MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 211/02/92C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of disciplinary proceedings against **IAN SCOTT LITTLE** medical practitioner of Christchurch

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mrs J Courtney, Dr A D Stewart, Dr J L Virtue, Dr L F Wilson (Members)

Ms K L Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Thursday 5 September 2002

APPEARANCES: Mr M F McClelland for a Complaints Assessment Committee ("the CAC")

Mr C W James for Dr I S Little.

The Charge

1. Dr Little was charged by the CAC pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 (the Act) that:

   (a) on or about 16 August 2001 he was convicted by the High Court in Christchurch of an offence punishable by imprisonment for a term of 3 months or longer, namely: failure to provide the necessaries of life, section 151 Crimes Act 1961;

   (b) on or about 3 February 2000, Dr Little was convicted by the District Court Christchurch of advertising the availability of Exoderm Facial Peel before the consent or provisional consent of the Minister to the distribution of Exoderm had been notified, s20(2) (Medicines Act 1981 x 2). These offences also being punishable by a term of imprisonment of 3 months or longer.

2. The charge alleged that the circumstances of the offences reflect adversely on Dr Little's fitness to practice medicine.

3. Dr Little was initially charged with manslaughter and failing to provide the necessaries of life following the death of his patient, Mrs Leona Steven, during an elective cosmetic appearance procedure known as an "Exoderm Facial Peel" undertaken by him on 22 February 1999.

4. In what was described by the trial judge as a "*late change of plea*" made after the jury had been empanelled, Dr Little pleaded guilty to the lesser charge of failing to provide the

necessaries of life. He was then discharged pursuant to s 347 of the Crimes Act in respect of manslaughter charge. The maximum penalty for the charge upon which Dr Little was convicted is 7 years imprisonment. There was at the time of sentencing no maximum fine and Dr Little was fined $30,000 with a direction that the fine be paid in equal proportions to Mrs Stevens' children.

5. On 3 February 2000 Dr Little, having pleaded guilty in relation to the charge brought under the Medicines Act, was convicted in the District Court in Christchurch and fined $5,000 on each charge plus costs. The maximum penalties for the two charges pursuant to the Medicines Act are a period of imprisonment for up to 6 months or a fine of $20,000.

6. Pursuant to section 85 of the Act, the relevant Court Registrar is required to notify the President of the Medical Council if a medical practitioner is convicted of any offence punishable by imprisonment for a term of 3 months or longer and the President is required to refer that complaint to a CAC, who in turn is required to determine whether or not the conviction should be considered by this Tribunal.

7. The facts giving rise ultimately to this professional disciplinary charge have previously been set out at length in the sentencing remarks of both the High Court Judge and the District Court Judge, and in the submissions made to this Tribunal by Mr McClelland on behalf of the CAC. However, given the serious nature both of Dr Little's misconduct, which this Tribunal is satisfied is established, and the penalty which this Tribunal is satisfied is required, the Tribunal has taken a similar approach and set out the factual background that is relevant in this present context in detail in this decision.

Factual Background

8. In 1999, Dr Little was practising as a general practitioner specialising exclusively in the field of appearance medicine. Dr Little obtained his general medical degree from Dundee University, graduating in 1979, and he also held a diploma in anaesthetics and worked as an anaesthetic registrar between August 1982 and July 1983. From 1983 to approximately 1996, Dr Little practised as a general practitioner.

9. In approximately April 1998, Dr Little was approached by Ms Bat-Zion Susskind, the New Zealand distributor of a phenol-based preparation known as "Exoderm" which was marketed as a safer alternative to other phenol-based preparations used in appearance medicine. Dr Little gave evidence to the Tribunal that he had been doing chemical face peels since he completed a 4-day cosmetic peel workshop in California in 1993 run by Dr Mark Reuben, a recognised leader in the field, and he therefore had considerable experience in carrying out the procedure when Ms Susskind approached him.

10. Phenol (also known as carbolic acid) produces a chemical peeling effect when applied to the face. It removes wrinkles and pigmented spots. From approximately the early 1960s, doctors (usually plastic surgeons or dermatologists) began to use phenol-based preparations for the purpose of chemical face peeling procedures. However one of the known side-effects of phenol is that it can cause cardiac arrhythmia and, on occasions, cardiac arrest. As a result, doctors using phenol-based preparations regarded continuous cardiac monitoring and the availability of appropriate resuscitative drugs and emergency equipment as essential when carrying out chemical face peeling procedures.

11. The Exoderm procedure was developed by an Israeli doctor, Dr Fintsi. In his statement to the Tribunal, Dr Little said that he was told that Dr Fintsi was a world authority on this type of deep peeling, that the Exoderm procedure gave better results and it was very safe. Dr Fintsi had presented his findings at multiple international dermatology conferences and was in high demand as an expert worldwide. Dr Fintsi had also published a paper in the American journal of cosmetic surgery entitled "*Exoderm – A Novel Phenol-based Peeling Method Resulting In Improved Safety*". In this article, Dr Fintsi referred to the history of chemical face peeling procedures and contended that Exoderm was "*devoid of the complications associated with conventional phenol peels*".

12. Evidence produced at the preliminary hearing of the criminal charges suggested that Exoderm had been applied worldwide on many occasions with no reported deaths (other than that of Mrs Stevens). Against this background, Dr Little entered into an exclusivity arrangement with Ms Susskind. This agreement gave Dr Little the right to perform the Exoderm procedure in New Zealand and they also agreed to market the Exoderm

procedure on a joint basis. This marketing exercise involved the use of a public relations firm.

13. Dr Little travelled to Israel and observed Dr Fintsi using Exoderm to perform chemical peeling procedures. He spent two days with him in his rooms and participated in two Exoderm procedures. He was assured that there was no risk from cardiac arrhythmia, such as was present with the existing chemical peel procedures.

14. On his return to New Zealand, Dr Little performed ten Exoderm procedures without incident. The tenth of these procedures was filmed and shown on the Holmes television programme. The sentencing judge, His Honour Justice Willy Young found that this latter procedure was a marketing exercise. Dr Little told the Tribunal that he also discussed the Exoderm procedure with his colleagues in New Zealand.

15. In some but not all of the ten procedures undertaken, Dr Little used a pulse oximeter (which monitors oxygen levels in the blood and also the patient's pulse). The use of a pulse oximeter is recommended in Dr Fintsi's article referred to above, and was used in the procedure shown on the Holmes show.

16. The procedure performed on Mrs Steven was also carried out as part of a marketing exercise. Dr Little decided to perform the procedure in the presence of a photographer who was to take photos for publication in an article in the New Idea women's magazine. Dr Little offered to provide a free Exoderm procedure to a patient who would agree to participate in the New Idea story and Ms Shelley Scott, who was Mrs Steven's daughter, told her mother about Dr Little's offer and it was decided that the free procedure would be carried out on Mrs Steven.

17. Mrs Steven had a number of risk factors for cardiac disease. However Justice Young found that in February 1999 when she presented for the procedure, Mrs Steven was symptom free, fit and in apparently good health. Mrs Steven was a registered nurse and qualified beautician (as was Ms Scott). She was 57 years of age, fit and healthy, and a much loved mother and grandmother. The Victim Impact Reports also refer to her work in the community caring for children who were disabled, abused or crippled.

Relevant guidelines for anaesthesia

18. The relevant guidelines for the administration of sedation for diagnostic and surgical procedures are issued by the Australian and New Zealand College of Anaesthetists (ANZCA). These guidelines were described by Justice Young as the "*core requirements*" or "*minimum standards*" for those using sedation procedures. These guidelines have previously been referred to in relevant Tribunal decisions, for example, in *CAC v Chan*, Decision No 159/00/67C, as setting minimum standards for the administration of sedation by non-anaesthetist general practitioners.

19. Amongst other things, the guidelines require:

> "*1. A person administering sedation, should have the basic knowledge to detect and manage appropriately any complications and to be skilled in airway management and cardiovascular resuscitation.*
>
> *2. There must be an assistant present during the procedure appropriately trained in resuscitative measures who is to monitor the level of consciousness and cardio-respiratory function of the patient.*
>
> *3. At any time that rational communication with the patient is lost, the practitioner must cease the procedure and devote full-time attention to monitoring the patient until another practitioner is available to assist.*
>
> *4. The facilities available are required to include a supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient, a means of inflating the lungs with oxygen (eg a range of pharyngeal airways and self-inflating bags suitable for artificial ventilation) and a pulse oximeter.*
>
> *5. Patients undergoing intravenous sedation must be monitored continuously with pulse oximetry. This equipment must alarm when certain set limits are exceeded.*"

20. At the time of the procedure, Dr Little had ordered a resuscitation kit and a pulse oximeter but on the date of Mrs Steven's procedure, neither had arrived. Prior to the procedure being commenced, Mrs Steven signed a consent form but that form did not alert Mrs Steven to the fact that Dr Little intended to carry out the procedure in a way which did not conform either to Dr Fintsi's recommendations (that pulse oximetric monitoring be

maintained during the procedure) or to the ANZCA guidelines for "*Sedation for diagnostic and surgical procedures*" (referred to above).

21. As arranged, the procedure was photographed by a New Idea photographer. The Exoderm distributor, Ms Susskind, was also present throughout the procedure as was Dr Little's nurse, RN Dunn. Dr Little sedated Mrs Steven and the evidence before Justice Young was that from a very early stage after the administration of the sedation Mrs Steven was, or appeared to be, in deep sleep and did not grimace or flinch on the application of Exoderm nor did she respond when spoken to. There was evidence that she snored during the procedure.

22. Justice Young found that "*rational communication*" was lost from the outset of the procedure and for that reason, Dr Little should immediately have ceased the procedure and should not have resumed unless another doctor was available to monitor Mrs Steven and to take responsibility for further sedation, analgesia or resuscitation. But as Justice Young noted (at para 33), compliance with the guidelines would have meant total cessation of the Exoderm procedure as there was no other practitioner available.

23. Justice Young also found that by proceeding without a pulse oximeter Dr Little was proceeding in breach of the guidelines as well as Dr Fintsi's recommendations (at para 34), and that there was no continuous monitoring of "*the level of consciousness and cardio-respiratory function of the patient*" which was required under the guidelines, particularly as there was no pulse oximeter (at para 35).

24. About 30 minutes into the operation, at a time when Dr Little was working on Mrs Steven's eyelids, she gave a bit of a start and took a gasp of breath and then seemed to sigh. Dr Little responded by administering morphine.

25. At the final stage of the procedure, which involved taping up Mrs Steven's face, Mrs Steven gave a loud sign or groan and it was at about this time that it became apparent to those present that there was a major problem. Dr Little called out to Mrs Steven but there was no response. It was discovered that she had no pulse and was not breathing. At this time the photographer was requested to leave and he did.

26. Dr Little and Ms Dunn attempted to resuscitate Mrs Steven. In breach of the guidelines an artificial airway was not available, it was in the back of Dr Little's car. Dr Little did not have oxygen available nor did he have a suction device or manual resuscitator.

27. Justice Young found that Ms Dunn had a current CPR certificate but that Dr Little had no experience or training in CPR since working as an anaesthetics registrar in the early-1980s and for this reason the Trial Judge found that Dr Little was not well placed to deal with the emergency that arose (paras 39–40).

28. An ambulance was summoned and with their equipment the ambulance officers were able to continue resuscitation attempts but were unsuccessful. After approximately 30 minutes or so, the ambulance officers formed the view that the situation was hopeless. Dr Little instructed the officers to continue resuscitation in the ambulance on the way to hospital and eventually Mrs Steven was successfully resuscitated in the ambulance to the extent that full cardiac activity was restored. However, by then she had suffered irretrievable brain damage and she died in hospital on 15 March 1999.

The necessaries of life which were not provided

29. The Trial Judge identified the following necessaries of life as having not been provided by Dr Little:

> "*1. A pulse oximeter. This is required under the guidelines as a required facility. It is also regarded as being a minimum requirement for the application of phenol-based preparations in chemical face peeling procedures.*
>
> *2. A supply of oxygen and devices for the administration of oxygen as required by the same guidelines and possibly other emergency equipment as well, such as a suction device.*
>
> *3. A means of inflating Mrs Steven's lungs with oxygen along the lines of 'a range of pharyngeal airways and self-inflating bags suitable for artificial ventilation'. You did have an artificial airway but this was in your car and not in the procedure room.*
>
> *4. Continuous monitoring of Mrs Steven's condition with a pulse oximeter.*

5. A cessation of the procedure once Mrs Steven became unconscious and a devoting of your entire attention to monitoring and treating her until such time as another practitioner became available.

6. Continuous monitoring of her state of consciousness and cardio-respiratory function." (para 45)

30. As stated above Dr Little ultimately pleaded guilty to the charge of failing to provide the necessaries of life and the manslaughter charge was withdrawn. At paragraphs 47 - 53 of his Sentencing Notes, Justice Young outlined why the Crown did not proceed with the manslaughter charge and concluded:

"*The fact that the Crown has elected not to proceed on the manslaughter count means that I must sentence you on the basis that there is at least a reasonable doubt as to whether your criminal negligence caused, in the legal sense the death of Mrs Steven. I should, however, emphasise that the legal concept of causation for these purposes is a narrow one and my view is that the difference in terms of culpability between the manslaughter count and the count to which you have pleaded guilty is fine - certainly rather finer than you seem to think...*" *(para 53)*

Dr Little's level of culpability

31. Dr Little's level of culpability was also considered by Justice Young. Having observed that a doctor prosecuted for such a case (criminal and disciplinary) will often see the process as involving bad luck and being unfair, and that Dr Little was certainly of the view that this was so in his case, Justice Young nonetheless found that this could not fully explain Dr Little's case for four reasons:

"*1. The extent to which your behaviour deviated from what other doctors performing the procedure see as appropriate. The deviation was so major as to make it almost inevitable that a jury would have concluded that you were criminally negligent.*

2. Why was there such a major deviation between what should have happened and what did happen? I think that the fundamental problem was that you allowed your good judgment as a doctor, to be affected by the commercial requirements of the Exoderm marketing programme. There was no need to carry out the procedure on Mrs Steven before the arrival of the pulse oximeter and the oxygen and associated equipment which you had ordered. I cannot help but think that the presence of the New Idea photographer and general

arrangements as to publicity were a factor in your decision to proceed with this procedure on 22 February. I think that Mrs Steven's lipstick was left on. This would make the photographs of the procedure more attractive in a marketing sense, although it was not sensible medically. Then when Mrs Steven lost consciousness it was your duty under the guidelines to abandon the procedure. But how would that have looked with a New Idea photographer there? I think that the presence of that photographer put pressure on you to proceed... What I am satisfied about is that the whole concept of performing a serious medical procedure as a publicity exercise was fundamentally flawed.

3. You knew what the proper precautions were and you elected not to take them. I think that this is apparent from the equipment which you ordered and the use of the pulse oximeter on earlier occasions. In proceeding in circumstances where you did not take proper precautions you took a risk with Mrs Steven's health and, indeed, her life. You no doubt thought that there was not much of a risk. But I do find it hard to see how you could not have recognised that you were endangering her safety. You did this when, as I have indicated, there were marketing considerations which conflicted with your obligations to Mrs Steven. So it is possible to regard your conduct as at least bordering on recklessness.

4. Finally, this was the eleventh procedure which you carried out. In respect of some at least of the first nine procedures, your conduct was broadly similar to the way in which you dealt with Mrs Steven. So this is not a one-off case, an isolated error of judgment."(para 56)

32. Justice Young found that Dr Little's fundamental fault was in allowing commercial and marketing considerations to intrude into a situation which called primarily for the exercise of a good sound professional judgment.

33. Finally, Justice Young found:

"*Given the facilities that you had available, it was criminally negligent of you to embark on the chemical face peeling procedure which you performed on Mrs Steven. Because I am of the view that she would not have died if you had not performed the procedure, this means that you, by your criminal negligence, provided the occasion for her death. It was also criminally negligent of you not to stop the procedure when she lost consciousness. I am satisfied that if you had stopped the procedure then, she would not have died. So this is a second respect in which your criminal negligence provided the occasion for her death. I accept that, as matter of law, providing the occasion for a death is not the same as causing it. But the case against you involves a little more than simply providing the occasion for her death. The risk of a patient having a cardiac arrest during a chemical face peeling procedure is one of the reasons why competent doctors take the precautions which I have been discussing*

but which were not taken by you. In that sense, her death can be seen as falling squarely within the risk which you ought to have taken precautions to avoid. The concept of injury within risk is often relied on in civil case as establishing causation."(para 63)

Victim Impact Reports

34. Justice Young had regard to the Victim Impact Reports provided by Mrs Steven's children and copies of these were provided to the Tribunal. They are self- explanatory and have fairly been described as "*harrowing*". There can be little doubt that Mrs Steven's family's suffering was greatly increased by their ordeal during the three weeks following her resuscitation until her death.

The Medicines Act Convictions

35. On 1 November 2000 Dr Little pleaded guilty in the Christchurch District Court to two charges under s20 of the Medicines Act 1981. The first charge related to brochures advertising Exoderm which Dr Little made available to his patients in Christchurch and elsewhere in New Zealand during the period from 1 December 1998 to 1 March 1999. The second charge related to an advertisement for Exoderm which was published in "The Press" on 4 February 1999.

36. On 1 December 2000 the District Court Judge Abbott fined Dr Little $5,000 on each charge together with Court costs and a contribution towards the costs of prosecution (District Court Decision page 17).

37. In his judgment Judge Abbott described the advertisements in the following terms:

"*The advertisement which was published in "The Press" on 4 February 1999 was a two-column advertisement on page 4, which was the editorial page. Somewhat ironically, the subject of the editorial that day was the alleged failure of the recent reforms of the health system.*

The advertisement contained a heading referring to "Exoderm Lift", two black and white "before" and "after" photographs of a middle-aged woman patient, three paragraphs of text about the benefits and safety of the Exoderm procedure, a photograph of Dr Little, and his name, address and contact details, with references

to his specialisation in appearance medicine and to the availability of "an explanatory brochure".

The brochure was a glossy colour fold-out publication, with four sets of "before" and "after" photographs, the three paragraphs of text which appeared in the newspaper advertisement, five "frequently asked questions" (and the answers), a photograph of and biographical material about Dr Little, and contact information. As with the advertisement, the brochure referred to Exoderm being available exclusively through Dr Little, while the "blurb" on the back page of the brochure included the statement that Exoderm was "an international facial peel method" which was practised in 13 named countries, including New Zealand." (pages 7 - 8):

38. When assessing the appropriate penalty to impose, Judge Abbott considered the level of Dr Little's culpability and found that:

"*In my view Dr Little's culpability in the context of the two offences which he has admitted should be categorised as medium to high.*

As Mr Stannaway said in his submissions, although Dr Little was the "end user", he is a medical practitioner of considerable experience in the field of appearance medicine. In those circumstances, given his significant specialist expertise, it is surprising that it did not apparently even occur to Dr Little that he should check with the Ministry of Health regarding the status of Exoderm in this country. After all, Exoderm was a new product, he was to be the exclusive licensee in New Zealand, it was a product which could be used solely in his own specialist field of appearance medicine, and the treatment could be administered only by a medical practitioner with appropriate training and expertise.

In those circumstances, I would have thought that Dr Little would not have been content to rely on assurances from the manufacturer and the New Zealand distributor of the product, each of whom had a vested interest in it being successfully marketed, and/or on informal discussions with professional colleagues. On the latter point, the colleagues with whom he discussed the matter may have been less experienced in the field than Dr Little himself, and those discussions apparently related not so much to the status of Exoderm in terms of any consent issue but to the safety of the procedure.

Furthermore, the Medicines Act is legislation with which every medical practitioner should be familiar. While a medical practitioner is not expected to be a lawyer, it is self-evident from the description of Exoderm which I have given in this judgment that, adapting paragraph (f) of the definition of "therapeutic purpose" in section 4 of the Act, its use "interferes temporarily with the normal operation of a physiological function", namely the skin, from which it follows that Exoderm was in

fact a "medicine" in terms of the definition in section 3 of the Act. Put shortly, I find it surprising that that issue apparently did not even occur to Dr Little.

Furthermore, and this is in a sense a corollary of the last point, Exoderm was available in New Zealand only through Dr Little. The advertisement in "The Press" and the patient brochure emphasised both the efficacy and the safety of the Exoderm procedure, and both the advertisement and the brochure derived authority from the association between Exoderm and Dr Little, who held himself out as a specialist in the appearance medicine field.

In conclusion in respect of this factor, I agree with Mr Stannaway's submission that Dr Little's culpability is as great as, if not greater than, the culpability of Farra Cosmetics." (pages 12-13)

39. Judge Abbott also considered deterrence as a relevant factor and in doing so referred to the principal purpose of the Medicines Act as being to protect the public. He stated:

"*The next factor which is relevant in the context of the present case relates to deterrence.*

In my view this factor is important, particularly in respect of the issue of general deterrence. The Medicines Act controls and regulates the availability of medicines and other similar products. The purpose of the regulatory provisions of the Act is to protect the public, with particular reference to issues of safety, quality and efficacy of medicinal products. As it was put in the summary of facts, those three elements must all be assured if the public is to be adequately protected from products which have the potential to harm if they do not meet the standards which are claimed for them or if they are used unwisely or inappropriately.

Against that background, there is a very real public interest in ensuring that medical practitioners, who have total responsibility in respect of the prescription and administration of medicines, are fully cognisant of the corresponding responsibility to ensure that medicinal products which they prescribe and medicinal-based treatment procedures which they administer have the appropriate New Zealand regulatory approval. As Judge Somerville implied when sentencing Farra Cosmetics, that is of particular importance in a society in which general publicity of the availability of a medicinal product or treatment is now a fact of life." (page 15)

Submissions on behalf of CAC

40. Mr McClelland referred to the primary purpose of the professional disciplinary jurisdiction as the protection of the public, although there is also a punitive element: *Taylor v General*

Medical Council [1990] 2 A11 ER 263, 266/c-d, *Ziderman v General Dental Council* [1976] 2 A11 ER 334, 336/b-c. A further purpose is to maintain the integrity of the profession: *Dentice v The Valuers Registration Board* [1992] 1 NZLR 720, 724-725:

"***The disciplinary procedure***

Although, in respect of different professions, the nature of the unprofessional or incompetent conduct, which will attract disciplinary charges, is variously described, there is a common thread of scope and purpose. Such provisions exist to enforce a high standard of propriety and professional conduct; to ensure that no person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public, and the profession itself, against persons unfit to practise; and to enable the profession or calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them; see, generally, In Re a Medical Practitioner [1959] NZLR 784 at pp 800, 802, 805 and 814. In New Zealand, such provisions exist in respect of medical practitioners, barristers and solicitors, dentists, architects, pharmacists, real estate agents and a number of other professions and callings, as well as valuers. See Medical Practitioners Act 1968, Part III; Law Practitioners Act 1982, Part VII; Dental Act 1988, SS45-68; Architects Act 1963, SS41-45; Pharmacy Act 1970, Part III; Real Estate Agents Act 1976, Part VII. The very nature of the professions mentioned indicates the significance of the subject matter for the public interest that in respect of such professions and callings, high standards of conduct should be maintained."

See also Guy v Medical Council of New Zealand [1995] NZAR, 67, 73.

41. In *B v Medical Council* Elias J described the disciplinary process as being in part one of setting standards:

"*The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards.*"

42. Mr McClelland submitted that the criminal proceedings which Dr Little has been subject to are quite separate and distinct from the disciplinary procedures pursuant to Section 109 of the Act. Mr McClelland submitted that the Tribunal can and should take into account the sentencing comments made by both the High Court Judge and the District Court Judge and that s109 proceeds on that basis. However, at the end of the day, Mr McClelland stated, it is for the Tribunal alone to determine whether the circumstances of Dr Little's offending reflect adversely on his fitness to practise medicine and if so what sanctions should be imposed, bearing in mind the overriding purpose of the Act being to protect the health and safety of members of the public.

43. In relation to a question from the Tribunal as to what extent the Tribunal should take into account subsequent events, that is, events occurring after 22 February 1999, Mr McClelland suggested that the Tribunal is entitled to, and should, take into account subsequent events. Those include the suffering endured by Mrs Steven's family over the three weeks between the date of the procedure and her death in Christchurch Hospital, the matters referred to in the Victim Impact Reports, and any changes in Dr Little's subsequent practice.

44. The thrust of Mr McClelland's submissions were that Dr Little's fundamental fault was allowing himself to be influenced to the extent that he was by commercial and marketing considerations. In this regard, Mr McClelland referred to findings by the Judge that the presence of the New Idea photographer and general publicity arrangements were a factor in Dr Little's decision to proceed despite not having a pulse oximeter and the other oxygen and associated equipment which had been ordered.

45. These findings that public safety was compromised by commercial marketing considerations particularly when Dr Little knew that he should have had appropriate safety mechanisms and monitoring equipment in place must raise serious questions as to Dr Little's fitness to practise medicine. Mr McClelland also referred to Dr Little's apparent lack of insight into his actions and their consequences. In his sentencing remarks, Justice Young expressed the view that Dr Little might have viewed the prosecution as involving bad luck and being unfair (paras 55-56).

46. Mr McClelland submitted that this lack of insight could also be seen from Dr Little's letter to the CAC earlier this year when it was investigating his conviction. In that letter, Dr Little blames the suppliers of Exoderm for failing to tell him that the product had not been authorised for use as a medicine in New Zealand and he refers to the decision to prosecute by Medsafe as being "*an unusual step*" brought about by Mrs Steven's death and the subsequent media response.

47. Similarly Dr Little blames systems failures and 'stones cast by others' as leading to the death of Mrs Steven and explains how he "*is lost as to why the Police did not investigate it as an accident but chose to present biased evidence to the Crown Prosecutors*" and concludes "*I can only wonder if they were biased by recent media war on doctors and the fact that the deceased was a policeman's widow*".

48. In terms of penalty, Mr McClelland submitted that Dr Little's name should be removed from the register or alternatively that he be suspended from practice. The CAC acknowledged that Dr Little has practised safely for the last three and a half years and is now practising subject to conditions agreed to by him, but there remains a very real concern that his lack of insight into his actions and their consequences will make it difficult for him to address his shortcomings as a medical practitioner and that this in turn will potentially compromise patient safety.

49. It was also submitted that such a penalty would send a very clear message to those practising in the highly publicised field of appearance medicine that under no circumstances will the medical profession and the public tolerate patient safety being compromised for commercial or marketing reasons. These are the standards that the Tribunal must set. Mr McClelland also sought orders that Dr Little should practise subject to the conditions already imposed by the Tribunal on an interim basis, publication of the Tribunal's decision and costs.

Submissions on behalf of Dr Little

50. On behalf of Dr Little, Mr James submitted that Dr Little was remorseful and very conscious of the fact that the procedure carried out by him had led to Mrs Steven's death.

He expressed his deep regret to Mrs Stevens' family who were present at the hearing. Mr James said that Dr Little felt let down and very angry with Dr Fintsi. Dr Little was naïve and gullible, and was angry more at himself rather than Dr Fintsi.

51. He conceded that Dr Little had initially blamed others for what had occurred and that he had taken some time to come to a full and open acceptance of the part he had played in Mrs Steven's death. But Dr Little's perspective has changed over the three and a half years since the events had occurred. He now accepts that he was totally responsible for what had occurred and Dr Little confirmed this is in his own statement to the Tribunal. Mr James suggested that the Tribunal might consider there "*was something redeeming in that*."

52. These events have now been the subject of seven or eight court proceedings and had received the close attention of the media. Dr Little accepted that he must be accountable for what had occurred, and he had suffered a range of emotions - sorrow, remorse, sadness, anger and chagrin. The Victim Impact Reports had a harrowing effect on Dr Little. He accepted that his medical management at the time was deficient, and that this reflected on his fitness to practise.

53. Dr Little also accepted Justice Young's comments that there was a 'fine line' between the charge he was convicted on and manslaughter, and that manslaughter was only one small step above failing to provide the necessaries of life. Dr Little pleaded guilty in both the High Court and the District Courts.

54. He has discontinued this area of practice. He has ceased administering anaesthesia and he has been open with his colleagues in highlighting the dangers of the procedure for the purposes of educating other practitioners. He has accepted conditions on his practice and has been co-operative and compliant with the Medical Council in its review of his competence and mentoring provided by the Council.

55. He has paid all fines imposed on him from his own resources and he is fully cognisant that his conduct is deserving of approbation. Dr Little seeks the understanding of the Tribunal. There is no pattern of aberrant conduct or practice; no thread of fault or flaw in his

conduct. Mr James referred to an affidavit from Dr Little's mentor which he submitted was relevant to Dr Little's current practice. Other references referred to his insight and openness about the events.

56. Mr James submitted that Dr Little is not now seen by his mentor as lacking insight and that is the person charged by the Medical Council to make that assessment. Dr Little is not an isolated practitioner. In terms of penalty, Mr James asked the Tribunal to bear in mind the considerable length of time since these events occurred and that Dr Little has been under supervision, and the conditions imposed. He has not erred during the time he has been under close scrutiny. It is appropriate that the conditions imposed continue in that form.

57. Mr James also submitted that some training as suggested by the CAC may be appropriate and that Dr Little may take some training in professional development. The possibility of suspension was viewed with some trepidation, and would be onerous bearing in mind the level of betterment that Dr Little has gone through in recent years, the acknowledgments made by him, and that he is redeemable.

58. Dr Little accepts that censure is inevitable and appropriate, and an order of costs. In terms of the latter, he has modest means. He has paid all of the fines ordered against him, and a field of medicine that might have been open to him is now denied to him, which is appropriate.

Decision and reasons

59. **Censure**: Dr Little is censured, and he accepts that censure is inevitable and appropriate.

60. **Removal of Dr Little's name from the register**: For the reasons which follow, the Tribunal has determined that Dr Little's name should be removed from the register and that he may not apply for restoration to the register for a period of not less than six months.

61. The Tribunal took a good deal of time to consider all the facts and circumstances giving rise to this charge, and the submissions made by both counsel. This is a difficult case, made even more so by the utterly tragic nature of Mrs Steven's death, the degree of

distress caused to her family and the extent of their loss. There can be little doubt that their grief is compounded by the knowledge that if she had received only the minimum amount of care and protection she was entitled to expect from Dr Little, she would most likely still be alive today.

62. In his sentencing notes, Justice Young also referred to the sadness Mrs Steven's children feel about her death, the consequences it has had for them, and their anger towards Dr Little. He stated that "*given the circumstances of her death and the pointlessness of it and given, as well, the ghastliness for them of the period that elapsed between 22 February and her death in mid March 1999, I can understand how they feel.*"

63. He went on to state:

"*I have no doubt that you will yourself have found that the Victim Impact Reports make harrowing reading. On the other hand, I suspect that in your mind you will bat away what appears in the Victim Impact Reports on the basis of your rationalisation of events in which you dismiss the possibility of a connection between your actions and Mrs Steven's death. As is apparent from what I have just said, I think that this rationalisation under-allows for the causal potency and significance of your actions. On the other hand, I recognise that you have not been convicted of manslaughter and there is a real sense in which the Victim Impact Reports appear to have been written as if that were the crime for which you now appear for sentence.*

Plea for guilty

You pleaded guilty but this came late in the piece. Having explored some months ago the possibility of the case being resolved on the basis of a plea of guilty to count 2, my impression is that the Crown would have accepted this plea had it been offered at that time.

Given the type of sanction I propose to impose, the significance to be attached to this plea is much less than would normally be the case." *(paras 67-69)*

64. The Tribunal agrees with all of those comments. Notwithstanding the submissions made on his behalf and his evidence given at the hearing, the Tribunal equally has concerns about the level of insight Dr Little truly has about the nature of his failure to provide adequate care to Mrs Steven and the degree to which he fell short of acceptable standards of care. He

seems still to blame others for what happened, suggesting that he was naïve and gullible to trust the word of others.

65. The Tribunal has already referred to Dr Little's letter to the CAC investigating his conviction (paras 47 and 48 above). He told the Tribunal that he now accepts that the police were 'just doing their job'. The Tribunal has also taken into account that against that evidence, Dr Little also gave evidence of the changes he has made to his practice, and the efforts he has made to educate his colleagues about the risks during the past three and a half years.

66. However, in terms of his professional obligations towards Mrs Steven on the day of the procedure, and especially in the course of administering and managing her sedation, there can be no suggestion that others could, or should, have done more to keep his patient safe. The relevant anaesthetic guidelines make it clear that the objective of sedation for diagnostic and surgical procedures carried out by non-anaesthetists is to "*… produce a degree of sedation of the patient,* ***without loss of consciousness,*** *so that uncomfortable diagnostic and surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render loss of consciousness unlikely*" (Section 1 of the Guidelines, emphasis added).

67. The underlying principle is that an anaesthetist should be present unless "*rational communication*" with the patient is continuously possible during the procedure (Section 2.5). The practitioner preoccupied with surgical tasks cannot safely undertake the necessary monitoring of a patient in a state of heavy sedation. As a practitioner who was regularly administering anaesthetic drugs for the purposes of 'sedation', who had experience with procedures using phenol-based solutions, and his experience as an anaesthetic registrar, Dr Little knew, or ought to have known, the nature and degree of the risks involved, including the particular side-effects of the procedure being carried out, and thus the potential consequences for Mrs Steven if things went wrong.

68. He also knew, or ought to have known, that if an emergency occurred the nature of it would require quick thinking and prompt action on his part, and, most importantly, immediate access to the necessary equipment.

69. He also knew what sort of equipment was required, and had ordered the equipment but not taken delivery of it. Even the most basic equipment that he had available to him was not immediately to hand but left in his car outside of the room where the procedure was being undertaken. The significance of the risks to Mrs Steven, and therefore the degree of Dr Little's professional failure, cannot be underestimated.

70. It is also relevant that the procedure was elective, so there was no clinical reason why the procedure had to occur at that time, or even at all. This factor is relevant in two respects:

(a) First, it seems clear that even though Dr Little spent some time with Mrs Steven prior to the procedure (on 15 February 1999) he did not attach any significance to the episode of chest pain some years previously reported to him. He said that Mrs Steven told him that cardiac tests at the time had been negative and put down to dyspepsia. She told him that she had no symptoms since and was not on medication, and he apparently made no further inquiry. On the basis of his pre-procedure check, Dr Little was 'happy that she was a good candidate and physically fit for the procedure'.

(b) However, it is now well-established (and the Code of Health & Disability Consumers' Rights requires) that all practitioners must ensure that their patient is fairly and adequately informed of all of the risks, and benefits, of the surgery they are to undergo, and any alternatives. This applies even more so when the surgery is elective, and there is no element of necessity or emergency.

(c) ANZCA guidelines also require that the patient assessment procedure should include "*… performance of appropriate investigations and identification of risk factors"*. Equally, the patient must not be coerced, subtly or otherwise, into agreeing to undergo surgery. Again, such proscription is even more significant when the surgery is elective, and there is, actually or potentially, significant financial remuneration or other benefit to the practitioner;

(d) Notwithstanding his pre-operative meeting with Mrs Steven, and his physical examination of her, it subsequently became apparent that she had a number of risk factors for coronary disease; and

(e) Secondly, the elective nature of the procedure is relevant in the context of the submissions, evidence and Judge's comments to the effect that commercial and marketing considerations were at the forefront of Dr Little's mind.

71. The Tribunal is satisfied that Dr Little was motivated to carry out the procedure by commercial considerations and he failed to turn his mind to keeping his patient safe. It also appears to the Tribunal to be the case that he was lulled into a false sense of security by the success of the previous procedures he had undertaken. He ignored the risks involved with every such procedure and the individual needs of this patient.

72. The Tribunal is also concerned that because Dr Little failed to adequately monitor Mrs Steven during the procedure, he failed to notice warning signs that might have indicated to a more careful, or qualified, practitioner that she was becoming deeply unconscious and her cardio-respiratory functioning was deteriorating. As a result, by the time Dr Little became aware that Mrs Steven had no pulse and that she was not breathing, he could not have known precisely how long her cardio-respiratory function had been significantly compromised.

73. Because no artificial airway was available in the room (in breach of the guidelines) and there was no oxygen, suction device or manual resuscitation bags available in the room, Dr Little was unable to provide immediate, effective resuscitation. While Justice Young was of the view that Dr Little, and Ms Dunn, did in fact respond professionally and responsibly to the emergency, he also expressed the view that "*the probabilities are that the die was, by this stage, well and truly cast. Mrs Steven had a cardiac arrest. I suspect that most people who have cardiac arrest outside the well equipped environment of a hospital are not successfully revived*" *(para 40).*

74. By the time the ambulances arrived at Dr Little's room Mrs Steven was in a state of ventricular fribulation and for the next 35 minutes or so Dr Little and the ambulance officers continued resuscitation attempts and, as stated above, Mrs Steven's cardiac activity was eventually restored in the ambulance on the way to hospital.

75. It is the Tribunal's view that Dr Little's instructions to continue resuscitation paid little heed to the length of time that Mrs Steven's had been without cardio-respiratory function (possibly 45-50 minutes or so) and the likelihood that she would have suffered irretrievable brain damage. Mrs Steven never regained consciousness and the Victim Impact Reports confirm that the ensuing 3 weeks prior to her death caused hardship and enormous distress and suffering for her family.

76. Similarly, the Tribunal is satisfied that Dr Little should have made his own inquiry as to the status of Exoderm for use in New Zealand. It was not sufficient for him to rely on the assurances of a non-qualified person (the distributor) who had a vested interest in obtaining sales, or any informal discussions he had with other practitioners.

77. Dr Little entered into an 'exclusivity agreement' for the use of Exoderm in New Zealand, and he had the opportunity to ensure that it was approved for use in New Zealand, and that it was safe. It is appropriate that Dr Little now accepts that he should have made proper inquiry in this regard.

78. The Tribunal has put to one side the fact that Dr Little's conduct has already been the subject of other proceedings in other contexts. It has taken the approach that, while it should fairly take into account subsequent events, it must carry out its task objectively and fairly and quite separately from any other proceedings. It must adhere to the statutory purpose of the Act and other relevant provisions and therefore it cannot lose sight of the fact that Mrs Steven's death occurred squarely in the context of a doctor-patient relationship.

79. As her doctor, Dr Little owed obligations to Mrs Steven over and above any obligations he owed as a citizen. It is largely in that latter capacity that he was dealt with in the criminal courts. In that jurisdiction, the fact that his professional care, or lack thereof, provided the occasion for her death is almost a secondary consideration. In the professional disciplinary context, it is the primary consideration.

80. In that regard, the Tribunal is satisfied that Dr Little failed to take responsibility for his care of Mrs Steven in the following respects:

(i) Dr Little did not act in Mrs Steven's best interests in that he failed to have regard to either her particular interests as his patient, or her interests relative to his own;

(ii) Pre-procedure - Dr Little failed to make an adequate pre-procedure assessment of Mrs Steven's needs in terms of:

- her suitability to undergo the procedure,
- the presence of known risk factors in the context of the procedure,
- the likelihood that the risks known to be associated with phenol-based procedures might eventuate, and/or
- the need to ensure her safety during the procedure and in event of an emergency;

(iii) During the procedure – Dr Little's management of the major sedation he administered can only be described as "*abysmal*". He lacked basic equipment, and basic knowledge. The Tribunal does not accept his evidence that Mrs Steven was 'rousable', i.e. "*conscious*" as required under the relevant guidelines, during the procedure. For example, the evidence that she was snoring during the procedure suggests that her increasingly compromised cardio-respiratory functioning went unnoticed by Dr Little. His shortcomings in this regard is exacerbated by his unapproved use of a medicine with serious potential side-effects.

(iv) Emergency care – Dr Little's instruction to the ambulance officers to continue resuscitation notwithstanding their advice that it was hopeless and his own lack of knowledge as to precisely how long Mrs Steven's cardio-respiratory functioning had ceased, was not in the best interests either of Mrs Steven or her family and greatly increased their subsequent suffering and distress.

81. It has been accepted by all concerned that Mrs Steven would be alive today if the proper equipment had been available, and proper care given to her. It follows from that, she would be alive today if her doctor, to whom she entrusted her well-being, had been properly motivated. The Tribunal is satisfied that he was not and that his failure to provide

proper care to Mrs Steven constitutes the most serious departure from professional standards.

Delay

82. The Tribunal has also taken into account the fact that it is now three and a half years since the events giving rise to this charge occurred and also that this Tribunal, when considering an application for suspension of Dr Little's registration made by the CAC, permitted Dr Little to continue to practise and was satisfied that it was not necessary to suspend Dr Little from practice to protect the health or safety of members of the public.

83. In relation to the issue of delay, the Tribunal considers that is unfortunate for all concerned that such a delay has occurred. However, Dr Little faced serious criminal charges and he elected to defend those charges, and the Tribunal is not critical of him for that. Having elected to defend the charges until after the trial jury was empanelled, the defended charges took some time to be resolved. In Dr Little's case, he was not sentenced in relation to the criminal charges until 16 August 2001 and the certificate of conviction forwarded to the Medical Council is dated 18 September 2001.

84. The CAC is then required under the Act to carry out its own investigation and to determine whether or not a charge should be laid. In that context also, the CAC is required to undertake its procedures in accordance with the Act, and relevant legal principles, including the principles of natural justice. Dr Little exercised his right to attempt to persuade the CAC that a charge should not be laid. As stated above the Tribunal intends no criticism of Dr Little for exercising his rights to defend the allegations and charges laid against him.

85. Having completed its investigation, the CAC presented the professional disciplinary charges to the Tribunal on 28 May 2002. The Tribunal's hearing was original scheduled for July but subsequently postponed to September. By order dated 18 June 2002, the Tribunal dismissed the CAC's application for suspension of Dr Little's registration and ordered instead that he was to continue his practice under conditions which had been in

place since 1999. Dr Little also advised the Tribunal on that occasion that he no longer practised chemical face peel procedures, such as that undertaken on Mrs Steven.

86. The Tribunal has taken all of these matters into account. It is satisfied that its task is to objectively consider all of the evidence, material and submissions provided to it in order to fulfil all of its relevant statutory and legal obligations. While it accepts that it is fair and reasonable to take into account subsequent events rather than confining its deliberations only to the events giving rise to the charge, it has consistently taken the approach in cases presented to it that the central issue for determination by this Tribunal is to ascertain whether or not the practitioner's conduct and management of his or her patient's care (at the relevant time) constituted an acceptable discharge of his or her professional and clinical obligations.

87. While subsequent events, and the practitioner's conduct since the events in question occurred, are relevant considerations, the Tribunal's primary focus must, in fairness to all of the affected parties, be directed at the events giving rise to the charge and the degree to which the practitioner's conduct, or misconduct, departed from acceptable professional standards at the time.

88. Having reviewed all of the material placed before it, and bearing in mind that the principal purpose of the Act is to protect the health and safety of members of the public, and the other findings made by it, the Tribunal is satisfied that Dr Little's name should be struck of the register and that there should be a minimum period stipulated before he may apply for restoration.

89. In this regard, the Tribunal accepts the CAC's submission that in addition to the punitive element of the penalty the Tribunal may impose, it is equally important that the Tribunal sends a clear message to practitioners in general, as well as those practising in the field of appearance medicine, that significant departures from acceptable standards will attract the ultimate sanction, especially in circumstances where patient safety has been compromised for commercial reasons or the practitioner has otherwise put his own interests ahead of his or her patient's.

90. **Conditions on practice**: The Tribunal is also satisfied that, if Dr Little's name is restored to the register after six months, then for a period of three years from the date of this decision Dr Little is to practise under the following conditions:

(a) Dr Little is not to undertake procedures that involve sedation; and

(b) Anaesthesia is to be restricted to local anaesthesia; and

(c) In order to ensure compliance of this condition, Dr Little is to keep a log of procedures including medication that is to be countersigned by a registered nurse who has knowledge of the procedures performed. That log is to be available for regular review; and

(d) In the event that any procedures requiring the administration of sedation are undertaken at any clinic owned and/or operated by Dr Little, then an appropriately trained medical practitioner other than the practitioner carrying out the procedure must be present and be responsible for the administration of sedation and monitoring the patient; and

(e) If there is a risk of loss of consciousness during any procedure undertaken by or under the supervision of Dr Little, then an anaesthetist must be present to care exclusively for the patient.

91. **Fine:** Pursuant to s110(3) the Tribunal is not permitted to impose a fine following conviction.

92. **Costs:** The Tribunal is satisfied that Dr Little should pay 50% of the costs and expenses of and incidental to any or all of the CAC's inquiry and prosecution of the charge and the hearing by the Tribunal. The Tribunal considers that an order in this amount fairly takes into account the amount of the fines paid in other proceedings, Dr Little's modest means, the penalty imposed, the seriousness of the offending, and like cases.

DATED at Wellington this 25th day of September 2002

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal