Dr Alison Burke, a specialist anaesthetist, who has worked with Dr Chee in Port Macquarie.

Which, if any, of the Particulars of the Complaints are proven to the comfortable satisfaction of the Committee?

74. The Committee is comfortably satisfied that all of the Particulars of the Complaint are proven.

75. Dr Chee admits that he incorrectly clipped the right renal artery. Although he may have dissected the colon off the kidney and pushed the colon and pancreas medially, he did not do an appropriate anatomical dissection to identify the correct artery. Further dissection was needed and he did not take the necessary steps to properly identify the artery he was clipping. The Committee considers Particular 3 is proven.

76. After clipping the artery Patient A experienced bleeding and, regardless of any semantic distinction between a vascular emergency and a massive bleed, it is clear that the source of the bleeding was not determined and there was significant blood loss (7.6 litres of blood). In circumstances where there is unexpected, unexplained and extensive bleeding, consideration should have been given to the possibility of a vascular emergency. Dr Chee felt that the bleeding was significant enough to warrant converting to an open procedure, but he did not call a vascular surgeon.

77. Dr Chee asserts that it was practical and logical in the circumstances to call for help from Dr Peck, especially when the attendance of the vascular surgeon could not be guaranteed. However, the evidence does not establish that Dr Chee was certain a vascular surgeon was unavailable. It would have been reasonable to explore this possibility and ascertain if a vascular surgeon was in rooms and could attend.

78. In any event, regardless of the involvement of Dr Peck, Dr Chee did not call a vascular surgeon, at any time, during the procedure and the Committee is satisfied that Particular 2 is proven.

79. Particular 1 gives rise to the question of whether Dr Chee knew Patient A had an anatomical abnormality? Inspection of Patient A's CT scan alone is unlikely to have alerted Dr Chee to this. It is either the case that he was aware of this situation because of a conversation with Dr Nolan prior to the surgery or that he reflected on this possibility as a result of discussions with colleagues after the event.

80. Dr Chee wrote to Dr King in January 2014, only two months after the surgery, and asserted that he was aware of an anatomical abnormality, but Dr Nolan's evidence supports Dr Chee's later assertion that he was not aware of any abnormality when the surgery was performed.

81. It is difficult for the Committee to form a clear view on this matter, however, regardless of whether Dr Chee was aware of any anatomical issues for Patient A, it was incumbent on him to correctly identify the right renal artery. If excessive bleeding prevented this during the laparoscopic procedure, then when he converted to the open procedure he had another opportunity to check the vascular anatomy, but again failed to do so in an appropriate or thorough way.

82. Finally, Dr Chee has acknowledged that he did not consider damage to the right renal artery during the surgery and on the basis of his evidence, the Committee is satisfied that Particular 4 is proven.

Does the proven conduct amount to unsatisfactory professional conduct?

83. Unsatisfactory professional conduct in respect to this Complaint requires consideration of whether Dr Chee has engaged in conduct

that demonstrates the knowledge or skill he exercised, in his practice of medicine, is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

84. Dr Chee is an experienced specialist urologist. He has undertaken extensive training in urology and is a Fellow of the Royal Australasian College of Surgery (Urology).

85. It is Dr Chee's professional conduct, during the surgery on Patient A, which is the subject of this Complaint. Put simply, Dr Chee should have done more before applying clips to Patient A's artery. He should have performed further dissection and tracing so as to correctly identify the artery being clipped.

86. When bleeding occurred to a degree that required conversion to an open procedure and significant blood transfusion, Dr Chee should have considered the possibility of a vascular emergency and sought appropriate assistance.

87. After converting to an open procedure and stopping the bleeding there was a further opportunity to check that the correct artery had been clipped, but Dr Chee again failed to recognise or contemplate that he had damaged the right renal artery.

88. Dr Hayden expressed the view that Dr Chee's conduct was significantly below the appropriate standard and the Committee agrees with Dr Hayden's assessment, noted above,

> *"It is hard to understand how an operation to remove a left kidney could have resulted in ligation of the artery to the right kidney…… my conclusion is that he did not adequately expose the anatomy and did not recognise where the vessels were at that time of the procedure. As such I disagree with his conclusion that this is something which could have occurred even in the most experienced hands."*

89. The Committee is satisfied that Dr Chee's conduct, considered as a whole, amounts to unsatisfactory professional conduct.

Are orders or directions pursuant to the National Law appropriate and if so, what should they be?

General considerations

90. It is well established that the jurisdiction exercised by a Professional Standards Committee is protective, not punitive. Disciplinary proceedings against members of a profession are intended to maintain proper professional standards, primarily for the protection of the public but also for the protection of the profession. (Health Care Complaints Commission v Litchfield (1997) 41 NSWLR 630).

91. The Committee also has a role in maintaining public confidence in the profession, and maintaining the reputation of the profession and orders of the Committee may operate to have a general deterrent effect for other members of the profession. (Prakash v Health Care Complaints Commission [2006] NSWCA 153).

92. In relation to the relevant protective orders to be made, the Committee notes that the powers available to it in this regard are set out in section146 (B) of the National Law which provides as follows:

A Committee may do one or more of the following:

a. *caution or reprimand the practitioner;*

b. *direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;*

c. *order that the practitioner seek and undergo medical or psychiatric treatment or counselling;*

d. *order that the practitioner complete an educational course specified by the Committee;*

e. *order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;*

f. *order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.*

Submissions

93. The Commission submits that Dr Chee should be reprimanded, be subject to a formal mentoring arrangement and not perform radical laparoscopic nephrectomy except under supervision for the next 12 months.

94. The Respondent submits that, if the Committee finds unsatisfactory professional conduct, a caution rather than reprimand is appropriate based on the fact that Dr Chee has been honest, forthright and contrite throughout the investigation and proceedings.

95. While noting that Dr Chee is open to mentoring, it is also submitted that requiring direct supervision of his performance of laparoscopic nephrectomy is not necessary as he has already successfully undergone a process of supervision and review to the satisfaction of both Port Macquarie Private Hospital and Port Macquarie Base Hospital.

Reprimand

96. The Committee accepts that Dr Chee has demonstrated remorse for his actions. He has apologised to Patient A and has seriously reflected on his professional conduct. Counsel for Dr Chee urged the Committee to regard him as a sincere, honest and insightful practitioner who was a credible and reliable witness.

97. However, the Committee does note that Dr Chee changed several aspects of his evidence about Patient A's surgery over time. The Committee also notes that Dr Chee gave contradictory evidence about his current practice and it would appear that his initial comments to the Committee on this matter were not truthful.

98. More importantly, the Committee considers that the nature and seriousness of Dr Chee's unsatisfactory professional conduct warrants a reprimand rather than a mere caution. This is appropriate both as a specific deterrent for Dr Chee and as a general deterrent in relation to other members of the profession.

Mentoring

99. The Committee accepts that mentoring conditions will serve to support Dr Chee, both personally and professionally and in doing so will operate to promote the health and safety of the public.

100. The Committee also notes that Dr Chee does not oppose a mentoring arrangement.

101. The Committee considers that an intensive mentoring program involving monthly meetings and monthly reporting should be in place for at least the first 12 months of mentoring.

Supervised practice

102. Dr Chee has himself recognised that he should not independently undertake laparoscopic nephrectomy at the present moment. The Committee concurs with him on this matter. The low number of nephrectomies which he has performed since practising in New South Wales combined with the fact that he has not undertaken any such procedures since operating on Patient A in November 2013, means it would be inappropriate for him to commence performing these procedures without retraining and supervision.

103. The Committee considers that Dr Chee should be subject to direct Category A supervision in relation to aspects of his surgical practice. This supervision should continue until Dr Chee can demonstrate that he has the satisfactory skills to perform laparoscopic nephrectomy independently. The Committee considers that he should successfully perform at least 10 such operations in any 12 month period prior to consideration being given to the amendment or removal of this condition.

DETERMINATION

104. The Committee finds Particulars 1, 2, 3 and 4 of the Complaint proven and finds that Dr Chee's proven conduct amounts to unsatisfactory professional conduct within the meaning of section139B (1)(a) of the National Law (NSW).

REPRIMAND

Dr Chee is hereby reprimanded.

ORDERS

The following conditions are imposed on Dr Chee's registration:

1. To nominate a registered experienced specialist urologist to act as his professional mentor for approval by Medical Council of NSW in accordance with the Medical Council of NSW's Compliance Policy – Mentoring (as varied from time to time) and as subsequently determined by the appropriate review body.

    a) To meet with his mentor monthly and authorise the mentor to report, in an approved format, to the Council every month about the fact of contact, and to inform the Council if there is any concern about his professional conduct, or personal wellbeing.

    b) At each meeting the practitioner is to include discussion of the following:

        i) his personal and professional development;

        ii) medical practice issues, including the issues highlighted in this decision, in particular identifying renal veins and arteries, seeking intraoperative assistance, identifying and recognising intraoperative vascular damage;

        iii) any personal and/or medical practice issues that may arise

    c) To authorise the Medical Council of NSW to provide proposed and approved mentors with a copy of the decision which imposed this condition;

    d) To be mentored for a minimum period of 12 months and as subsequently determined by the Council.

2. The practitioner must only perform laparoscopic (or laparoscopic assisted) nephrectomy surgery under category A supervision in accordance with the Medical Council of NSW's Compliance Policy - Supervision (as varied from time to time) and as subsequently determined by the appropriate review body.

a) The requirements of the Compliance Policy - Supervision are varied so that the practitioner is only required to attend a review meeting if he has performed laparoscopic (or laparoscopic assisted) nephrectomy surgery in the preceding week.

b) Within 7 days of the end of each calendar month, he is to provide the Medical Council of NSW with a record of all laparoscopic (or laparoscopic assisted) nephrectomy surgeries performed in that calendar month. The report must include the following:

i. The date of each procedure
ii. The Medicare item number (if applicable)
iii. The patient's name and date of birth
iv. The nature of the procedure
v. The hospital/facility at which each procedure was performed
vi. Any complications arising as a result of the procedure (and specifically advising of any unplanned return to theatre)
vii. The signature of the Council-approved supervisor, attesting that he or she was present at each procedure.

The practitioner must also inform the Council if he does not perform any laparoscopic (or laparoscopic assisted) nephrectomy surgeries in that calendar month.

c) To authorise the Medical Council of NSW to provide proposed and approved supervisors with a copy of the decision which imposed this condition

3. Within 7 days of the end of each quarter, the practitioner is to provide to the Medical Council of NSW a report signed by the Director of Medical Services or equivalent at every public and private hospital/facility where he performs procedures advising whether or not the practitioner has performed any laparoscopic (or laparoscopic assisted) nephrectomy surgery in the preceding quarter and if so, the date(s) on which the practitioner performed each procedure.

4. To authorise and consent to any exchange of information between the Medical Council of NSW and Medicare Australia for the purpose of monitoring compliance with these conditions.

5. The Medical Council is the appropriate review body for the purposes of Part 8, Division 8 of the Health Practitioner Regulation National Law (NSW).

6. Sections 125 to 127 of the Health Practitioner Regulation National Law are to apply whilst the practitioner's principal place of practice is anywhere in Australia other than in New South Wales, so that a review of these

conditions can be conducted by the Medical Board of Australia.

APPEAL AND REVIEW RIGHTS

109. Dr Christopher Tien Yen Chee has the right to appeal this decision to the NSW Civil and Administrative Tribunal.

110. An appeal must be lodged with the Tribunal within 28 days of the date of these written reasons.

111. Dr Christopher Tien Yen Chee also has the right to seek a review by the Medical Council of NSW of the Committee's order to impose conditions. Should Dr Christopher Tien Yen Chee's principal place of practice be anywhere other than NSW at the time of seeking a review of conditions, Dr Christopher Tien Yen Chee may make an application for review to the National Board.

NON-PUBLICATION ORDER

112. A non-publication order was made on 25 September 2017 in respect of Patient A so that the name, address and any information identifying this person is not to be published.

DISTRIBUTION OF DECISION

113. A copy of this written statement of our decision will be provided to Dr Christopher Tien Yen Chee, the Commission, the National Board and the complainant.

Diane Robinson
4 December 2017

Annexure A

COMPLAINT

HEALTH PRACTITIONER REGULATION NATIONAL LAW

Executive Officer
Medical Council of NSW
Punt Road
GLADESVILLE NSW 2111

The **Health Care Complaints Commission** of Level 13, 323 Castlereagh Street, Sydney NSW, having consulted with the **Medical Council of New South Wales** in accordance with sections 39(2) and 90B(3) of the *Health Care Complaints Act 1993* and section 145A of the *Health Practitioner Regulation National Law* (NSW) ("*the National Law*")

HEREBY COMPLAINS THAT

Dr Christopher Tien Yen Chee ("the practitioner") of 19 The Summit Road, Port Macquarie, NSW 2444 being a medical practitioner registered under the *National Law*,

COMPLAINT ONE

is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that the practitioner has:

i. engaged in conduct that demonstrates the knowledge or skill exercised by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Each of the particulars of this Complaint in itself justifies a finding of unsatisfactory

professional conduct. In the alternative, when two or more of the particulars are taken together, a finding of unsatisfactory professional conduct is justified.

BACKGROUND TO COMPLAINT ONE

The practitioner was first registered in New South Wales on 22 April 2002 and obtained a Fellowship of the Royal Australasian College of Surgeons, Australia in 2007.

At all times relevant to the particulars of this Complaint, the practitioner was working as a Visiting Medical Officer, Consultant Urologist, at Port Macquarie Private Hospital ("the Hospital").

Patient A was referred to the practitioner by Patient A's gynaecologist when a CT scan incidentally identified a 5cm left renal tumour. Patient A consulted with the practitioner on 21 October 2013 and 30 October 2013 and the practitioner recommended that a radical left nephrectomy via laparoscopy be performed with a possible need for conversion to an open procedure ("the procedure").

Following the consultation on 21 October 2013, the practitioner discussed Patient A's CT findings with Dr Kim Nolan, Radiologist. Dr Nolan was of the view that the right kidney and aorta were a little more to the left of the body, with vessels splaying out.

On 19 November 2013, Patient A was admitted to the Hospital to undergo the procedure. Early in the procedure, the practitioner encountered oozing from the renal artery which could not be secured. Continued heavy bleeding necessitated conversion to open surgery.

PARTICULARS OF COMPLAINT ONE

1. After the practitioner converted to open surgery and stopped the bleeding, the practitioner failed to appropriately check the vascular anatomy, particularly the left renal artery, in that he failed to expose the aorta in more detail in

circumstances where he was aware of the anatomical abnormality relating to the right kidney.

2. The practitioner failed to consider that the extensive bleeding could have been a result of a possible vascular disaster and failed to call a vascular surgeon to come into the operating theatre.

3. During the procedure, the practitioner incorrectly clipped the right renal artery instead of the left renal artery because he:

   a) did not do an appropriate anatomical dissection to identify the left renal artery as did not fully dissect the colon off the kidney and push the colon, pancreas and duodenum medially; and

   b) dissected the left kidney superiorly by tracing the gonadal vein to the left renal vein which resulted in the incorrect artery being identified as the aorta was more towards the left than usual.

4. The practitioner failed to recognise and/or consider the damage caused to the right renal artery in that he did not contemplate that the right renal artery had been obstructed by the surgical procedure and presumed the extensive bleeding was related to damage to the left renal artery or nearby vessels.

Dated ……..

_____

Karen Mobbs
Director of Proceedings
Health Care Complaints Commission

Annexure B

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally [NSW]

(1) **"Unsatisfactory professional conduct"** of a registered health practitioner includes each of the following-

(a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

(b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

(c) A contravention by the practitioner (whether by act or omission) of-
(i) a condition to which the practitioner's registration is subject; or
(ii) an undertaking given to a National Board.

(d) A contravention by the practitioner (whether by act or omission) of a decision or order made by a Committee or the Tribunal in relation to the practitioner.

(e) A contravention by the practitioner of section 34A(4) of the *Health Care Complaints Act 1993* .

(f) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for-
(i) referring another person to the health service provider; or
(ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.

(g) Accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product, but does not include accepting a benefit that consists of ordinary retail conduct.

(h) Offering or giving a person a benefit as inducement, consideration or reward for the person-
(i) referring another person to the registered health practitioner; or
(ii) recommending to another person that the person use a health service provided by the practitioner or consult the practitioner in relation to a health matter.

(i) Referring a person to, or recommending that a person use or consult-
(i) another health service provider; or
(ii) a health service; or
(iii) a health product;
if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of the interest to the person before or at the time of giving the referral or recommendation.

(j) Engaging in overservicing.

(k) Permitting an assistant employed by the practitioner (in connection with the practitioner's professional practice) who is not a registered health practitioner to attend, treat or perform operations on patients in respect of matters requiring

professional discretion or skill.

(l) Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession.

(2) For the purposes of subsection (1)(i), a registered health practitioner has a **"pecuniary interest"** in giving a referral or recommendation-

(a) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a public company and the practitioner holds 5% or more of the issued share capital of the company; or

(b) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a private company and the practitioner has any interest in the company; or

(c) if the health service provider, or the supplier of the health product, to whom the referral or recommendation relates is a natural person who is a partner of the practitioner; or

(d) in any circumstances prescribed by the NSW regulations.

(3) For avoidance of doubt, a reference in this section to a referral or recommendation that is given to a person includes a referral or recommendation that is given to more than one person or to persons of a particular class.

(4) In this section-

"benefit" means money, property or anything else of value.

"recommend" a health product includes supply or prescribe the health product.

"supply" includes sell.

146B General powers to caution, reprimand, counsel etc [NSW]

(1) A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-

(a) caution or reprimand the practitioner;

(b) direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;

(c) order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order that the practitioner complete an educational course specified by the Committee;

(e) order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;

(
f) order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.

(2) If the relevant health practitioner is not registered, a direction may still be given under this section but has effect only so as to require the conditions concerned to be imposed when the health practitioner is registered.

(3) If a Committee acting under this section makes an order or directs that any condition be imposed on a health practitioner's registration, the Committee may order that a contravention of the order or condition will result in the health practitioner's registration in the health profession being cancelled.

(4) The order or condition concerned is then a
"critical compliance order or condition" .