Our Ref: H18/10352 : DD20/09534

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 Francis Cheuk Kin Chu
MED0001176024
321758

Date/s of Inquiry:	6 & 7 February 2020
Committee members:	Ms Diane Robinson Associate Professor Ian Rewell Dr Michael Hollands Ms Maria Kelly
Appearance for Health Care Complaints Commission:	Ms Emma Bayley, Legal Officer
Appearance for Dr Francis Cheuk Kin Chu:	Mr Michael Windsor of counsel, instructed by Ms Leonie Beyers of HWL Ebsworth
Date for final submissions:	27 March 2020
Date of decision:	14 May 2020
Decision	The Committee made findings of unsatisfactory professional conduct and determined to reprimand Dr Chu and impose conditions on his registration.
Publication of decision:	Refer to page 23 of this decision for details of non-publication directions

REASONS FOR DECISION

INTRODUCTION

THE COMPLAINTS

1. Dr Chu performed liver resection surgery on Patient A in October 2014. Patient A's daughter, Person B, made a complaint to the Health Care Complaints Commission (the Commission) in relation to Dr Chu's management of her father's surgery.

2. On 13 December 2018 the Commission made two formal complaints alleging that Dr Chu is guilty of unsatisfactory professional conduct. Those Complaints are now being prosecuted before this Professional Standards Committee.

3. In summary, Complaint One alleges that Dr Chu failed to provide adequate information to Patient A about the possibility of his liver resection surgery being performed at St George Public Hospital and failed to obtain informed financial consent prior to performing that surgery at St George Private Hospital. In addition, it is alleged that Dr Chu failed to exercise proper care and judgment when signing a form for the early release of Person B's superannuation.

4. Complaint Two alleges that Dr Chu failed to record sufficient information in his medical records concerning Patient A.

5. The Complaints contain several Particulars and are set out in full in Annexure A to this decision.

LEGISLATIVE PROVISIONS

6. 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.

7. It is also defined to include improper or unethical conduct relating to the practice or purported practice of medicine.

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 Chu 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 Chu. 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).

ISSUES

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

    a. Which, if any, of the Particulars of the Complaint 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 Chu

12. Dr Chu graduated Bachelor of Medicine and Bachelor of Surgery from the University of Sydney in 1996. He completed his intern, resident and accredited surgical registrar training at St. George Hospital. He completed his specialist fellowship training at Nepean Hospital, Royal Prince Alfred Hospital and St George Hospital. He has been a Fellow of the Royal Australasian College of Surgeons since 2005.

13. Since 2010 Dr Chu has been a Visiting Medical Officer in general and hepatobiliary surgery at St George Public Hospital. He has similar appointments at Sutherland Hospital, St George Private Hospital and Kareena Private Hospital.

Patient A

14. In September 2014 Patient A was a 72 year old retired man who was in receipt of a pension and had no private health insurance. He had had a number of health problems, including prostate cancer, ischaemic heart disease and depression.

15. He consulted Dr Chu about cancer in his bile duct. Following a series of investigations the decision to operate on his cancer was made and Patient A had liver resection surgery at St George Private Hospital on 2 October 2014. He was discharged home on 21 October 2014 and remained well until early 2016 when the cancer recurred. He consulted Professor David Morris but further surgery was not possible. Patient A passed away some time later.

EVIDENCE

16. In addition to the documentary material provided by the parties, the Committee heard evidence from the following people:

- Dr Chu, the Respondent
- Person B, the complainant and Patient A's daughter
- Person C, Patient A's wife
- Professor Maddern, expert witness for the Commission
- Dr Puhalla, expert witness for the Respondent, by conference telephone

COMPLAINT 1 - Particular 1

17. Particular 1 alleges that Dr Chu failed to obtain informed financial consent from Patient A before performing his liver resection surgery at St George Private Hospital.

18. Dr Chu admits Particulars 1a, 1b, and 1c. He admits that he knew Patient A was 72 years of age, retired and an age pensioner. He admits that he knew Patient A did not hold private health insurance. He also admits Patient A was eligible to undergo the liver resection surgery at St George Public Hospital.

19. Dr Chu does not admit Particular 1d, that it was likely that Patient A would have been able to undergo the liver resection surgery at St George Public Hospital within an appropriate time frame.

Patient A's clinical needs

20. Both Professor Maddern and Dr Puhalla told the Committee that the decision to perform surgery on Patient A was made on 10 September 2014. This was acknowledged by Dr Chu and is not in dispute.

21. Professor Maddern stated that Patient A had a Klatskin tumour, which is a slow growing tumour and while it needs to be removed promptly, it does not require emergency treatment. A problem may arise if the tumour causes a blockage in the bile duct, but in Patient A that possibility had been managed by the insertion of a stent to ensure adequate drainage.

22. Professor Maddern opined that given the nature and size of Patient A's tumour, his general health and the protective factor of the stent, surgery within 3 to 6 weeks from the decision to treat would have been appropriate.

23. Dr Puhalla stated that a Klatskin tumour may be slow growing or aggressive and a tissue sample would be required to ascertain the progress of Patient A's tumour. He agreed that the size of the tumour and the patient's general health are relevant factors when considering the urgency of surgery. He also agreed with Professor Maddern that the insertion of a stent was a protective factor.

24. Dr Puhalla considered that 4 weeks from the decision to treat would be an appropriate time frame for Patient A's surgery.

Surgery waiting times

25. Professor Maddern told the Committee that when the decision to treat is made, patients are given a category that reflects the urgency of their need for surgery. Patients given category 1 status should receive treatment within 30 days. Category 2 cases receive treatment in 30 - 90 days and category 3 patients will be treated between 90 days and one year. A patient's treating doctor should select the best category for each individual patient.

26. Dr Chu's evidence indicates that had Patient A been admitted to St George Public Hospital he would have been admitted as a category 1 patient.

27. In his most recent written statement, dated 12 September 2019, Dr Chu said that in his experience the average waiting time for surgery for a category 1 admission to St George Public Hospital is approximately 1 to 2 months. This is consistent with a letter he wrote to the Commission, dated 7 July 2017. However, on earlier occasions, for example in his letter to the Chief Executive, South Eastern Sydney Local Health District, dated 23 September 2016 he said he informed Patient A that the waiting time "was likely to be around 30 days". He made a similar statement in his letter to the Commission dated 22 December 2016.

28. Mr Gerry Marr, Chief Executive, South Eastern Sydney Local Health District (LHD) provided information about waiting times for surgery at St George Public Hospital in 2014. The mean days waiting for category 1 patients was 16.59 days in September 2014 and 12.94 days in October 2014.

29. In relation to Dr Chu's category 1 bookings, Mr Marr provided information that the mean waiting days in September 2014 was 1 day and in October 2014 it was 19.5 days, with a range of 16 – 23 days.

30. Dr Chu prepared a list of the waiting times for his category 1 patients between August and November 2014. This information was provided at the hearing. There was dispute about the calculation of these waiting times and after further information was received from St George Public Hospital, Dr Chu's list was amended. The amended list consisted of six patients. One patient was operated on in August, 3 in September, 1 in October and 1 in November 2014. One patient waited 15 days, one waited 34 days, two waited 38 days, one 45 and one 60 days for their surgery.

31. The disparity between the LHD information and Dr Chu's information can be explained by the different ways waiting times have been calculated. The LHD waiting time is calculated from the time the patient presents to the hospital with the Request For Admission (RFA) form, and is added to the waiting list, to the time they undergo surgery. Dr Chu calculated his waiting time from the time the patient signs the consent form in his rooms, to the date of surgery.

32. Dr Chu stated neither he nor his Registrar check on the status of a patient's admission process and he may only be contacted by the hospital if a patient is about to "breach". Relevantly, he stated that he does not know when a patient presents the RFA form to the hospital. A comparison of the two lists indicates some patients may have waited some time after leaving Dr Chu's rooms before they presented the RFA to the hospital. Dr Chu gave evidence that he was not aware of this, given he has no knowledge of when his patients actually present the form.

33. Professor Maddern did not regard Dr Chu's list as providing useful information as he considered none of the procedures involved Klatskin tumours. He noted that some procedures were not urgent and more akin to Category "one and a half". He explained that a longer wait is clinically appropriate for a procedure, such as a 'redo liver resection'.

34. Dr Chu told the Committee most of his patients have cancer or gall bladder problems or hernias. He has predominantly category 1 and category 3 patients. Dr Chu's Category 1 list indicates that he operated at St George

Public Hospital on 18 August 2014 (one liver resection), 15 September 2014 (two liver resections), 29 September 2014 (one liver resection), 13 October 2014 (redo liver resection) and 10 November 2014 (one liver resection). He had a scheduled operating day on 27 October 2014 but no procedures were performed.

35. Dr Chu was asked why he only performed one liver resection on some days while he had done two resections on15 September 2014. He said that the hospital arranges the list and sometimes it has no rhyme or reason. He said sometimes if there are two liver resections in one day there may be difficulties getting an ICU bed and difficulties with running over time.

36. Dr Puhalla was asked whether it was likely that a surgeon with only six category 1 patients in a four month period would have a waiting time of 1 to 2 months. He said this was unusual, but explained that waiting times can depend on the capacity for surgery, which is impacted by the number of lists available to the surgeon.

Additional considerations

37. Mr Marr stated,

> *"It is difficult to be certain as to whether Patient A would have been seen in a clinically appropriate time for category 1 surgery between September 2014 and October 2014. If he were on the public hospital waiting list, his case would have been managed in accordance with the policy…….As a category 1 booking, he may have either been put ahead of some of these cases or…..alternatively he may have had his urgency reviewed."*

38. Professor Maddern said that if a hospital is not giving appropriate priority to a patient, his doctor may have to intervene and assert the need for the patient's treatment to be undertaken sooner. That type of intervention is part of a doctor's obligation towards his patient. Professor Maddern said that a hospital waiting list is not a queue. It is a collection of cases that have to be shuffled according to need.

39. Dr Chu stated that he does alert the admissions office if he has to rearrange his list, however he did not contact the admissions office in relation to Patient A, as he knew *"there was at least four cancers on the list before him*" and considered he was *"not likely to get him in within 30 days".*

40. Dr Puhalla stated that there are a number of options if a problem arises around the timing of surgery in a public hospital. It may be possible to arrange an additional surgical list or it may be possible to involve another surgeon. He said he would discuss a complex patient at a multidisciplinary team (MDT) meeting and also with individual radiologists, pathologists and oncologists outside that meeting.

41. Dr Chu stated in oral evidence that he did not make enquiries about the availability of colleagues. Professor Morris is the other surgeon who operates in the hepatobiliary unit at St George Public Hospital. While Dr Chu has one surgical list each fortnight, Professor Morris has three lists each week. Dr Chu said he did not contact Professor Morris in relation to Patient A's surgery as he thought he would be too busy to assist. He did not inquire about extra theatre time at St George Public Hospital. He said any extra available theatre

time generally went to Professor Morris. Dr Chu told the Committee that he and Professor Morris did not have the 'most friendly' relationship.

42. Dr Chu said he was concerned about the availability of an ICU bed causing a delay to Patient A's surgery at the public hospital. Professor Maddern acknowledged that sometimes surgery can be cancelled because of a shortage of ICU beds. Dr Puhalla stated this did not happen frequently, but could be a reason for delay. Professor Maddern said generally cancer patients are given priority over patients with non-malignant disease in the allocation of ICU beds.

43. Dr Chu was asked if he provided patients with the opportunity to be a self-insured private patient in the public hospital system, where it would be expected that the self-insured patient is charged just the scheduled fee. He stated he did not.

44. He was also asked if he offered any financial assistance to uninsured private patients in financial difficulties, for example, by only charging the scheduled fee and asking his anaesthetist to do the same. He indicated he had not done so.

The Committee's decision

45. Particular 1d requires a determination as to whether or not it was likely that Patient A would have been able to undergo liver resection surgery at St George Public Hospital within an appropriate time frame. The Committee does not accept the respondent's submission that a degree of speculation as to what would have actually happened to Patient A if he had been admitted to St George Public Hospital is required to determine this Particular.

46. The views of Professor Maddern and Dr Puhalla about the appropriate time frame for Patient A's surgery are not widely divergent. In any event there is no dispute that Patient A was correctly classified as a category 1 patient. Dr Puhalla suggested the surgery should be done within 4 weeks, which accords with the category 1 standard. Professor Maddern's suggested 3 – 6 week time frame may simply have recognised the fact that for Patient A the insertion of a stent was a protective factor.

47. The relevant Ministry of Health policy states that surgery should be available to a category 1 patient in the public system within 30 days. The evidence from Mr Marr indicates that at the relevant time St George Public Hospital was able to conform to this policy.

48. The average waiting time for Category 1 patients at St George Public Hospital in September 2014 was 16.59 days and in October 2014 it was 12.94 days. The LHD information was that Dr Chu's own category 1 patients waited between 16 – 23 days in October 2014. This accords with Dr Chu's early statements that he advised category 1 patients that surgery would be done in the public system within 30 days.

49. Dr Chu's later statements are inconsistent with this information as they refer to a waiting time of between 1 – 2 months. These assertions appear to be based on the information Dr Chu compiled about his own waiting times. It might be assumed that, for category 1 patients, the decision to treat made in the doctor's rooms would be followed very close in time with the presentation of the RFA at the hospital. If that were the case, the difference between the LHD waiting times and Dr Chu's waiting times may not be so great. However,

this does not appear to be the case for several of Dr Chu's category 1 patients in late 2014 and his calculation of waiting times will be impacted by this.

50. The 'official' LHD information (and indeed some of Dr Chu's own statements about waiting times) indicates that surgery in the public hospital was possible within 30 days. In preferring the LHD information to Dr Chu's calculations of his waiting times, the Committee notes Professor Maddern's evidence that the patients on Dr Chu's "list" were not requiring surgery for a liver resection of a Klatskin tumour. Even if Dr Chu's surgical waiting time was on occasion more than 30 days, there is no evidence about his waiting times for patients with the kind of liver cancer suffered by Patient A.

51. Importantly, if particular difficulties had arisen for Patient A, a number of accepted strategies exist to enable his case to be re-prioritised. As Professor Maddern explained it is the duty of a treating doctor to advocate for treatment in accordance with patient need. Dr Puhalla explained the options available if there is a problem with the timing of surgery in the public system. Dr Chu had the capacity to manage his lists and advocate for the particular needs of Patient A, whether by seeking an additional surgical list or enquiring about transferring his care to another surgeon. He did neither in relation to Patient A.

52. The decision to operate on Patient A was made on 10 September 2014. Dr Chu performed one category 1 procedure on both 29 September and 13 October 2014. In response to questions from the Committee, Dr Chu relied on hospital listing and ICU availability to explain why two resections might not be performed on the one day. However, in relation to both these matters Dr Chu had the capacity to advocate on behalf of his patient.

53. The available evidence indicates the likelihood of Patient A being able to have his surgery at St George Public Hospital in an appropriate time frame, and the Committee is comfortably satisfied that Particular 1 is proven.

COMPLAINT 1 - Particular 2

54. Particular 2 alleges that Dr Chu failed to provide adequate information and/or advice to Patient A in relation to undergoing liver resection surgery at St George Private Hospital.

55. Dr Chu admits Particulars 2a and 2b but denies that he failed to sufficiently explore the possibility of Patient A undergoing liver resection surgery at St George Public Hospital.

<u>Patient A's wife</u>

56. Patient A's wife stated that she was present with her husband during his consultations with Dr Chu. She said they knew Patient A had cancer and at the consultation on 10 September 2014, Dr Chu told them he could operate on Patient A. He said he wanted to do so *'sooner rather than later'*. He said this was because the cancer could *'move from the liver*.' Patient A's wife recalls Dr Chu saying that the surgery was urgent. He said it needed to be done straight away and before he went on holidays in 2 weeks time.

57. Patient A's wife said that Dr Chu told them he *'could not get Patient A into the public hospital in time'.* She believes these were the words Dr Chu used. He told them he had rung the public hospital and *"they can't get him in".*

58. She said Dr Chu asked them whether they had private health insurance, if they had any family, the occupations of their children and if the family could help to pay for the surgery. He asked if they had superannuation funds.

59. She said Dr Chu sent them to the private hospital with admission forms to get a quote. They did that immediately after leaving Dr Chu's office. They returned with the quote and saw Dr Chu again. He provided them with a quote for his costs in relation to the surgery. They told Dr Chu they would proceed with surgery at the Private Hospital. She said they were happy to pay as they considered Patient A's life to be more important than money.

60. Patient A's wife told the Committee that during the consultation on 10 September 2014, Dr Chu did not discuss the possibility of the surgery being done at St George Public Hospital.

"Mr Windsor:	*Well, you did know that there was a discussion about whether the surgery could be done in the public hospital, didn't you?*
Patient A's wife:	*It wasn't discussed.*
Mr Windsor:	*Did you understand that the surgery could be undertaken in the public hospital?*
Patient A's wife	*Dr Chu stated he could not get him into the public hospital, therefore, it wasn't discussed."*

61. Patient A's wife said that Dr Chu discussed aspects of the private hospital system. In the private hospital he would perform the surgery and be available at all times. His assistant would also be available. X-ray and other facilities were easily accessible. Dr Chu told them Patient A would be in intensive care for around four nights after the surgery. He did not discuss the difficulty of getting an intensive care bed in the public hospital system.

62. Patient A's wife told the Committee that her husband did not ask to have his operation in the private hospital. She said that her husband had had experience in both the public and private health systems and he did not believe private care was better than public care. She said his view was that the food and the number of nursing staff in the private system were inadequate.

63. They decided to go into St George Private Hospital as they believed Dr Chu could not get Patient A into the public hospital. She said, *"we trusted Dr Chu and did what he asked us to do"*. She said they were seeking the best possible chance for a cure. They wanted the surgery done and were happy to have an admission date for the private hospital. But Patient A's wife said they were not given the opportunity of going into the public system. They were presented with St George Private as the only option, as they were told Patient A could not get into the public system in time.

64. Patient A's wife stated that Dr Chu provided excellent clinical care to her husband and she had no concerns or complaints of a clinical nature. Her concern is that they were not offered the choice of an operation at the public hospital. She said she could have had money 'to live the rest of her life'. They

paid $75,000 for private care and this has had a significant impact on her financial security.

Patient A

65. Prior to his death, Patient A signed a statutory declaration, on 24 March 2016, in which he stated that on 10 September 2014,

> *"Dr Chu said he would not be able to get me into the public hospital in time to have my surgery before the cancer spread, and the operation needed to be done quickly…… We didn't think that I had any other option than to go into the Private Hospital."*

66. Patient A was interviewed by the Director of Clinical Services at St George Hospital on 12 April 2016. The transcript of the interview reads, in part:

> *"Dr Mackertich:* *Dr Chu says he offered you to go to the public hospital as an urgency category one and you chose to go to the private hospital.*
>
> *Patient A:* *No, no, no."*

67. Patient A was asked why he chose to be a private patient when he wasn't insured.

> *"Patient A's wife:* *No, we just told him that Dr Chu told us that's where he could get us in to do the operation*
>
> *Patient A:* *That was it.*
>
> *Patient A's wife:* *Dr Chu, and I don't mean to be horrible, but he never mentioned public hospital. He asked us were we insured and we said no.*
>
> *Patient A:* *He wouldn't get us into the public hospital.*
>
> *Patient A's wife:* *He said he couldn't get us into the public hospital in time because it was aggressive cancer and it would have been out of the liver and once it was out there……."*

Dr Chu's evidence

Waiting times

68. Dr Chu stated that he advised Patient A that his operation would be performed in the Public Hospital as a category 1 patient. He denied that he had told Patient A he could not get him into the public hospital. He denied making a telephone call to the public hospital in relation to Patient A's admission.

69. Dr Chu made a series of statement in 2016 to the effect that he had told Patient A he could treat him in St George Public Hospital within 30 days. For example, in his letter to the Chief Executive, South Eastern Sydney Local Health District, dated 23 September 2016 he said he informed Patient A that the waiting time "*was likely to be around 30 days".*

70. However, in correspondence dating from December 2016 onwards, Dr Chu stated that he told Patient A "the average waiting time was approximately 1 to 2 months." In his letter to the Commission dated 7 July 2017 he said,

> *"my experience with public hospital waiting times for category 1 admissions is that on average, they are over 30 days. It is my practice to explain to patients my own experience and say that I expect the waiting time for public hospital admission in these circumstances, would be on average one to two months."*

71. He made a similar assertion in his written statement to the Committee dated 12 September 2019.

72. The Committee asked Dr Chu about the apparent discrepancy in his evidence. He said he told Patient A he would try to get him in to the public hospital with in 30 days but he could not guarantee it. He said he knew there were 4 cancer patients ahead of him, so he thought it was unlikely Patient A would be operated on within 30 days.

> *"I knew in my mind there was at least four cancers on the list before him. (indistinct) amount of rearranging is - I don't think from (indistinct) from this point of view (indistinct) likely to get him in within 30 days. And I told him (indistinct) 30 days (indistinct) going on to three months."*

<u>The choice of St George Private Hospital</u>

73. Dr Chu said Patient A asked if his operation could be done anywhere other that St George Public Hospital and Dr Chu told him it could be done at St George Private Hospital. He said that Patient A initiated discussion of admission to the private hospital. Dr Chu said he did not recommend this course of action and instead recommended the surgery be performed in the public system. Dr Chu stated that he did not try to persuade Patient A to have his surgery in the private hospital, but felt he had to respect his decision to do so, once that has been made.

74. Dr Chu denied discussing Patient A's financial position or the finances of his children and family. He denied suggesting that his family could assist in paying for the surgery in the private hospital.

75. In his written statement, dated 12 September 2019, Dr Chu advised of the issues he routinely discusses with patients, such as Patient A, in relation to hospital admission.

76. In relation to a public hospital admission, he advises that he has no control over hospital waiting times and that the average waiting time for category 1 admission is 1 to 2 months. He discusses the need for an ICU bed and a possible delay if one is unavailable. He discusses the level of his involvement in the surgery and the other medical staff who may be involved with him. He states the public system is free.

77. In relation to a private hospital admission, he indicates that a date for surgery can generally be chosen and booked. He will do all of the surgery with a surgical assistant of his choice and will be on-call for the entire admission. He indicates that the private hospital experience might be "*a nicer experience around service and comfort"* but that significant costs are involved. He explains that risks and outcomes are the same in both systems.

78. In his 2019 statement Dr Chu stated,

> *"At the conclusion of my consultation Patient A informed me of his choice to have his surgery performed at St George Private Hospital. I recall that Patient A told me that he chose that course because he wished to have certainty concerning the timing of the surgery."*

The Committee's decision

79. The respondent submits that in many respects the recollection of Dr Chu and Patient A's wife align, but in light of contested recollections Particular 2 is not made out.

80. The Committee considers that the evidence given by Dr Chu and Patient A's wife as to the advice and information provided by Dr Chu differs considerably. Dr Chu states that he discussed the differences between having surgery in the public and private hospitals. Patient A and his wife assert that the possibility of having surgery in the public system was not discussed.

81. Dr Chu says he recommended the public system and Patient A asked to go to the private hospital. Patient A's wife stated that no such request was made and the private hospital was presented and accepted as the only available option.

<u>How to assess this evidence?</u>

82. The Committee considered Patient A's wife to be an honest and forthright witness. She did not prevaricate in her response to questions and the view of the Committee is that she made a genuine attempt to answer each question directly and frankly. In general, her oral evidence was consistent with statements she made shortly after the consultation with Dr Chu and with her written statements.

83. The Committee appreciates that the weight, which can be attached to Patient A's evidence, is impacted by lack of cross-examination, however it is noted that his statutory declaration supports the evidence given by his wife.

84. Dr Chu's evidence was problematic.

85. At his interview with the Director of Clinical Services at St George Hospital on 2 May 2016, Dr Chu stated that his recollection of the consultation with Patient A was fairly vague. At another meeting on 18 May 2016 Dr Chu again stated he did not have a strong recollection of the consultation with Patient A.

86. However, in that most recent statement, dated 12 September 2019, Dr Chu states that he has a recollection of what he said to Patient A and his wife when he spoke to them in 2014.

87. When asked about this apparent inconsistency, Dr Chu said that in May 2016, he had some recollection, although not a strong recollection, of the conversation. He said his recollection was poor at the time because he was shocked and anxious.

88. Dr Chu's evidence about the advice he provided in relation to hospital waiting times was inconsistent. His early statements referred to a wait of up to 30 days for category 1 patients. His later statements, from December 2016 onwards, refer to a wait of 1 to 2 months and in his oral evidence to the

Committee he referred to a wait between 30 days "*going on to three months*". He was unable to clearly explain the differences in his evidence over time.

89. Dr Chu's recollection of why Patient A decided to use the public system was also problematic. In his interview in May 2016 Dr Chu said he could *"not remember exactly why Patient A decided not to take a public offer."* However in his 2019 statement Dr Chu said he did recall the reason for this decision,

> *"I recall that Patient A told me that he chose that course because he wished to have certainty concerning the timing of the surgery."*

90. This later evidence does accord with his letter to the Chief Executive, South Eastern Sydney Local Health District on 23 September 2016, in which Dr Chu stated that Patient A requested certainty and "*the only location I could offer him was in St George Private Hospital."*

91. The Committee accepts that Patient A's wife has a recollection of the conversation with Dr Chu. She was already aware her husband had cancer and was keen to hear if an operation was possible and when and how it could be carried out. While upset by her husband's circumstances, she was not distressed to a degree that might impair her general understanding of the conversation.

92. In contrast, Dr Chu has had at times a vague or poor recollection of his discussion with Patient A and many of his accounts rely on his usual or routine practice rather than his actual practice on the day in question.

93. The essence of Patient A's wife's account of the discussion on 10 September 2014 has been consistent over time. Despite confusion about the amount of money quoted for the private hospital procedure, her oral evidence to the Committee was consistent with her previous statements.

94. Dr Chu's accounts have not been consistent over time. His account of his advice about waiting times has varied. He was initially unable to recall or explain why Patient A sought to have a costly procedure in the private system, when he was eligible for free medical care in the public hospital. He later recalled that Patient A's decision was based on his desire for clarity or certainty.

95. Overall, the Committee considers the evidence of Patient A's wife to be more reliable and prefers that to the evidence of Dr Chu.

<u>Decision</u>

96. The decision was made on 10 September 2014 for Patient A to have his surgery at St George Private Hospital. No Request for Admission form for the public hospital was issued. The only request for admission was made to the private hospital. Patient A's wife says she was happy to pay for the private hospital, as her husband's life was *'more important than money'*. It is understandable that a person in Patient A's circumstances would want certainty about the timing of their surgery, particularly if they had been told there was an urgent need for that surgery.

97. The question is whether Patient A's desire for certainty and decision to have surgery in St George Private Hospital reflects a decision he made when fully informed of all the options, both clinical and financial.

98. As noted above, the Committee accepts the evidence of Patient A's wife about the conversation with Dr Chu that occurred on 10 September 2014. Her evidence was that there was little if any discussion of the possibility of surgery in the public system. This was because Dr Chu stated he could not get Patient A *"into St George Public Hospital in time".*

99. It is difficult to state precisely what Dr Chu told Patient A in relation to public hospital waiting times, as his evidence about this has varied over time. His most recent assertion, in oral evidence, is that he knew there were four cancers on the list before Patient A and so it was unlikely his operation would occur within 30 days in the public hospital. If this evidence is accepted, it supports Patient A's assertion that treatment in the public hospital system was not presented as a timely option.

100. The Committee does not accept Dr Chu's assertion that Patient A requested admission to the private hospital, after being fully informed of the alternatives and after a recommendation was made by Dr Chu that he have his surgery in the public hospital. The Committee accepts the evidence of Patient A's wife that her husband's admission to the private hospital occurred in response to information that the public hospital was not available to him.

101. The Committee also accepts that in these circumstances Dr Chu did not discuss the alternative of the public system in adequate detail. Even if Dr Chu referred to the public hospital system, by way of comparison with the private system, it was the private hospital that was offered to Patient A as the only way he could have his surgery in an acceptable timeframe.

102. Particular 2 alleges that Dr Chu failed to sufficiently explore the possibility of surgery at St George Public Hospital. On the basis of Dr Chu's admissions and the evidence of Patient A's wife, the Committee is comfortably satisfied that Particular 2 is proven.

Does the proven conduct amount to unsatisfactory professional conduct?

103. It is convenient to consider Particulars 1 and 2 together. Dr Chu failed to provide adequate information and advice about the possibility of Patient A having liver resection surgery at St George Public Hospital and he failed to obtain informed financial consent prior to performing that surgery at St George Private Hospital.

104. Professor Maddern's view is that "*patients who are not well off financially should be managed in the public hospital system which deals with category 1 cancer type patients in a timely fashion".*

105. He stated there may be some circumstances where it is appropriate to treat uninsured patients in the private system, but this is unusual and would only relate to simple, short stay procedures with low risk and low costs. A complicated procedure such as the one Patient A required carries the risk of complications which can prolong a hospital stay and add to overall expenses.

106. Dr Puhalla agreed that treating uninsured patients in the private system may be reasonable in less complex cases. Consideration needs to be given to the type of surgery, the length of stay and whether an ICU stay is required. He

agreed with Professor Maddern that if an ICU stay of 4 nights was expected, an uninsured patient should not be treated in a private hospital.

107. Professor Maddern states that Dr Chu should have made it absolutely clear that the operation can be conducted in the public hospital in a timely fashion and that using the private hospital would provide no additional clinical benefit to the patient's outcome. His view is that if Dr Chu did not make every effort to encourage and organise for Patient A to have the procedure conducted as a public patient, his conduct was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. Professor Maddern is strongly critical of such conduct.

108. In his written report Dr Puhalla stated, *"A patient needs to be informed of all relevant factors to make a fully informed consent and choice of surgery venue is a highly relevant consideration."*

109. In his oral evidence Dr Puhalla told the Committee that the patient should be informed of all information relating to both public and private hospital admission. He said if Dr Chu discussed the differences between the public and private hospitals with Patient A, his care and management would be of a reasonable standard. However, if the patient is naïve about the health system and Dr Chu did not provide all the necessary information, his conduct would be significantly below the relevant standard. He added it would be relevant to consider if the patient understands the system, for example, if he has received treatment before.

110. Professor Maddern said that a patient should be well informed so he is able to understand the options. He stated that if Dr Chu had discussed the private and public hospitals as he claimed then he should have been able to make a compelling case that there was no significant clinical advantage in having the operation performed in the private hospital. Professor Maddern believes Patient A was not adequately counselled on the hospital system and how it works.

111. Professor Maddern also stated that it was not reasonable for Dr Chu to say he had no control over the waiting list at the public hospital. Treating doctors are able to advocate for their patients to be re-prioritised. An unacceptable wait in the public system, is an issue to be raised with the public hospital.

The Committee's decision

112. The Committee is satisfied that Dr Chu did not provide sufficient information about the possibility of treatment in the public hospital, nor did he obtain a fully informed financial consent to treatment in the private system.

113. Dr Chu had a patient whom he knew to have limited financial capacity, he knew the necessary treatment was available in the public sector at no cost, but was prepared to subject the patient to considerable cost, despite his lack of insurance. He asserts that he was respecting a choice made by the patient. However, as both experts explained, a surgeon has to advise and advocate for his patient, particularly in a stressful situation involving a cancer diagnosis and when patients may be poorly informed about the workings of the hospital system. Dr Chu's "hands off" approach to advocating for Patient A is not consistent with satisfactory professional conduct.

114. Dr Chu also asserts his approach to Patient A's treatment was based on his understanding of his waiting times. However, waiting times in the public

system can be adjusted according to need. As Dr Puhalla explained there are a number of available strategies to manage delay in the public system.

115. Dr Chu failed to adequately discuss the public hospital as an option for Patient A, and he failed to consider the financial impact of that failure. The Committee is comfortably satisfied that his conduct, as set out in Particulars 1 and 2, is significantly below the appropriate standard and constitutes unsatisfactory professional conduct within the meaning of section 139B(1)(a) of the National Law.

116. The Commission also alleges that Dr Chu's conduct is unsatisfactory professional conduct within the meaning of section 139B(1)(l) of the National Law. It is alleged that his conduct should be characterised as improper or unethical conduct. It is unfortunate that while the Complaints refer to section 139B(1)(l), the Commission has provided no submissions on issues relevant to this claim.

117. Improper or unethical conduct is not defined in the National Law, but the meaning of this phrase has been discussed in a number of recent cases, for example, *HCCC v Liu [*2016] NSWCATOD 133 and *HCCC v Nguyen* [2018] NSWCATOD 168. Improper conduct is often described as conduct that is inappropriate or demonstrates impropriety or is not in conformity with standards of professional conduct. Unethical conduct is often regarded as a more serious matter and refers to conduct demonstrating an element of dishonesty or a deliberate disregard for professional ethics.

118. For the reasons expressed above, the Committee consider that Dr Chu's conduct can be regarded as improper conduct within the meaning of section 139B(1)(l) of the National Law.

COMPLAINT 1 - Particular 3

119. Particular 3 alleges that Dr Chu failed to exercise appropriate care and judgment when he signed a form for the early release of Person B's superannuation.

Person B

120. Dr Chu was asked to complete a report, as Patient A's medical practitioner, entitled "Early Release of Superannuation on Specified Compassionate Grounds." Person B, Patient A's daughter, needed the report for the purpose of accessing her superannuation funds, so she could repay a loan to her parents to assist them to pay for her father's surgery and related expenses.

121. Person B completed parts of the form. She had no direct communication with Dr Chu about the form, although she did mark some questions with an asterisk to direct his attention to those questions. Person B told the Committee that in preparing the form, she did not answer questions related to her father's medical condition, being questions 12, 13 and 14. She completed all other questions, apart from questions about Dr Chu's personal and practice details.

122. She gave the form to her mother who delivered it to Dr Chu's surgery. Dr Chu completed the form, signed it and the form was returned to Person B.

Dr Chu

123. Dr Chu told the Committee that he was not aware that the form related to Person B's superannuation and mistakenly believed it was for the release of Patient A's funds. He admits he read or he should have read the response to question 16 and the declaration at question 28 on the form. Dr Chu admits that he failed to take sufficient care to satisfy himself that the content of the form was correct before he signed it.

The Committee's decision

124. Particular 3 has 9 sub-particulars, most of which Dr Chu admits.

125. Dr Chu neither admits nor denies Particulars 3 b, 3 c and 3 h. Particulars 3 b and 3 c relate to the actions of Person B and her evidence, that she did complete questions 1, 9 and 16 on the form, satisfies the Committee that those matters are established. Particular 3 h alleges that the response to question 16 is incorrect and the Committee is satisfied this is proven on the basis of the evidence and findings referred to in relation to Particular 1.

126. Dr Chu acknowledges he should have been more careful in the manner in which he completed the form. The Committee is satisfied that Particular 3 is proven.

Does the proven conduct amount to unsatisfactory professional conduct?

Expert evidence

127. Both Professor Maddern and Dr Puhalla were critical of Dr Chu for completing and signing a form that he had not properly read.

128. In his written report Dr Puhalla said that even if parts of a form are filled out by a patient or family member, a surgeon should still pay attention to the form he is signing. In his oral evidence Dr Puhalla said the form should be taken seriously as Dr Chu was making a declaration that the information in the form was correct and complete. Dr Puhalla stated,

> *"It is my opinion that in misreading the form Dr Chu's care and management fell below the standard expected of a practitioner of an equivalent level of training or experience."*

129. Professor Maddern stated that if the form was new or unfamiliar to Dr Chu he should have taken the time to read it. He noted it was not a long or detailed form, yet Dr Chu had not taken the time to properly review it. He expressed concern that Dr Chu had signed the declaration at the end of the form, in which he stated that the contents of the form was true and said that he should not have so without checking the contents.

130. In his written report Professor Maddern expressed the view that Dr Chu's conduct in relation to the form was significantly below the relevant standard. However in his oral evidence his criticism was equivocal. When clarification was sought, Professor Maddern stated,

> *"Whether it's just below (sic) or significantly, I think it's tough to tease that out. I don't think it's a huge problem. I'm just surprised it wasn't picked up by an attentive surgeon."*

The Committee's decision

131. Dr Chu's belief that the form related to the release of Patient A's superannuation rather than funds held by his daughter indicates that he paid very little attention to the details of the form he was completing. Dr Chu has acknowledged that he did not take sufficient care in relation to the contents of the form before he signed it. His cavalier attitude is of particular concern given that he signed a declaration stating the contents of the form to be true when he was not fully aware of what they were.

132. While both experts are of the view that Dr Chu's behaviour was below the standard which would be expected from a specialist medical practitioner with his training and experience, Dr Puhalla does not consider that his conduct was significantly below that standard and Professor Maddern's view is somewhat equivocal, with his initial criticism being modified during the hearing.

133. The Committee considers that Dr Chu's conduct was careless and inappropriate, but concurs with the experts that it does not constitute unsatisfactory professional conduct.

COMPLAINT 2

134. Complaint 2 alleges that Dr Chu contravened provisions of the Health Practitioner Health Regulation (NSW) Regulation 2010 (now repealed) by failing to record sufficient information in his medical records in relation to his consultation with Patient A on 10 September 2014.

135. Dr Chu admits that he did not record sufficient information regarding the plan for Patient A's liver resection surgery at St George Private Hospital. He also admits that he failed to record sufficient information regarding advice he provided to Patient A in relation to that surgery. The other allegation in Complaint 2 is that Dr Chu failed to record sufficient information regarding Patient A's consent to liver resection surgery at St George Private Hospital. This is also admitted by Dr Chu.

136. The letter from HWL Ebsworth Lawyers to the Commission, dated 20 September 2019 states,

> *"In response to Complaint Two: the Respondent admits that his records for his consultation on 10 September 2014 do not comply with the Health Practitioner Regulation (NSW) Regulation 2010, and that this amounts to unsatisfactory professional conduct."*

The Committee's decision

137. On the basis of Dr Chu's admissions, the Committee finds Complaint Two proven and finds that Dr Chu's failure to make adequate medical records constitutes unsatisfactory professional conduct within the meaning of section 139B(1)(b) of the National Law.

138. The Committee is also satisfied that Dr Chu's conduct can be characterised as improper conduct and so constitutes unsatisfactory professional conduct within the meaning of section 139B(1)(l) of the National Law.

Are orders or directions under the National Law appropriate?

<u>General considerations</u>

139. 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).

140. 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).

141. 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.*

Dr Chu's evidence

142. Dr Chu said it is rare for him to treat an uninsured patient in the private system. Since 2005 he has treated about 60 uninsured private patients.

143. In his statement to the Committee Dr Chu apologised for the stress and anxiety caused to Patient A and his family. He felt there had been a misunderstanding in his communication with Patient A and his wife. In oral evidence, he said that despite explaining the options, Patient A only heard one aspect of the communication, that the wait for the public hospital might be 1 – 2 months.

144. He told the Committee he has changed his practice and now spends more time discussing an admission. He would now ask a patient to explain why they were choosing the private hospital. Dr Chu has completed a communication course through the Cognitive Institute, which he believes will assist him to listen more empathically and ask questions to check that patients have understood what he has told them.

145. Dr Chu also said he has developed a new form for patients who choose to go to a private hospital. Patients are asked to acknowledge that Dr Chu offered an operation at St George Public Hospital and "after consideration of the waiting times, and the costs involved to be a private patient", they have decided to be admitted to a private hospital as a self funded patient. He

hopes this will avoid future problems, similar to those which arose in relation to Patient A.

146. Dr Chu also said that the complaint had been made after Patient A spoke with Professor Morris and Dr Mackertich, both of whom told him that the operation could have been done at the public hospital. Dr Chu told the Committee that his relationship with Professor Morris was not "the most friendly' and in his letter dated 22 December 2016 he stated,

> *"I am extremely devastated that the family has been made to be so upset at me by both Professor David Morris and Dr Martin Mackertich…… I am extremely embarrassed that they have been dragged through what is effectively a political stoush."*

147. Dr Chu's work arrangements have changed. He stated that in 2014 he was often working a 12 hour day. He now works between 7 am and 4 pm. He still operates at 4 hospitals - St George Public Hospital, St George Private Hospital, Sutherland Hospital and Kareena Private Hospital. However, Dr Chu stated he has recently reduced his operating work and increased his clinic time. He has also reduced his on call availability and is now on call every fourth day. He has half a day off each fortnight.

148. He asserted he is more diligent in relation to his medical records and now makes more comprehensive clinical notes. He stated,

> *"I am now more detailed and proficient in what I document in my records. The content of my handwritten notes is more detailed in regards to recording my findings, risks that are discussed with the patient, and matters relating to financial consent."*

149. Dr Chu provided a number of references from colleagues. He also provided information about his continuing professional development, which has recently included an Ethics at Work seminar at the Ethics Centre on 12 August 2019.

Submissions

150. The Commission submitted that the Committee should reprimand or caution Dr Chu. The Commission also proposed a number of conditions including a medical records audit and that Dr Chu be required to provide to the Council a log of uninsured patients treated in the private hospital system.

151. Dr Chu did not oppose the imposition of a condition requiring an audit of his medical records. He submitted that no other conditions, nor a caution or reprimand, are required.

The Committee's decision

152. The Committee considers that the nature of Dr Chu's unsatisfactory professional conduct is such that a reprimand is appropriate. Dr Chu allowed and facilitated an elderly uninsured pensioner to have expensive private treatment when similar clinical care was available to him at no cost in the public hospital.

153. Dr Chu said he felt he had to respect Patient A's choice. Patient A was seriously ill. He may have had some experience of the hospital system as a result of past treatments, but as would be expected, his understanding of how to best manage his cancer diagnosis was informed almost entirely by the

advice provided by Dr Chu. Dr Chu failed to provide adequate information about the option of the public hospital and he failed to obtain informed financial consent.

154. Patient A's condition, the nature of the treatment, the risks involved and the very real possibility of complications requiring additional time in hospital did not alter Dr Chu's approach to his admission. In addition, he appeared either unaware or disinterested in any of the alternative ways of financially assisting private patients without health insurance. In not fully exploring the possibility of an admission to the public hospital, he did not consider the financial harm that could be caused to the patient and his family.

155. The Committee accepts the Commission's submission that a reprimand will signify to Dr Chu that his conduct is not acceptable and encourage him to exercise greater care to ensure that his uninsured patients can make properly informed decisions and that his records properly comply with relevant regulations. A reprimand will also alert other members of the profession that such conduct is not acceptable.

156. In response to Complaint 1 the Committee accepts the Commission's submission that a condition should be placed on Dr Chu's registration requiring him to provide a log to the Council at 3 monthly intervals providing information about each uninsured patient he treats in a private hospital.

157. Despite expressing regret for the stress experienced by Patient A's family, Dr Chu's explanation for the complaint was that there had been a communication problem or misunderstanding, and also what he called "a political stoush".

158. To explain the situation simply as a misunderstanding reflects poorly on Dr Chu's level of insight into his obligations as a treating surgeon and his role in Patient A's decision to have private hospital treatment. The Committee appreciates Dr Chu may have had interpersonal or professional difficulties with colleagues, but his obligation to his patient means these matters must be managed so that patient care is not compromised.

159. The Committee considers the log will encourage Dr Chu to reflect more carefully on the appropriateness of treating uninsured patients in the private system and discourage the repetition of the conduct which impacted so negatively on Patient A and his family.

160. The Log should include the following information:
    - the full name and date of birth of the patient,
    - the nature of the surgical procedure(s) performed,
    - the date and time of the procedure(s),
    - all MBS item number(s) billed for the procedure(s),
    - the location where the surgical procedure(s) took place,
    - any complications arising as a result of the procedure(s).
    - the nature and extent of information given to the patient before the decision to have private hospital treatment is made
    - the availability of care in the public system within a clinically appropriate time frame
    - the likely duration of private hospital stay including the estimated number of ICU bed nights

- the estimate of total out-of-pocket expenses of private hospital care

161. In completing the log for each uninsured private patient, it is recommended that Dr Chu complete the Australian Medical Association (AMA) Estimate of Medical Fees form or equivalent.

162. In response to Complaint 2, the Committee orders that Dr Chu submit to an audit of his medical records, as directed by the Council. Dr Chu made admissions in relation to the unsatisfactory nature of his medical records and he does not oppose an audit. Dr Chu asserted he has improved his records, and the audit will enable an assessment of his compliance with his professional obligations in relation to his clinical records.

ORDERS

Dr Chu is reprimanded.

Conditions:

1. To submit to an audit of his medical practice, by a random selection of his medical records by a person or persons nominated by the Medical Council of NSW and:
    a. The audit is to be held within 6 months from 14 May 2020 and subsequently as required by the Council.
    b. The auditor(s) is to assess his compliance with good medical record keeping standards and legislative requirements and compliance with conditions.
    c. The auditor is to be provided with a copy of the logs outlined in condition 2.
    d. The auditor(s) should pay particular attention to:
        - Information about consultations and plans for surgery
        - Advice provided to patients about surgery
        - Matters relating to informed consent
    e. To authorise the auditor(s) to provide the Council with a report on their findings.
    f. To meet all costs associated with the audit(s) and any subsequent reports.

2. The practitioner must maintain a log listing all uninsured patients he treats in the private system. The log is to include:
    - the full name and date of birth of the patient
    - the nature of the surgical procedure(s) performed
    - the date and time of the procedure(s),
    - all MBS item number(s) billed for the procedure(s),
    - the facility where the surgical procedure(s) took place,
    - any complications arising as a result of the procedure(s).
    - the nature and extent of information given to the patient before the decision to have private hospital treatment is made

- the availability of care in the public system within a clinically appropriate time frame
- the likely duration of private hospital stay including the estimated number of ICU bed nights
- the estimate of total out-of-pocket expenses of private hospital care

a) The practitioner must forward to the Council a copy of the log within seven days of the end of each calendar month.

3. To authorise and consent to any exchange of information between the Medical Council of NSW, Medicare Australia and the Pharmaceutical Regulatory Unit of NSW Health for the purpose of monitoring compliance with the conditions imposed.

4. These conditions may be altered, varied or removed by the Medical Council of New South Wales and the Medical Council is the appropriate review body for the purposes of Division 8 of the Health Practitioner Regulation National Law (NSW)

APPEAL AND REVIEW RIGHTS

Dr Chu has the right to appeal this decision to the NSW Civil and Administrative Tribunal.

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

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

NON-PUBLICATION ORDER

A non-publication order was made on 22 January 2020 preventing the publication of:

1. the name, address and any evidence identifying the person identified as Patient A in the Schedule to the complaint of the Health Care Complaints Commission in these proceedings, dated 13 December 2018;
2. the name, address and any evidence identifying the wife of Patient A;
3. the name, address and any evidence identifying the person identified as Person B in the Schedule to the complaint of the Health Care Complaints Commission in these proceedings, dated 13 December 2018.

DISTRIBUTION OF DECISION

We will provide a copy of this written statement of our decision to Dr Chu, the Commission, the National Board, the complainant.

Ms Diane Robinson
Chairperson

15 May 2020

Annexure A

COMPLAINT
HEALTH PRACTITIONER REGULATION NATIONAL LAW (NSW)

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 908(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 Francis Cheuk Kin Chu ("the practitioner") of 3C/4 Belgrave Street Kogarah NSW 2217, being a medical practitioner registered under the *National Law,*

COMPLAINT ONE

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

i. engaged in conduct that demonstrates the judgment possessed 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; and/or
ii. engaged in improper or unethical conduct relating to the practice or purported practice of medicine.

BACKGROUND TO COMPLAINT ONE

The practitioner obtained a MBBS and was first registered as a medical practitioner in 1996. The practitioner obtained a Fellowship of the Royal Australasian College of Surgeons in 2005. In 2010, the practitioner began working as a Visiting Medical

Officer in general and hepato-biliary surgery at hospitals including St George Private Hospital andSt George Public Hospital.

On 3 September 2014, Patient A attended a consultation with the practitioner at his private consulting rooms in Kogarah. Patient A presented with liver cancer in his bile duct.

On 10 September 2014, Patient A attended a second consultation with the practitioner at his private consulting rooms. The practitioner recommended liver resection surgery. Patient A was 72 years old, retired, on the pension and did not have private health insurance.

On 2 October 2014, the practitioner performed liver resection surgery on Patient A at St George Private Hospital.

On 21 October 2014, Patient A was discharged from St George Private Hospital.

PARTICULARS OF COMPLAINT ONE

1. Between 10 September 2014 and 2 October 2014, the practitioner failed to exercise appropriate judgment in that he failed to obtain informed financial consent from Patient A before he performed liver resection surgery at St George Private Hospital in circumstances where:
    a. The practitioner knew that Patient A was 72 years old, retired and an age pensioner;
    b. The practitioner knew that Patient A did not hold private health insurance;
    c. Patient A was eligible to undergo the liver resection surgery at St George Public Hospital;
    d. It was likely that Patient A would have been able to undergo the liver resection surgery at St George Public Hospital within an appropriate timeframe.

2. Between 10 September 2014 and 2 October 2014, the practitioner failed to exercise appropriate judgment in that he failed to provide adequate information and/or advice to Patient A in relation to undergoing liver resection surgery at St George Private Hospital in circumstances where:
    a. On 10 September 2014, the practitioner wrote item numbers on a form titled "St George Private Hospital Doctor Admission Request

Form" and gave it to Patient A so he could obtain an estimate of St George Private Hospital fees;

b. On or after 10 September 2014, the practitioner gave Patient A a quote for the practitioner's fees to perform the surgery at St George Private Hospital;
c. On 10 September 2014, the issue of the possibility of Patient A undergoing liver resection surgery at St George Public Hospital was not sufficiently explored.

3. On about 16 September 2014, the practitioner failed to exercise appropriate care and judgment when he signed a form titled "Early Release of Superannuation on Specified Compassionate Grounds Report by Medical or Dental Practitioner and/or Specialist" for release of Person B's superannuation ("the form") in circumstances where:
    a. The partly completed form was provided to the practitioner's practice on or before 16 September 2014 by Patient A or a member of his family;
    b. Person B had already completed question 1 (patient details) and question 9 (person applying for superannuation) on page 2 of the form;
    c. Person B had already completed question 16 on page 3 of the form ("Is the medical treatment readily available through the public health system?") by marking the box "No" with a cross;
    d. The practitioner read, or should have read, the responses to question 1 (patient details) and question 9 (person applying for superannuation) on page 2 of the form;
    e. The practitioner completed question 12 (name of condition) and question 13 (name of medical treatment) on page 2 of the form;
    f. The practitioner read, or should have read, the response to question 16 ("Is the medical treatment readily available through the public health system?") on page 3 of the form;
    g. The practitioner read, or should have read, the declaration at question 28 on page 4 of the form;
    h. The response to question 16 on page 3 of the form is incorrect;
    i. The respondent failed to take sufficient care to satisfy himself that the content of the form was correct before he signed it.

COMPLAINT TWO

is guilty of unsatisfactory professional conduct under section 139B(b) and/or (I) of the *National Law* in that the practitioner has contravened a provision of the *Health Practitioner Regulation (New South Wales) Regulation 2010* (repealed) and/or engaged in improper or unethical conduct relating to the practice or purported practice of medicine.

BACKGROUND TO COMPLAINT TWO

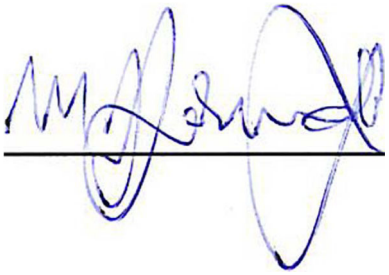
As for Complaint One.

PARTICULAR OF COMPLAINT TWO

1. On 10 September 2014, the practitioner contravened clause 7 of the *Health Practitioner Regulation (New South Wales) Regulation 2010* (repealed) and clauses (1)(2)(b), (1)(3) and/or (1)(5) of Schedule 2 of that Regulation by failing to record sufficient information in the note of the consultation with Patient A on 10 September 2014 in that he did not record:

a. sufficient information regarding the plan for liver resection surgery at St George Private Hospital;
b. sufficient information regarding any information or advice provided by the practitioner to Patient A in relation to the proposed liver resection surgery at St George Private Hospital;
c. sufficient information regarding Patient A's consent to undergo liver resection surgery at St George Private Hospital.

Dated 13 December 2018



Michael Darmody

Acting 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 over servicing.

(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"** .