IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2022] SMCDT 2

Between

Singapore Medical Council

And

Dr Teo Sze Yang

… *Respondent*

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

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Singapore Medical Council
v
Dr Teo Sze Yang

[2022] SMCDT 2

Disciplinary Tribunal – DT Inquiry No. 2 of 2022
Prof Ho Lai Yun (Chairman), Dr Andrew Tan Gee Seng, Mr Kow Keng Siong (Legal Service Officer)
11 to 15 October 2021, 11 January 2022, and 17 February 2022

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

8 March 2022

GROUNDS OF DECISION

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

Introduction

1 The Respondent is Dr Teo Sze Yang. He has been in practice since 2007. At all material times, the Respondent was practicing at his own clinic at Redhill ("**the Clinic**").

2 On 17 March 2018, Ms P ("**the Patient**"), a domestic worker from Myanmar, visited the Respondent's Clinic. She was accompanied by her employer, Ms PW1 ("**PW1**"). The purpose of the visit was for the Patient to undergo a routine medical screening required by the Ministry of Manpower ("**MOM**") for foreign work permit holders. As one of the screening requirements was tuberculosis ("**TB**"), the Respondent ordered a chest X-ray to be done on the Patient.

3 On 25 March 2018, the Respondent received the Patient's chest X-ray report dated 24 March 2018 ("**24 March CXR**"). It stated the following:

"Airspace shadows are seen in *both mid and upper zones*, suspicious for infection.
…
Conclusion:
There are airspace shadows in both lungs in keeping with infection.
Further management and follow-up is suggested"[1]

[emphasis added]

4 Based on the "abnormal" findings[2] in the 24 March CXR, the Respondent suspected that the Patient might have TB.[3] As such, he arranged for her to see him for an urgent review.[4]

5 The review took place on 29 March 2018. Ms PW2 ("**PW2**"), PW1's sister, accompanied the Patient to see the Respondent. It was not disputed that during the review, the Patient had fever, cough, and sore throat.[5] (There was a dispute as to whether PW2 had informed the Respondent about the duration of the Patient's cough.) The Respondent prescribed antibiotics and cough mixture for the Patient. According to the Respondent, he decided (a) to treat the Patient for Community Acquired Pneumonia ("**CAP**"), and (b) to refer her to the TB Control Unit ("**TBCU**") within a week if needed.

6 On 29 March 2018, soon after the review was completed, the Respondent's Clinic submitted electronically the Patient's medical examination form dated 17 March 2018 to MOM ("**the Form**"). In the Form (which was signed by the Respondent), he had certified that the Patient was negative for TB.[6] (The circumstances in which the Form had been submitted was disputed.)

7 On 31 March 2018, PW1 visited the Respondent's Clinic. (There was a dispute as to whether the Patient was also present during the visit.) The Respondent issued some

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1 Agreed Bundle of Documents Volume 1 ("**1AB**") at page 733.
2 The Respondent's Closing Submissions at [45].
3 The Respondent's letter to the Complaints Committee ("**CC**") dated 8 October 2020 at [8]: 1AB at page 440; The Respondent's Closing Submissions at [10(j)], [11(b)], [52], [114], [116], [124], [125] and [128].
4 The Respondent's letter to the CC dated 8 October 2020 at [7]: 1AB at page 439.
5 The Respondent's Closing Submissions at [48].
6 1AB at page 437.

over-the-counter medication for the Patient's cough. He did not refer the Patient to TBCU. Neither did the Respondent report to MOM that she was not cleared of TB.

8 The Patient did not recover and continued coughing. On 5 May 2018, she was admitted to Institution A and diagnosed to have TB. On 1 November 2018, Dr C, then-Director of TBCU, lodged a complaint against the Respondent with the Singapore Medical Council ("**SMC**").

9 At the inquiry, it was not disputed that based on the 24 March CXR and the Patient's diagnosis of multi drug resistant pulmonary TB on 5 May 2018, it was likely that she would already have TB during the 29 March 2018 review.[7]

The Charges

10 The SMC took the view that the Respondent displayed professional misconduct in how he had managed the Patient's case. In the circumstances, the SMC preferred two charges against him under section 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("**MRA**"):

(a) **First Charge.** The First Charge alleged that the Respondent had failed to provide appropriate care to the Patient.

(i) The basis of this allegation was that despite (1) the 24 March CXR and (2) the Patient having presented symptoms of TB during the 29 March 2018 review, the Respondent had firstly, *failed to carry out an adequate evaluation* of her, and secondly, *failed to refer* her to the TBCU or a TB specialist for further assessment and management.

(ii) Regarding the allegation of inadequate evaluation of the Patient, the SMC's case was that the Respondent had failed to elicit the relevant medical history from the Patient during the 29 March 2018 review. [8] It was also the SMC's case that PW2 had informed the Respondent during the review that the Patient (1) had been coughing since the Chinese New Year of 2018 (i.e., 16 / 17 February 2018) and (2) had felt hot and cold

[7] Agreed Statement of Facts ("**ASOF**") at [29].
[8] Prosecution's Closing Submissions at [59] and [103].

for some time. According to the SMC, such symptoms would have greatly increased the suspicion that the Patient had TB and the need to refer her to TBCU promptly.[9]

(b) **Second Charge.** The Second Charge alleged that the Respondent had certified in the Form that the Patient was negative for TB when there was in fact no basis for him to do so.

11 Each of the two charges asserted that based on the relevant facts, the Respondent was guilty of *either* –

(a) an intentional, deliberate departure from standards of the medical profession (**main charge**), or

(b) such serious negligence that it objectively portrayed an abuse of the privileges accorded to a medical practitioner (**alternative charge**).

The Defence

12 The Respondent disputed the charges. His defence was as follows:

(a) **First Charge** (Failure to take appropriate care of the Patient):

(i) The Respondent denied that PW2 informed him that the Patient had been coughing since Chinese New Year of 2018. According to the Respondent, he was told that the Patient had a cough and sore throat for only "a few days to one week".

(ii) The Respondent asserted that he had taken the Patient's detailed medical history during the 29 March 2018 review. Based on the information obtained, there was nothing to suggest to him that the Patient needed to be referred to TBCU immediately.[10]

(iii) The Respondent contended that the applicable Ministry of Health ("**MOH**") guidelines did not stipulate that a patient must be referred to the TBCU immediately if his X-ray screening was abnormal. According to the Respondent, the applicable standards of the medical profession accepted that doctors might seek to treat their patients first and to refer them to TBCU thereafter only if the symptoms persisted.[11]

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[9] Prosecution's Closing Submissions at [49], [57] – [61].
[10] The Respondent's Closing Submissions at [10(f)] – [10(i)].
[11] The Respondent's Closing Submissions at [10(a)] – [10(d)].

(b) **Second Charge** (Wrong certification in the Form):

(i) The Respondent's case was that he had pre-signed the Form on or around 17 March 2018 (i.e., the day the Patient first visited his Clinic for her medical screening).

(ii) The Respondent accepted that his certification in the Form (that the Patient was negative for TB) was wrong. Specifically, The Respondent accepted that it was wrong for him to certify that the Patient was negative for TB when (1) the 24 March CXR showed abnormal findings, and (2) no further tests were done to exclude her for TB.[12]

(iii) The Respondent however denied that he was guilty of professional misconduct because, the pre-signed Form was submitted by his clinic assistant, one Ms DW1 ("**DW1**"), without his instructions due to an "administrative error".[13]

The Legal Principles

13 The legal principles applicable to the Respondent's inquiry are well-established.

14 **Burden of proof.** The SMC had to prove the two charges against the Respondent *beyond reasonable doubt*. All that the Respondent needed to do was to cast a reasonable doubt in the SMC's case: *SMC v Lam Kwok Tai Leslie* [2017] 5 SLR 1168 at [36].

15 **Mental element for professional misconduct.** It was held in *SMC v Low Cze Hong* [2008] 3 SLR(R) 612 at [37] that professional misconduct can be made out in two situations.

(a) The first is where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency" ("**the Intentional Departure Limb**").

(b) The second situation is where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner" ("**the Serious Negligence Limb**"). It was held in *SMC v Lim Lian Arn* [2019] 5 SLR 739 ("***Lim Lian Arn***") at [38] that –

[12] The Respondent's evidence: Transcripts for 14 October 2018 at page 119 line 15 – page 120 line 6; page 124 line 16 – page 127 line 16.

[13] The Respondent's Closing Submissions at [11(e)].

> "Serious negligence portraying an abuse of the privileges which accompany registration as a medical practitioner would generally cover those cases where, on a consideration of all the circumstances, it becomes apparent that *the doctor was simply indifferent to the patient's welfare or to his own professional duties, or where his actions entailed abusing the trust and confidence reposed in him by the patient.* On the other hand, *it would not typically cover one-off breaches of a formal or technical nature where no harm was intended or occasioned to the patient or where harm was not a foreseeable consequence; nor would it ordinarily cover isolated and honest mistakes that were not accompanied by any conduct which would suggest a dereliction of the doctor's professional duties."* [emphasis added]

It was also held in *Lim Lian Arn* at [37] that the following factors are relevant in considering whether a professional misconduct fell within the Serious Negligence Limb of section 53 of the MRA:

(i) The nature and extent of the misconduct;

(ii) The gravity of the foreseeable consequences of the doctor's failure;

(iii) The public interest in pursuing disciplinary action;

(iv) The importance of the rule or standard that has been breached;

(v) The persistence of the breach; and

(vi) The relevance of the alleged misconduct to the welfare of the patient or to the harm caused to the doctor-patient relationship.

16 **Analytical framework.** The test for professional misconduct involves the following three-stage inquiry: *Lim Lian Arn* at [28] and [29].

(a) What is the applicable standard of conduct among members of the medical profession of good standard and repute in relation to the misconduct alleged against the defendant-doctor?

(b) Has the doctor departed from the applicable standard – either on the Intentional Departure Limb or the Serious Negligence Limb of professional misconduct?

(c) If the doctor has departed from the applicable standard, then is the departure sufficiently egregious as to amount to professional misconduct?

Issues to be determined

17 In light of the applicable tests and the case for the respective parties, the issues which we had to determine were as follows.

18 **First Charge**.

(a) In what manner did the Respondent conduct his evaluation of the Patient during the 29 March 2018 review?

(b) What are the applicable standards regarding how an evaluation to rule out active TB should be conducted?

(c) Do the applicable standards require the Respondent to refer the Patient to TBCU or a TB specialist for further assessment and management after the 29 March 2018 review without delay?

(d) Did the Respondent depart from the applicable standards?

(e) If the answer is yes, then was the Respondent's departure from the applicable standards –

(i) intentional or negligent?

(ii) sufficiently egregious as to amount to professional misconduct?

19 **Second Charge**.

(a) How did the Form come to be submitted to MOM?

(b) What are the applicable standards for signing of medical certifications?

(c) Did the Respondent depart from the applicable standards?

(d) If the answer is yes, then was the Respondent's departure from the applicable standards –

(i) intentional or negligent?

(ii) sufficiently egregious as to amount to professional misconduct?

Applicable standards and expert witnesses

20 At the inquiry, it was common ground that the applicable medical standards for managing patients suspected to have TB had been set out in the MOH Singapore Clinical Practice Guidelines 2016 on Prevention, Diagnosis and Management of TB ("**MOH Guidelines**").

21 To assist the Disciplinary Tribunal in making the relevant findings, the parties called the following expert witnesses:

SMC's expert witnesses

(a) Dr PE1, a specialist in Respiratory Medicine and Intensive Care Medicine. He worked at Institution B.[14]

(b) Dr PE2, a Senior Consultant Family Physician at Institution C[15]. Dr PE2 had conducted foreign worker medical screenings from 1995 to 2013.[16]

The Respondent's expert witnesses

(c) Dr DE1, a Family Physician who ran Institution D.[17]

(d) Dr DE2, a Senior Family Physician who ran Institution E. He had been practising Family Medicine for the last 26 years.[18]

First Charge – How did the Respondent conduct the evaluation of the Patient during the 29 March 2018 review?

22 To recap – After receiving the abnormal 24 March CXR, the Respondent recalled the Patient for an urgent review. This review took place on 29 March 2018. The Patient attended the review together with PW2.

23 By the time of the inquiry, the Patient had already been repatriated. In the circumstances, the only witnesses who testified at the inquiry on what transpired during the review were PW2 and the Respondent. Both of them gave vastly different accounts of the review.

PW2's account

24 PW2's account was as follows:[19]

(a) PW1 had asked her to bring the Patient to the Respondent's Clinic. At the material time, PW2 did not know that the purpose of the visit was to discuss about the abnormal 24 March CXR findings. She was under the impression that the visit was regarding the Patient's persistent cough.

(b) Accordingly, when she brought the Patient to the Clinic on 29 March 2018, PW2 specifically informed the Respondent that the Patient had been coughing since

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14 Statutory Declaration of Dr PE1 at [1].
15 Statutory Declaration of Dr PE2 at [1]: 1AB 18.
16 Transcripts for 11 October 2021 at page 91 line 13 – line 19, page 115 line 19 – page 117 line 6, page 166 line 3 – line 17.
17 Medical Expert Report of Dr DE1: 1AB at page 443.
18 Medical Expert Report of Dr DE2 at [3]: 1AB at page 590.
19 PW2's statutory declaration dated 24 September 2021 at [9] – [14].

Chinese New Year ("**the Disclosure**"). She also informed him that the Patient had cough, fever, sore throat and had been feeling hot and cold for many days. According to PW2, the Respondent then measured the Patient's temperature, checked her throat and listened to her chest using a stethoscope.

(c) During the consultation, PW2 asked the Respondent about the Form as she was aware that it was overdue for submission to MOM. The Respondent told her that he would "take care" of the Form. PW2 understood this to mean that the Respondent would clear the Form.[20]

(d) After the consultation, PW2 made payment at the Clinic counter. As she found the consultation charges to be expensive, she asked the clinic staff about the charges. At about this time, the Respondent came out of the consultation room. When he heard PW2's question, the Respondent explained that the high charges were because he had prescribed "good" antibiotics. As PW2 was leaving the Clinic with the Patient, the Respondent told her that he hoped that *"this is a case of virus infection, if it is tuberculosis it will be very troublesome*". He also told PW2 to monitor the Patient's condition and to bring her back for further consultation if her condition did not improve.

(e) According to PW2, the Respondent did not mention anything about the Patient's chest x-ray scan. Neither did he mention that they were to return to the Clinic in seven days (i.e., on 5 April 2018) for a follow-up review.

PW2's evidence was supported by PW1. The latter testified that after the 29 March 2018 review, on the same night, PW2 updated her about what had transpired during the review. PW1 recalled PW2 mentioning the Disclosure to the Respondent.[21]

The Respondent's account

25 The Respondent's account of the 29 March 2018 review was as follows:

(a) He first told the Patient and PW2 that there were some issues with the Patient's X-ray report and asked if the Patient had any problems/complaints, to which they replied in the negative.

(b) The Respondent then took the Patient's temperature and discovered that it was 39.1 degrees. The Respondent informed them of the same and sought to elicit

[20] Transcript for 11 October 2021 at page 188 line 20 – page 189 line 8; PW2's statutory declaration at [11].

[21] Transcript for 12 October 2021 at page 7 line 23 – page 8 line 5; Transcript for 12 October 2021 at page 27 line 3 – page 27 line 10.

more information from the Patient and PW2. They then revealed that the Patient had a cough and sore throat for a few days. The Respondent asked if the Patient had night sweats and they replied no.[22]

(c) The Respondent ran further routine respiratory checks including hearing the Patient's lungs, saturation and blood pressure. He found that the Patient did not have any respiratory compromise and was haemodynamically stable. She did not exhibit or complain of haemoptysis, night sweats or weight loss which are the usual symptoms of TB.[23] According to the Respondent, he did not record such information in his case notes as they were normal findings.

(d) As the Patient did not exhibit any other TB symptoms apart from fever and dry cough, and given that the 24 March CXR had only flagged out the possibility of a lung infection, the Respondent decided to first treat the Patient and exclude possible CAP.

(e) The Respondent informed the Patient and PW2 that the Patient could have TB and that it would be troublesome. He also said that he might need to send her to the hospital if there was no improvement of the Patient's symptoms after the treatment for CAP.[24]

Considerations when assessing PW2's evidence

26 In deciding whether to accept PW2's evidence about the Disclosure, we were mindful of the following:

(a) That PW2 had failed to mention about the Disclosure during her interview by on 17 September 2019, and

(b) That PW2 disclosed during cross-examination that she had a discussion with PW1 to "counter-check*"* the facts before testifying at the inquiry.[25]

27 We were mindful where there is a discussion of evidence among witnesses, there is a risk that the evidence may be contaminated (innocently infected) or fabricated: *AOF v*

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22 Transcript for 13 October 2021 at page 79 line 8 – page 81 line 22; page 190 line 14 – 23.

23 The Respondent's witness statement dated 24 September 2021 at [21]; Transcript for 11 October 2021 at page 232 line 22 – page 233 line 1; Transcript for 13 October 2021at page 79 line 8 – page 81 line 22; The Respondent's letter dated 8 October 2020 at [8] – [12]: 1 AB at page 440.

24 The Respondent's Closing Submissions at [10(k)] and [52].

25 The Respondent's Closing Submissions at [112].

Public Prosecutor [2012] 3 SLR 34 at [210] – [212]; *Ernest Ferdinand Perez De La Sala v Compañia De Navegación Palomar, SA* [2018] 1 SLR 894.[26]

28 Accordingly, we approached PW2's evidence about the Disclosure with caution and carefully considered *first*, whether such evidence was reliable and credible, and *second*, if we were to accept PW2's evidence, then whether it should be given full weight.

PW2 did make the Disclosure

29 Having considered the matter, we found that PW2 did make the Disclosure during the 29 March 2018 review.

(a) PW2 had given a very credible reason as to why she recalled *specifically* highlighting the Disclosure to the Respondent. This is because at the material time, she was under the impression that the *purpose of the visit* to the Respondent's Clinic was to deal with the Patient's chronic cough.

(b) Two features about PW2's evidence stood out and (in our view) lent credibility to her account about the Disclosure. The first was her query to the Respondent about the Form. The other was PW2's query to the clinic staff about the expensive consultation charges. The apparently trivial nature of these matters added texture to her evidence and made it more realistic. Importantly, the Respondent's responses to PW2's two queries were also striking. His comments that he would "take care" of the Form and that the Patient might have TB were both unusual in the context of a consultation about the Patient's chronic cough. In fact, the latter comment would conceivably have been alarming to PW2 and the Patient.

(c) We accepted PW2's explanation that she did not mention about the Disclosure at the SMC interview because she was not specifically asked about it. We saw no reason to doubt her explanation.[27] It was not implausible that PW2 did not realise the importance of the Disclosure at the material time.

(d) It was clear to us that when PW2 testified that she had "counter-checked" with PW1 about the 29 March 2018 review, what she meant was that she had sought to *refresh her (PW2's) memory* of what she (PW2) had updated her (PW1) about

[26] The Respondent's Closing Submissions at [94] and [95]; The Respondent's Reply Submissions at [15].
[27] Transcripts for 11 October 2021 at page 211 line 14 – line 15.

the review.[28] There was no evidence that in the process of refreshing PW2's memory, PW1 had tainted the latter's memory regarding the Disclosure.

(e) Finally, there was no evidence to suggest that PW2 and PW1 had colluded to give false evidence about the 29 March 2018 review.

(i) These two witnesses impressed us as unbiased witnesses who had simply given evidence on what they could recall and without any ulterior motive. PW2 and PW1 responded to Counsel's questions in a forthright manner and candidly admitted when they were unable to provide some of the evidence sought by Counsel. We should add that such evidence related to minor details and did not diminish the overall weight of their evidence.

(ii) In their closing submissions, Counsel for the Respondent highlighted the discrepancies between PW2 and PW1's evidence. We noted that these discrepancies related (1) to why PW1 had asked PW2 to bring the Patient to see the Respondent on 29 March 2018, (2) the sisters' views about the seriousness of the Patient's condition at the material time, and (3) their communications with Dr A (another doctor whom they consulted after visiting the Respondent) and Institution A about the Patient's symptoms.[29] If PW2 and PW1 had colluded to give false evidence, one would have expected them to tailor their evidence so that it is seamless.

30 Unlike PW2's evidence which is coherent and intrinsically had a ring of truth about it, we found the Respondent's evidence to be lacking in credibility.

(a) The Respondent's evidence regarding his extensive examination of the Patient during the 29 March 2018 review and having informed PW2 of the possibility of TB was not supported by the very brief case notes that he had taken during the review. These notes stated only the following:

> "CXR – lung infection? on screening
> fever 39.1 cough mild ST
> lungs clear
> review 7 days PRN."[30]

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28 Transcripts for 11 October 2021 at page 237 line 6 – page 239 line 17.
29 The Respondent's Closing Submissions at [10(h)], [10(i)], [32], [73] and [74].
30 1AB 732.

(b) To explain away why critical medical history which he had purportedly obtained from the Patient (e.g., that the Patient did *not* have a chronic cough or suffered a loss of weight) was not in his case notes, the Respondent claimed that he did not record such normal / non-positive findings.[31]

(c) Coming from a doctor who had been in practice for 14 years, we found the Respondent's answer to be astonishing. The requirement to record information material to either normal or abnormal findings in the case notes was well-established. For instance –

(i) The SMC's Ethical Code and Ethical Guidelines at [4.1.2] clearly stated that, "All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented".

(ii) The SMC had also helpfully referred us to the case of *SMC v Eu Kong Weng* [2011] 2 SLR 1089 which stressed the importance of doctors recording their case notes with proper details.

(iii) Even the Respondent's own expert witness, Dr DE1, testified that if there was a negative finding or a discussion regarding a plan for managing the Patient's infection, these should have been documented in the case notes.[32]

(d) What was even more startling was the Respondent's admission that he had made the following entries in his case notes *retrospectively* on 17 May 2018 – i.e., *almost two months after* the 29 March 2018 review – when PW1 informed him that the Patient had TB:[33]

> "<Amended on 17-May-2018 9:14 AM>
> employer PW1 mentioned the patient underwent TB confirmation and possible TB treatment currently
> reprinted earlier CXR reviewed with employer option for thorough further check and blood declined despite adv pt treated empirically for atypical pneumonia fr CXR no obv TB signs – LOW LOA haemoptysis SOB asked for an urgent review in few days however patient lost to f/up, sought treatment again at other GP 1 month later for persistent cough – repeated CXR then (at hospital)"

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31 Transcript for 13 October 2021 at page 191 line 5 – line 16.
32 Transcript for 15 October 2021 at page 22 line 5 – page 24 line 11; page 25 line 17 – line 24.
33 1AB at page 732.

(e) The Respondent explained that he had inserted the above information because he wanted to add all the information that he could remember about the Patient in his case notes before his memory deteriorated with the passage of time.[34]

(f) We make following observations regarding the Respondent's retrospective entries in the case notes:

(i) The Respondent's explanations for making these entries showed that the relevant information *was in fact* material to his evaluation of the Patient's condition. If the information was not material, why then was there a need to make these entries in the first place?

(ii) When the Respondent testified about the 29 March 2018 review, we had the distinct impression that he could not recall what had transpired during the review. As the SMC had right pointed out,[35] this was evident from the equivocal manner in which the Respondent testified about the review, frequently qualifying his evidence with expressions such as "I supposed so" and "probably this is what happened".

(iii) The entire foundation of the Respondent's evidence regarding the 29 March 2018 review was based on the reliability and credibility of his retrospective entries in the case notes. Bearing in mind that these notes were made about *two months after* the review, we found it incredible that the Respondent could recall the details of how he had conducted the review and the information that was exchanged at the material time, given the lapse of time. This was especially so when PW2 and the Patient were merely two of the many patients that he had seen in his Clinic during the two-month period.

(iv) We agreed with the SMC that the fact that the Respondent had made the retrospective entries showed that he knew the importance to record normal / non-positive findings. We also accepted the SMC's submissions that these entries were created to justify his failure to refer the Patient and his certification that the Patient was negative for TB.[36]

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34 The Respondent's Reply Submissions at [21].
35 Prosecution's Reply Submissions at [16].
36 Prosecution's Closing Submissions at [36] and [60].

31 To conclude, we preferred PW2's account of the 29 March 2018 review over the Respondent's. We found that during the review –

(a) PW2 *did* specifically inform the Respondent that the Patient had been coughing since Chinese New Year, and that the Patient been feeling hot and cold for many days.

(b) After simply checking the Patient's temperature and throat and listening to her lungs, *the Respondent was apparently satisfied* that there was no need to take any other steps to exclude the suspicion that she had TB. He did not go on to ask targeted questions to find out whether the Patient had the clinical symptoms of TB (such as whether she had suffered a loss of weight). Neither did the Respondent discuss with PW2 about a plan to exclude the Patient for TB.

(c) The Respondent did not mention about the 24 March CXR during the review.

(d) The only time when the Respondent mentioned that the Patient might have TB was when he said in passing to PW2 – as she was leaving the Clinic with the Patient – that he hoped that *"this is a case of virus infection, if it is tuberculosis it will be very troublesome*".

(e) Contrary to his claim, the Respondent did not arrange for the Patient to return to the Clinic for a follow up review in seven days' time. He merely told PW2 to monitor the Patient's condition and to bring her back for further consultation if there was no improvement.

(f) The Respondent had informed PW2 that he would take care of the Form when queried by the latter.

First Charge – Did the Respondent depart from the applicable standards during the 29 March 2018 review, and if so, was this departure egregious?

What is the applicable standard?

32 **Requirement to evaluate.** According to the MOH Guidelines, the established medical opinion is that "any chest radiograph abnormality compatible with tuberculosis ... *should be evaluated further to rule out active tuberculosis*" (emphasis added): MOH Guidelines at page 72.[37] In the present case, it was undisputed that the 24 March CXR was an abnormal report "compatible with TB".

[37] 1AB at page 108. The guideline is graded "D". According to the MOH Guidelines, such a guideline is based on non-analytic studies, e.g., case report, case series" and "expert opinion": see 1AB at page 32.

33 **How was the evaluation ought to be done.** Under the MOH Guidelines, an evaluation to rule out active TB included looking out for the following:

(a) **Clinical symptoms.** A prolonged period of cough can be a strong indicator of TB. Pulmonary TB should be considered in patients who have unexplained cough of more than three weeks. This guideline is backed up by a strong body of research.[38] Apart from chronic cough, weight loss is another predominant symptom of TB.[39] In some cases of TB, patients may also complain of loss of appetite, fever, and night sweats lasting several months.[40]

(b) **Chest X-ray.** Chest X-rays have long been used as a tool in the diagnosis of pulmonary TB.[41] The chest X-ray image of a person with active TB would show the following:

(i) Consolidation (i.e., the airspaces within the lung parenchyma appearing cloudy or opaque);

(ii) Cavitary lesion (exhibited by darkened areas within the lung parenchyma);

(iii) Nodule (i.e., mass in the lungs) with poorly defined margins;

(iv) Pleural effusion (i.e., presence of a significant amount of fluid within the pleural space); and

(v) Hilar or mediastinal lymphadenopathy (i.e., enlargement of lymph nodes in one or both roots of the lungs).[42]

(c) **Sputum tests**. The opinion among the expert witnesses is that patients whose chest X-ray findings suggestive of TB should be referred *without delay* for further evaluation. Such evaluation includes taking two sputum samples from the patients for acid-fast bacilli (AFB) smear and culture: MOH Guidelines at page 36.[43]

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38 MOH Guidelines at page 26: 1AB at page 62. The guideline is graded "A". According to the MOH Guidelines, such a guideline is based on a body of evidence consisting of well conducted meta-analyses and systematic reviews of randomized controlled trials: see 1AB at page 32.

39 MOH Guidelines at page 25: 1AB at page 61.

40 MOH Guidelines at page 31: 1AB at page 67.

41 MOH Guidelines at [5.1.1] (page 33): 1AB at page 69.

42 MOH Guidelines at [5.1.1] (page 33): 1AB at page 70 – 71.

43 1AB at page 72. The guideline is graded "D", Level 4 and recommended best practice. According to the MOH Guidelines, such a guideline is based on non-analytic studies, e.g., case report, case series" and "expert opinion": see 1AB at page 32.

34 **What the Respondent was expected to do.** Based on the above, a proper evaluation of the Patient to rule out TB would entail the Respondent doing the following:

(a) Ask the Patient targeted questions during the 29 March 2018 review to establish whether she had any of the clinical symptoms of TB as stated in [34(a)] above.[44]

(b) Review the Patient's chest X-ray image to investigate into the abnormal findings highlighted in the 24 March CXR and to see if the image shows any of the features stated in [34(b)] above.

(c) Request the Patient to undergo sputum tests if the Patient's chest X-ray image shows the features stated in [34(b)].

The Respondent had departed from the applicable standards

35 We found that the Respondent had departed from the applicable standards for evaluating the Patient and ruling out active TB. This finding was based on (1) the scanty case notes made by the Respondent during the 29 March 2018 review (which indicated that he did not conduct a thorough investigation into the Patient's medical history) as well as (2) the following evidence:

(a) **Clinical symptoms.** Based on PW2's evidence (which we accept), the Respondent did not ask either her or the Patient targeted questions during the 29 March 2018 review to establish whether the Patient had any of the clinical symptoms of TB. Even though PW2 had informed him during the review that the Patient had a prolonged cough, the Respondent did not seem to have picked this up because it is not documented in his case notes.

(b) **Chest X-ray.** It was the Respondent's case that during the review, he had the 24 March CXR only and not the X-ray image itself.[45]

(i) In accordance with the applicable standards, The Respondent should have obtained the Patient's X-ray image so that he could *personally* investigate into the abnormal findings highlighted in the 24 March CXR. This was especially so (1) when The Respondent accepted that the extensiveness of the airspace shadows could not be determined from just the 24 March

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44 Evidence of Dr Wong: Transcripts for 14 October 2021 at page 152 line 4 – 22.

45 The Respondent's Reply Submissions at [5].

CXR alone and that the X-ray images needed to be examined,[46] and (2) if The Respondent had intended to treat the Patient for CAP (as he alleged).

(ii) According to the Respondent, he was not a radiologist and/or an expert in reviewing X-ray images. As such, he would defer to radiologists when interpreting X-ray images. Given that the radiologist who prepared the 24 March CXR did not specifically state in the report that there was a possibility of TB or that TB had to be excluded, the Respondent thought that it was more likely that the Patient was suffering from a lung infection instead of TB.[47] We did not agree with the approach taken by the Respondent. The radiologist *had already* red-flagged in the 24 March CXR that there were airspace shadows in both lungs in keeping with infection and suggested *"[f]urther management and follow-up"*. As stated earlier, X-ray images are a key tool in confirming or excluding active TB. If the Respondent did not have the necessary expertise to exclude TB based on the Patient's X-ray image, then he should have promptly referred her to TBCU or a TB specialist who have the competence to do so. This is position expressed in the MOH Guidelines[48] and by the expert witnesses.[49]

(c) **Sputum tests.** It was not disputed that the Respondent did not request the Patient to undergo sputum tests during the 29 March 2018 review. This was because his Clinic was not able to do such tests. According to the Respondent, if a patient was suspected to have TB, he would refer him to a tertiary centre to rule out TB.[50]

The departure from the applicable standards was egregious

36 We found that the Respondent's departure from the standards of the medical profession came within the *Serious Negligence Limb* and was egregious:

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46 The Respondent's Reply Submissions at [5].

47 The Respondent's written statement at [16] and [17]; Transcripts for 15 October 2021 at page 11 line 2 – line 22.

48 MOH Guidelines at page 26: 1AB at page 62.

49 See e.g., the evidence of Dr Wong: Transcripts for 14 October 2021 at page 152 line 4 – 22.

50 Transcripts for 15 October 2021 at page 11 line 14 – line 22.

(a) The Respondent clearly was alive to the fact that the Patient might have TB and that he had a duty to evaluate her further. That was why the 29 March 2018 review was scheduled.

(b) The Respondent's manner of evaluating the Patient was cursory. This was evident from the following:

(i) PW2's account of the 29 March 2018 review, which showed that The Respondent did not make any serious attempt to collect the Patient's medical history.

(ii) The Respondent's skimpy case notes of the review which corroborates PW2's account of the review.

(iii) The Respondent had missed out on an important disclosure by PW2 – i.e., that the Patient had a chronic cough at the material time.

(iv) The Respondent had assessed that the Patient was unlikely to have TB on the basis that the 24 March CXR did not expressly state that she might have TB or that TB had to be excluded.[51] This was clearly a disingenuous claim, given The Respondent's own evidence that based on the 24 March CXR, he had already suspected that the Patient might have TB and that he had to exclude this possibility.

(v) The Respondent had assessed that the Patient was unlikely to have TB without obtaining the Patient's X-ray image to review for himself whether there were indicators of TB and ordering sputum tests to be done.

37 Dr PE1 testified that the Respondent made no effort to rule out active TB.[52] We agreed with Dr PE1. The Respondent's cavalier attitude towards the entire review was evident from his remarks to PW2 as she was leaving the Clinic after the review that he had "hoped it is infection cos (*sic*) if it is TB, it will be *very troublesome*". According to the Respondent, he had made the remark because if it was TB, it would be troublesome and he would need to send the Patient to the hospital.[53] This piece of evidence was highly illuminating – it revealed the Respondent's frame of mind at the time of the review. It was also troubling as it suggested that the Respondent had a tendency of wanting to

51 The Respondent's witness statement at [16] and [17].
52 Transcripts for 13 October 2021 at page 67 line 23.
53 The Respondent's Closing Submissions at [52].

avoid trouble and inconvenience. Such a tendency was in fact evidenced again in another aspect of his clinic's practice – that of pre-checking and pre-signing MOM forms. More will be said of this later.

First Charge – Did the applicable standards require the Respondent to refer the Patient to TBCU for further assessment and management by 29 March 2018, and if so, was there a departure and was this departure egregious?

Undisputed facts

38 To recap, the Respondent did not dispute the following facts:

(a) As of 25 March 2018 (the day he received the 24 March CXR), he had already suspected that the Patient might have TB: the Respondent knew that (i) the Patient came from a country with a high prevalence of TB, (ii) her chest X-ray image showed consolidation (a TB indicator), and (iii) the Patient had been coughing (another TB indicator).[54]

(b) Given his suspicion that the Patient might have TB, pursuant to the MOH Guidelines, the Respondent ought to have referred her to TBCU or a TB specialist for further assessment and management.

(c) Despite the above, the Respondent did not make the referral at any point in time.

The Respondent's reason for not referring the Patient

39 To explain why he did not make the referral, the Respondent contended that the MOH Guidelines –

(a) were drafted in non-prescriptive language and were not intended to be mandatory,

(b) did not require him to immediately refer the Patient to TBCU or a TB specialist merely because the 24 March CXR was abnormal,[55] and

(c) did not take away his discretion, as the Patient's primary physician, to try to treat her for CAP first, and to refer her to the TBCU thereafter only if needed.[56]

What is the applicable standard?

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54 Transcripts for 13 October 2021 at page 329 line 4 – line 23.
55 The Respondent's Closing Submissions at [97] – [102].
56 The Respondent's Closing Submissions at [52], [108], [109] and [115].

40 We were unable to accept the Respondent's reason for not referring the Patient.

41 **Obligation to *notify and report* to TBCU**. TB is a "prescribed infectious disease" under the Infectious Diseases Act (Cap 137, 2003 Rev Ed): see section 2 of the Act read with the First Schedule (s/n 32). Section 6(1) of the Act stipulates that –

> "Every medical practitioner who *has reason to believe or suspect* that any person attended or treated by him is suffering from a *prescribed infectious disease* or is a carrier of that disease *shall notify* the Director within the prescribed time and in such form or manner as the Director may require." [emphasis added]

42 The MOH Guidelines reinforced the statutory requirement under the Infectious Diseases Act to report TB cases. Paragraph 8.5 of the MOH Guidelines[57] specifically reminded all medical practitioners that –

(a) they "*must* report both new or relapsed tuberculosis cases (including suspect tuberculosis) and their treatment outcomes to the Ministry of Health, in conformance with requirements under the Infectious Diseases Act" (emphasis added),

(b) "[n]otification of suspect and confirmed cases of tuberculosis is *mandatory* under the Infectious Diseases Act" (emphasis added), and

(c) a failure to notify a TB case in a timely manner is an *offence* under the Infectious Diseases Act.

43 The MOH Guidelines at [8.5] further stipulated that the notification of a suspected TB case must be given "within 72 hours".

44 **Obligation to *refer* suspected TB patients to TBCU**. Additionally, the MOH Guidelines stated the following:

(a) "Medical practitioners in primary care are *urged to refer* suspected tuberculosis cases to the Tuberculosis Control Unit or specialists with experience in tuberculosis management" (emphasis added).[58]

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57 MOH Guidelines at page 73: 1AB at page 109.
58 MOH Guidelines at page 26: 1AB at page 62.

(b) "Patients with chest radiographic findings that suggest active or inactive disease *should be referred without delay* for further evaluation including two sputum samples for acid-fast bacilli (AFB) smear and culture" (emphasis added).[59]

(c) "Applicants with tuberculosis-related abnormality in their chest x-ray *should be referred to the [TBCU]* for further tests and evaluation to exclude active tuberculosis" (emphasis added).[60]

45 The reason why doctors are obliged to *proactively refer* suspected TB patients to TBCU "*without delay*" – instead of waiting for TBCU call up these patients – is obvious: it is to reduce the risk of transmission and to ensure that suspected TB cases can be expeditiously managed by TBCU.

46 **Non-prescriptive language in the MOH Guidelines.** We were mindful that the relevant provisions in the MOH Guidelines were not written in prescriptive language. They used words like "urged to" and "should" – instead of "must". In our view, the use of such non-prescriptive language in the MOH Guidelines did not mean that the referral to TBCU need not be done expeditiously.

(a) Any undue delay in referring a suspected TB patient could potentially endanger the patient's health and frustrate national efforts to prevent the spread of TB in Singapore. It bears remembering that TB is a highly infectious disease. Time is of the essence in effectively managing the disease.

(b) We agreed with Dr PE1's evidence that the MOH Guidelines had been drafted in non-prescriptive language to cater for "exceptions" in the medical context.[61]

47 **Opinion of expert witnesses.** The Respondent referred to the evidence of the expert witnesses which appeared to suggest that they did not find it improper for him to try to treat the Patient for lung infection first.[62]

48 We do not agree with the Respondent's interpretation of the experts' evidence – he had taken such evidence out of context.

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59 MOH Guidelines at page 36: 1AB at page 72.
60 MOH Guidelines at page 72: 1AB at page 108.
61 Transcripts for 13 October 2021 at page 46 line 14 – line 18.
62 The Respondent's Closing Submissions at [10(c)], [10(m)], [99], [103] – [107] and [110].

(a) None of the expert witnesses testified that the Respondent could attempt to manage the Patient *to the exclusion* of his obligation to refer her to TBCU for further assessment and management.

(b) On the Respondent's own evidence, he did not have either the competence or the resources to exclude that the Patient for TB. The Respondent admitted that he did not have sufficient expertise to read X-ray images, and that his clinic would not do sputum tests, to exclude TB. We did not understand the expert witnesses to be saying that it was still proper for the Respondent in these circumstances to attempt to exclude the Patient for TB and to treat her for CAP.

(c) In fact, the expert witnesses had testified to the contrary.

Treatment vs referral

(i) Dr PE1 had made it very clear that in a screening scenario (such as in the Patient's case), there was "*no room for clinical decisions or trial of treatment*" as any form of clinical treatment would only lead to a delay in diagnosis.[63] According to Dr PE1, the practice was for doctors to refer patients for further management and assessment as long as their chest X-ray image was abnormal.[64]

(ii) Dr DE2 (expert for Dr Teo) expressed a similar view. He testified that if doctors felt strongly that there was a need to exclude TB or that there was a likelihood of TB, they would usually refer the patients to a respiratory physician or TBCU.[65]

(iii) Dr PE2 had also testified unequivocally that based on the findings of the 24 March CXR, the Patient "require[d] in-patient treatment".[66] In relation to the article R2 which dealt with the diagnosis and treatment of CAP, Dr PE2 testified that it was applicable only to a walk-in scenario and not a screening scenario.[67]

(iv) Dr C had testified that it was fine for a doctor to treat a patient with abnormal chest X-ray findings. This testimony was made on the premise

63 Transcripts for 13 October 2021 at page 5 line 15 – line 24, page 10 line 1 – line 9.
64 Transcripts for 13 October 2021 at page 16 line 11 – line 23.
65 Transcripts for 14 October 2021 at page 149 line 18 – page 150 line 4.
66 Transcripts for 11 October 2021 at page 174 line 8 – line 25.
67 Transcripts for 11 October 2021 at page 167 line 19 – page 168 line 19.

of a walk-in consultation scenario. She stressed that her evidence would not be applicable in the context of a screening scenario.[68]

Timing of the referral

(v) The expert witnesses were of the view that the Respondent ought to have referred the Patient to TBCU "*immediately*" (Dr DE1[69] and Dr PE2[70]) or "*urgently*" (Dr DE2[71]) if she still had fever and chronic cough during the 29 March 2018 review.

(vi) The presence of fever and chronic cough suggested that the Patient had active TB (Dr PE1) at the material time,[72] or minimally that the suspicion of TB was very high (Dr PE2[73] and Dr DE2[74]). Furthermore, the 24 March CXR revealed that the airspace shadows were in *both* mid and upper zones of *both* lungs. In Dr PE2 and Dr PE1's opinion, this showed that the lung infection was extensive and serious.[75] The defence experts did not provide a contrary opinion.

49 **What the Respondent was expected to do**. We now summarise what are the applicable standards in the present case:

(a) Given that the Respondent had suspected that the Patient might have TB as of 25 March 2018, in accordance with section 6(1) of the Infectious Diseases Act read with the MOH Guidelines, he was obliged to *notify TBCU* of his suspicion within 72 hours – i.e., by 28 March 2018.

(b) Based on the evidence of the expert witnesses, the Respondent should also have referred/informed the Patient to consult TBCU or a TB specialist to confirm whether she had active TB *during* the 29 March 2018 review.

The Respondent's claim that he had intended to treat the Patient for CAP lacks credibility

50 According to the Respondent, he had "determined at the material time that it was not necessary to refer the Patient to a hospital for further management and/or escalate the

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68 Transcripts for 11 October 2021 at page 74 line 19 – page 75 line 8, page 83 line 12 – page 85 line 9.
69 Transcripts for 15 October 2021 at page 21 line 4 – line 21.
70 Transcripts for 11 October 2021 at page 127 line 11 – line 24, page 129 line 23 – 130 line 6.
71 Transcripts for 14 October 2021 at page 164 line 18 – page 165 line 7.
72 Dr PE1's witness statement at [18]; Transcripts for 13 October 2021 at page 13 line 19 – 23.
73 Transcripts for 11 October 2021 at page 101 line 16 – line 20.
74 Transcripts for 14 October 2021 at page 156 line 3 – line 5.
75 Dr PE2: Transcripts for 11 October 2021 at page 97 line 23 – page 98 line 6, page 100 line 7; Dr PE1: Transcripts for 13 October 2021 at page 11 line 4 – line 5, page 14 line 1 – line 7, page 28 line 5 – line 15.

matter" because "the most appropriate course of action would be to first treat and/or exclude the possible CAP".[76]

51 **No basis to treat the Patient as a CAP case.** We found that there was no basis for the Respondent to treat the Patient's lung infection as simply a CAP case.

(a) It bears noting that the Patient was from Myanmar, a country with a high prevalence of TB.

(b) The Respondent had failed to conduct an adequate evaluation to properly exclude the Patient of TB during the 29 March 2018 review.

(c) Furthermore, we accepted Dr PE1's opinion that –

(i) it was "*not normal*" for CAP to affect *both* sides of the lungs and the *mid and upper zones* of the lungs,[77] and

(ii) chest X-ray images for CAP did not have features such as those presented in the 24 March CXR.[78]

52 **No evidence that the Respondent had a plan for managing the Patient as a CAP case**. The Respondent's claim that he had intended to manage the Patient as a CAP case was further discredited by the fact that he had failed to adduce any evidence to show that he had a plan to manage her as such.

(a) Based on *PW2's evidence*, the Respondent did not discuss any management plan for the Patient during the 29 March 2018 review.

(b) PW2's evidence was consistent with *the Respondent's case notes*, which were bereft of any record of a discussion about his management plan for the Patient, including her possible referral to a tertiary institution for further management.[79]

(c) It was *uncontroverted* evidence that the Respondent did not arrange for a *repeat chest X-ray* to be done on the Patient to confirm whether her lung infection had cleared following the medication that he had prescribed for her.[80]

(d) There was also no evidence to show that the Respondent had fixed an *appointment after the 29 March 2018 review* to assess whether the Patient's condition had improved. According to PW2, the Respondent did not tell her that

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76 The Respondent's Closing Submissions at [52].
77 Transcripts for 13 October 2021 at page 32 line 1 – line 18.
78 Transcripts for 13 October 2021 at page 48 line 1 – line 8.
79 Prosecution's Closing Submissions at [66] and [67].
80 Dr DE2: Transcripts for 14 October 2021 at page 150 line 11 – page 151 line 12.

he would like to see the Patient again after the 29 March 2018 review. The Respondent only told her to monitor the Patient's condition and to return to the Clinic *if needed*. Consistent with this, the Respondent's notes recorded "*review 7 days PRN"* which meant he would review the Patient in seven days, when necessary.[81] This was also the understanding of DW1.[82]

(e) According to the experts, if there was any discussion of a management plan, they would have expected the Respondent to document this in his case notes.[83]

(i) Such a discussion (if it had taken place) should have included the possible diagnosis of the Patient's condition, the treatment options, the Respondent's reasons for adopting one of these options in managing the Patient, the course of actions that the Respondent proposed to take, and what the Patient was supposed to do.[84]

(ii) According to Dr DE1, the Respondent would also need to explain to the Patient and her employer that because the Patient had abnormal shadows in her lungs, she had to be referred for exclusion of TB.[85]

(f) We agreed with the following submissions by the SMC:

> "99 … the treatment by Dr Teo, namely, the prescription of medications, would be limited to only helping the Patient feel more comfortable and to make her feel well. It follows that even if the Patient has recovered, it does not mean that the diagnosis of TB had been excluded for purpose of the Patient's Form. The Patient would still have to be referred to a Specialist at the next review unless a normal chest X-ray is obtained.
>
> 100 In order to rule out TB, the Patient would have to be sent to tertiary centres for sputum studies and specialised blood tests for TB which are generally not available to family physician. However, there has been "no efforts" in terms of ruling out active TB by Dr Teo. Dr Teo knew that he had to obtain a "normal x-ray" in order to certify the Patient's form. He could not have cleared the Patient for TB as he would still require a normal X-ray to complete his certification. Yet, he did not arrange for a repeat X-ray which meant he was ready to submit the Form and certify the Patient negative for TB. Clearly, Dr Teo did not intend to refer the Patient for such further testing to confirm that the patient did not have TB before he certified the Patient free from TB."

[footnoting from original text removed]

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81 ASOF at [11].
82 Transcripts for 14 October 2021 at page 209 line 11 – line 14.
83 Prosecution's Closing Submissions at [67] – [76].
84 See e.g., Dr PE2's evidence in transcripts for 11 October 2021 at page 163 line 11 – page 181 line 2.
85 Transcripts for 15 October 2021 at page 17 line 8 – line 20.

Consultation on 31 March 2018[86]

53 **Anomaly in the Respondent's case.** It is the Respondent's case that the Patient was supposed to see him for a review on 5 April 2018. However, the evidence revealed that –

(a) no such review had actually taken place, and

(b) the Respondent did not follow up with PW1, PW2 or the Patient to schedule an appointment to review her condition.[87]

54 **The Respondent's explanation.** To explain this anomaly in his evidence, the Respondent claimed that he did not insist that PW1 bring the Patient back for a review on or after 5 April 2018 because she appeared to have recovered well from her symptoms.[88] The Respondent based this opinion on the information purportedly provided by PW1 on 31 March 2018.

(a) On that occasion, PW1 went to his Clinic without the Patient. She informed that the Patient's fever had subsided and that the Patient was feeling better. She wanted to obtain some cough medication for the Patient.

(b) Pursuant to PW1's request, the Respondent issued off-the-counter medication for the Patient's cough and sore throat. The Respondent recorded the notes for this visit as "*cough mixture – dun take together, complete abx 10 days at home"*.

(c) According to the Respondent, PW1's visit to his Clinic to obtain medication was not a consultation.

(d) the Respondent's account was corroborated by DW1.

55 **PW1's account.** PW1 disputed the Respondent's account of the 31 March 2018 consultation. According to her, she had brought the Patient to see the Respondent because the Patient was still coughing badly. During the consultation –

(a) PW1 specifically told the Respondent that the Patient had been coughing persistently since Chinese New Year of 2018.[89]

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86 The Respondent's Closing Submissions at [10(e)].
87 The Respondent's Closing Submissions at [15].
88 The Respondent's witness statement at [40].
89 Transcripts for 12 October 2021 at page 50 line 9 – line 22.

(b) PW1 also asked the Respondent whether the 24 March CXR contained anything relevant to the Patient's condition.

(c) the Respondent did not inform PW1 that the Patient might have TB. Instead, he suggested doing a blood test to find out more about the Patient's condition. PW1 agreed.

(d) When the Respondent failed to draw blood from the Patient after a few attempts, he volunteered to "*clear*" the Patient's Form certifying that the Patient was negative for TB, noting that PW1's family would be stressed without a helper.

56 **PW1's account was more credible.** After careful consideration, we accepted PW1's account of the consultation on 31 March 2018:

(a) We found that PW1's account had a ring of truth. She had explained *why* she visited the Respondent's Clinic with the Patient on 31 March 2018 and could recall an *unusual* event – the Respondent's failure to draw blood from the Patient after multiple attempts. There was no reason why PW1 would want to fabricate such evidence (which is unrelated to the charges) or be mistaken about it.

(b) PW1's textured account of what transpired during the 31 March 2018 consultation was supported by PW2. According to PW2, on the same day after the consultation, PW1 updated her that (i) the Respondent would clear the Patient's Form and that (ii) he had tried taking blood from the Patient a few times and stopped when the Patient was in pain.

(c) PW1's account that there was a consultation with the Patient on 31 December 2018 was corroborated by the Respondent's own records. These records showed the following:

(i) The Respondent had charged the Patient $25 as *consultation fee* on that day.[90] There was no reason why the Respondent would have charged for consultation if none was provided. Indeed, DW1 confirmed that she would not have entered a consultation charge of $25 if there was no consultation and the Respondent was only speaking to the employer outside the consultation room.[91]

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91 Transcripts for 14 October 2021 at page 233 line 2 – line 7.

(ii) The *duration* between the time when the Patient's visit to the Clinic was registered and the time when medication was dispensed was about 30 mins. This duration was more consistent with PW1's account of the conversation that she had with the Respondent, including the various unsuccessful attempts by him to draw blood from the Patient, then the Respondent and DW1's accounts that PW1 was at the Clinic merely to obtain off-the-counter medication.[92]

(d) Finally, we found the Respondent's explanation to be unbelievable. If the Patient was recovering well, why did PW1 visit the Clinic barely two days after the 29 March 2018 review, as soon as cough medication ran out?[93]

57 **The Respondent's evidence is internally inconsistent**. According to the Respondent, he had intended to refer the Patient to TBCU if her condition did not improve after the 29 March 2018 review. Based on PW1's account –

(a) The Respondent must have known that the Patient *continued to be unwell* on 31 March 2018 (that was why he prescribed more medication for the Patient).

(b) Even if the Respondent had failed to pick up the fact that the Patient had been coughing since the Chinese New Year of 2018 during the 29 March 2018 review, he would have come to know of this fact since PW1 specifically raised it to him during the 31 March 2018 consultation.

In the circumstances, the Respondent's failure to refer the Patient to TBCU during the 31 March 2018 consultation discredited his claim that he intended to make the referral within a week of the 29 March 2018 review if her condition did not improve.

The Respondent departure from the applicable standards was egregious

58 To summarise –

(a) It is an undisputed fact that the Respondent had failed to refer the Patient to TBCU during the 29 March 2018 review when she presented symptoms of TB.

(b) The Respondent's failure to make the referral is a departure from the applicable standard.

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92 Prosecution Closing Submissions at [86] – [89].

93 During the 29 March 2018 review, The Respondent prescribed two – three days' supply of Sunsedyl.

(c) The Respondent had failed to provide any credible explanation for the departure.

59 We found that the Respondent's failure to make the necessary referral came within the *Serious Negligence Limb* and was egregious. He had displayed an appalling sense of indifference to the Patient's welfare and his professional duties despite suspecting that she might have TB.

(a) As soon as the Respondent suspected that the Patient might be a TB case, there was a pressing need to expeditiously refer her to TBCU so that she could be isolated and treated.

(b) It was an agreed fact that it was likely that the Patient would already have TB during the 29 March 2018 review.[94]

(c) Because of the Respondent's failure to make the referral, the Patient was diagnosed and treated for TB only in May 2018. In other words, for more than a month after the 29 March 2018 review, the Patient remained untreated.

(d) Because of the Respondent's failure to refer the Patient to TBCU for more than a month, persons residing with her and members of the public continued to be exposed to the risk of TB. In fact, PW1's brother was diagnosed to have contracted TB in September 2018 after contact tracing.[95]

(e) The Respondent did not have any good reason for failing to refer the Patient to TBCU. We found that his purported intention to treat the Patient as a CAP case, and to refer her to TBCU in about a week later, to be inherently unbelievable.

Second Charge – How did the Form come to contain the Respondent's certification that the Patient was negative for TB and to be submitted to MOM?

Undisputed fact

60 To recap –

(a) On 29 March 2018, soon after the review was completed, the Respondent's Clinic submitted electronically the Form (dated 17 March 2018) to MOM.[96]

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94 ASOF at [29].
95 PW1's evidence: Transcript for 12 October 2021 at page 14 line 1 – line 7.
96 1AB at page 420.

(b) According to the Form, the Respondent had certified that the Patient was negative for TB and had signed against the certification.

(c) The Respondent accepted that this certification was clearly wrong.

The Respondent's defence

61 According to the Respondent, he did not certify that the Patient was negative of TB, and that the Form had been submitted to MOM due to an "administrative error".[97] The Respondent provided the following account of this alleged error.

(a) On 17 March 2018 (i.e., when the Patient first visited the Clinic for the MOM routine screening), the Respondent had pre-signed the Form. At the material time, the box indicating that the Patient was negative for TB was not marked.

(b) On 29 March 2018, DW1 saw the Form. Thinking that the Form was ready for submission, she crossed the box negative for TB and submitted it on the same day to MOM. The Respondent did not give any instruction to her to submit the Form.[98]

62 During the inquiry, DW1 testified to corroborate the Respondent's defence.

The Respondent's defence lacks credibility

63 We were unable to accept the Respondent's defence.

64 **Prior inconsistent accounts.** First, we found that the Respondent's defence at the inquiry was materially inconsistent with his previous accounts of how the Form came to be made. These discrepancies could be summarised as follows:

	Version 1	**Version 2**	**Version 3**
	The Respondent's five written statements to the CC made on 8 August 2018[99] 30 March 2019,[100] 18 October 2019,[101] 23	**The Respondent's letter to the CC dated 8 October 2020[104]**	**The Respondent's witness statement dated 24 September 2021 and evidence at the inquiry**

97 The Respondent's Closing Submissions at [11(e)].
98 The Respondent's Closing Submissions at [11(e)].
99 1AB at page 398 – 400.
100 1AB at page 396.
101 1AB at page 405 – 409.
104 1AB at page 439 – 442.

	October 2019[102] and 31 October 2019[103]		
Did the Respondent certify in the Form that the Patient was negative of TB?	Yes	Yes	No
Was the box indicating that the Patient was negative of TB pre-checked?	No	Yes	No
Did the Respondent pre-sign the Form?	No.	Yes	Yes[105]
Was the Form submitted to MOM with the Respondent's knowledge?	Yes	No. DW1 had submitted the form mistakenly, without The Respondent's instructions	No. DW1 had submitted the form mistakenly, without The Respondent's instructions
The Respondent's account of the version	• The Respondent made the certification after he had spoken to PW1 and confirmed that Patient was well. The Respondent did not examine the Patient before making the certification. • The certification was made *on 5 April 2018* – the date when the Patient was due to see the Respondent for a review but had failed to turn up.[106] • The above position is clearly false – as the Form was *submitted*	• The Clinic had a long-standing practice[110] whereby – 1. his staff would *pre-check* all the boxes on the MOM forms to indicate that a patient was negative for the relevant medical conditions, *including TB*,[111] 2. they would thereafter pass the	On further examination of the Form, the Respondent realised that – 1. The cross in the box against "negative" for TB looked different from the other three crosses on the Form. 2. The box against "negative" for TB was originally left blank when the Respondent signed the Form. 3. After the 29 March 2018 review was

102 1AB at page 411 – 413.
103 1AB at page 427 – 431.
105 Transcripts for 14 October 2021 at page 128 line 2 – page 129 line 2.
106 Transcripts for 14 October 2021 at page 14 line 21 – line 25.
110 Transcripts for 14 October 2021 at page 49 line 10 – line 14.
111 Transcripts for 13 October 2021 at page 128 line 6, page 130 line 3 – line 4; Transcripts for 14 October 2021 at page 51 line 15.

	much earlier – on 29 March 2018.[107] • The Respondent stated that it was only after he had been notified that his matter had been referred to the DT on 12 August 2020 that he decided to "come clean".[108] The Respondent thus had to admit that his statements to the CC was completely false[109] and that he had lied to the CC.	pre-checked forms to him, 3. the Respondent would then *pre-sign* the forms, and 4. he would thereafter return the pre-signed forms to his Clinic staff.[112] • After the 29 March 2018 review was over, DW1 on her own initiative (without any instruction from the Respondent) submitted the Form to MOM. • The Respondent's letter dated 8 October 2020 contained a statutory declaration by DW1 corroborating the Respondent's account.	over, DW1 made the cross in the box on her own initiative (without any instruction from the Respondent) and submitted the Form to MOM.

65 **No satisfactory explanation for material discrepancies.** The Respondent had failed to give a satisfactory explanation for the material discrepancies between his previous accounts to the Complaints Committee and his evidence at the inquiry.

66 Starting with *Version 1* of the Respondent's account (contained in the Respondent's five statements made in 2018 and 2019) –

(a) At the inquiry, the Respondent admitted that Version 1 was incorrect. He explained that Version 1 came about because at the material time, he did not know when the Form was submitted to MOM.

(b) We found it inconceivable how Version 1 could have been given mistakenly. The statements containing Version 1 provided a detailed account of how, when and why the Respondent came to certify on the Form that the Patient was negative for TB. We rejected Counsel for the Respondent's submissions that

[107] 1AB Tab 6 (page 402).
[108] The Respondent's 8 October 2020 letter at 1AB page 437.
[109] Transcripts for 14 October 2021 at page 43 line 13 – line 18, page 44 line 25.
[112] 1AB Tab 13 – Letter at [6]; EIC the Respondent, 13 October 2021, 75:23 – 75:25

such an elaborate account was the product of a "confused and/or unclear" mind,[113] or for that matter, was an innocent and honest mistake.

(c) Furthermore, on or around 29 September 2019, MOM had already informed the Respondent that the Form was submitted on 29 March 2018. Despite this, the Respondent continued to maintain Version 1 and that the Form was submitted after 5 April 2018 in his statement to the CC on 18 October 2019.[114] It was clear to us that the Respondent had knowingly maintained a lie in his 18 October 2019 statement.

67 We now turn to *Version 3* of the Respondent's account (contained in his witness statement dated 24 September 2021 and in his evidence at the inquiry).

(a) Having examined the Form ourselves, we found it inconceivable how the Respondent could have concluded from a mere examination of the Form that the cross against the box "negative" for TB –

(i) was different from the other crosses, and

(ii) was made by DW1.[115]

(b) All the crosses looked similar and there was nothing on the face of the Form to indicate that the cross against the box "negative" for TB was made by DW1.

(c) We noted that the Respondent himself admitted that the difference in the crosses on the Form were not obvious.[116] He was unable to provide an explanation as to *how* he was able to identify that the last cross was not made by him.[117]

(d) Neither was the Respondent able to explain *why* he did not "realise" that the cross against the box "negative" for TB was not made by him much earlier, given the following:

(i) According to the Respondent, for several months, he had "scrutinised [the Form] clearly" and to "understand" it.[118]

(ii) By June 2020, he had pieced together the full chronology of events.[119]

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113 The Respondent's Closing Submissions at [13] and [14].

114 1AB at page 409.

115 1AB at page 403.

116 Transcripts for 14 October 2021 at page 17 line 3 – line 5.

117 Transcripts for 14 October 2021 at page 17 line 19 – line 25, page 18 line 15 – line 18.

118 Transcripts for 13 October 2021 at page 109 line 8 – line 15, page 153 line 8.

119 Transcripts for 14 October 2021 at page 310 line 15 – line 21.

It is noteworthy that despite this, the Respondent stated Version 2 – not Version 3 – in his letter to the CC on 8 October 2020.

(e) Finally, Version 3 contained many internal inconsistencies which the Respondent was unable to explain. As the SMC has rightly observed–

> "149 … Version 3 represents an aberration from Dr Teo's usual procedure in all aspects. In fact, Dr Teo himself admits that the usual process was Version 2 i.e. all boxes are pre-crossed and pre-checked but that this was not done in the present case. DW1 had also stated that this was an "exceptional" case where not all the boxes were crossed contrary to the Clinic's practice.
>
> 150 To explain why this Patient's case was an "exception", Dr Teo created yet another version in the course of his oral testimony. He claimed that the Clinic's protocol of pre-checking of boxes would never include the test for TB as this involved a chest X-ray ("**Version 3.1**"). Dr Teo explained that the reason for this was because there could be multiple variations to chest radiographic findings. Whilst Dr Teo's clinic staff nurses were trained to recognise a normal or abnormal X-ray, Dr Teo testified that his staff were aware that they were not supposed to pre-check the chest X-ray in all the cases. Dr Teo would also not allow the box for chest X-ray to be crossed out as there could be many variations to a chest X-ray.
>
> 151 However, this new information presented at the Inquiry is inconsistent with DW1's 5 Oct SD, where she did not mention any exceptions to the staff's practice of pre-crossing all the boxes and then passing the pre-crossed form to Dr Teo for signing. It is pertinent that Dr Teo had annexed DW1's 5 Oct SD to his 8 Oct Letter to support his position that the Form was pre-crossed by the staff and pre-signed by him even before the test results were out. When confronted with the discrepancy between this alleged Clinic practice and the new version which he raised in his testimony, Dr Teo was unable to answer the questions directly. Dr Teo then contended that he allowed an inaccurate statement by DW1 (about the Clinic's practice) to be annexed in his 8 Oct Letter.
>
> 152 Curiously, when Dr Teo took the stand the next day, he then testified that he was aware that the Clinic's practice for his staff was to cross out the four boxes for pre-checking and this was "the truth". The Respondent then backtracked and claimed that he had "no issue" with DW1's 5 Oct SD being annexed to his 8 Oct Letter. It is evident that Dr Teo had repeatedly flipped flopped even in the course of his testimony to cover up his lies when he was pressed for answers."

(footnoting deleted)

68 **DW1's corroborative evidence carried little weight.** In rejecting the Respondent's defence (Version 3), we were mindful that it has been corroborated by DW1.[120] In our view, it was not safe to give full weight to DW1's evidence. Our reasons are as follows:

[120] The Respondent's Closing Submissions at [11(e)] and [58].

(a) First, it was abundantly clear that DW1 did not have an independent recollection of being the one who had indicated on the Form that the Patient was negative of TB. She had simply gone along with what the Respondent had suggested to her regarding how the Form came to be completed and submitted, which suggestion was a reconstruction of the events by the Respondent himself. As the SMC rightly pointed out –

> "142 When DW1 was asked about this paragraph of her witness statement, she confirmed that it was Dr Teo who had informed her that he made the first three crosses and that she made the last cross, and suggested to her that the first three crosses looked different from the last cross. It was not DW1 who came to her own realisation that only the first three crosses were made by Dr Teo, or that she had made the last cross, or for that matter, that there was any distinction in the manner in which the first three crosses were written as compared to the last cross. In this regard, despite being shown a copy of the Form during her interview with SMC on 12 June 2020 and scrutinising the Form, DW1 did not realise that the crosses on the boxes were different. If indeed the manner in which she made the cross was so different from the manner which Dr Teo had made his crosses, this should be immediately apparent from her first scrutiny of the Form."
>
> [footnoting deleted]

(b) Second, there was a gap of about three and a half years between the 29 March 2018 review and the inquiry. We found it unbelievable that DW1 could allegedly clearly recall indicating in the Form that the Patient was negative for TB and then submitting the Form after the review despite such a long lapse of time. This was especially so when –

(i) DW1 had dealt with many patients before and after the 29 March 2018 review;

(ii) She did not explain why the 29 March 2018 review was so exceptional such that she could recall the events so vividly; and

(iii) DW1's recollection of her alleged actions vis-à-vis the Form after 29 March 2018 review was not aided by any record.

Circumstances in which the Form was certified and submitted

69 **How the Form came to be certified.** In our view, Version 2 probably contained the truth of how the Form came to be certified. In other words, on 17 March 2018 when the Patient visited the Clinic, in accordance with the usual practice at the Clinic –

(a) the staff had pre-checked the box to indicate that the Patient was negative for TB; and

(b) the Respondent had pre-signed the Form.

This finding was corroborated by DW1. She testified that the standing protocol in the Clinic was for the staff to pre-check all the boxes "for efficacy reasons and administrative purposes"[121] and the Respondent would then sign off the form "*straightaway*".[122]

70 **Who submitted the Form?** According to the Respondent, DW1 was the one who had submitted the Form. Given that this evidence was not seriously disputed during the inquiry, we proceeded on the basis that the Form was submitted by DW1.

71 **Was the Form submitted in breach of the Respondent's instruction?** At the inquiry, the Respondent's position was that he had *expressly instructed* DW1 on 29 March 2018 *not to submit* the Form.[123]

72 We were unable to accept this evidence:

(a) There was *no record* of the alleged instruction in the Patient's case notes. The Respondent did not produce any documentary record to substantiate his claim.

(b) The Respondent's position at the inquiry was *raised for the first time more than three years after the event*. It did not appear in any of his previous communications to the CC.

(c) The Respondent's position at the inquiry was *materially contradicted* by his witness statement which was prepared for the purpose of the inquiry. In that statement, the Respondent merely stated that he *did not give instructions* to his clinic staff to submit the Form. the Respondent did not provide any satisfactory explanation for the material inconsistency in his evidence.

(d) The Respondent's position at the inquiry was also *contradicted by DW1*. She testified that there was "*no standing instruction*" from the Respondent not to

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121 Transcripts for 14 October 2021 at page 176 line 7 – line 9.

122 Transcripts for 14 October 2021 at page 233 line 16, page 176 line 24.

123 Transcripts for 14 October 2021 at page 66 line 8 – line 11, page 69 line 1 – line 4, page 71 line 10 – line 19, page 73 line 16 – line 23, page 75 line 7 – line 16.

submit the Form.[124] She also testified that she would follow the Respondent's instructions to not submit the Form if there were such expressed instructions,[125] and that she would not disobey the Respondent and submit the Form on her own.[126] During the inquiry, the Counsel for the Respondent did not challenge DW1's evidence.

(e) Finally, the Respondent was *prone to embellishing his evidence* and had been shown to be an unreliable witness. For instance, he had admitted to giving false statements to the CC in 2018 and 2019 on the circumstances in which the Form was submitted to MOM.

73 **Was the Form submitted on the Respondent's instruction?** The SMC urged the DT to find that the Form was submitted with the Respondent's knowledge or on his instruction. In support of this submission, the SMC referred us to PW2's evidence. According to her, during the 29 March 2018 review, upon expressing her concerns that the Form was overdue, the Respondent replied that he would "take care" of it. PW2 understood the Respondent to mean that he would clear the form with MOM.[127]

74 We were unable to agree with the SMC. We could not rule out the possibility that DW1 might have submitted the Form to MOM as a matter of course after the 29 March 2018 review was over, without any specific instruction from the Respondent. We came to this view based on the following:

(a) There was a practice at the material time whereby the clinic staff would pre-check, and the Respondent would pre-sign, the MOM forms when the patients first visit the Clinic for the medical screening.[128] According to the Respondent, he pre-signed MOM forms for "logistical" convenience.[129] This evidence was consistent with DW1's, who testified that the standing protocol in the Clinic

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124 Transcripts for 14 October 2021 at page 205 line 16 – page 206 line 6.

125 Transcripts for 14 October 2021 at page 196 line 12 – line 25, page 245 line 24 – page 246 line 13.

126 Transcripts for 14 October 2021 at page 193 line 16 – 194 line 3, page 238 line 5 – page 238 line 6, page 241 line 10 – line 15.

127 Transcript for 11 October 2021 at page 188 line 20 – page 189 line 8; PW2's statutory declaration at [11].

128 The Respondent's letter dated 8 October 2021 at [6]: 1AB at page 439; The Respondent's written statement dated 24 September 2021 at [12(b)]; DW1's statutory declaration at [3.1] and [3.2] annexed to The Respondent's letter dated 8 October 2021: 1AB at page 444; DW1's written statement dated 24 September 2021 at [10(c)].

129 Transcripts for 14 October 2021 at page 131 line 25 – page 132 line 10.

was for the staff to pre-check all the boxes "for efficacy reasons and administrative purposes".[130]

(b) The pre-checked and pre-signed MOM forms would be kept by the clinic staff,[131] and would be submitted by them when the medical results were ready.[132]

75 **No system of managing MOM forms at the Clinic**. It was clear to us that the Respondent did not institute any system to ensure that the pre-checked and pre-signed MOM medical examination forms were properly managed. For instance:

(a) There was no evidence that the Respondent had taken any concrete steps after the 29 March 2018 review was over to ensure that the Form was not in fact submitted by his staff (e.g., by safekeeping the pre-checked and pre-signed Form himself).

(b) On the Respondent's own evidence, it was only on or around May 2018, when PW1 returned to his Clinic to request for the Patient's X-ray images, did he realise that the Form was still pending.[133] This showed that The Respondent did not have a system for monitoring the status of the MOM forms that he had pre-signed.

(c) If the Respondent had in fact given instructions regarding such forms, then it appeared that such instructions were communicated verbally only and were not documented. Such a manner of conveying instructions was prone to lapses. This was evident from the following account by DW1:

> "4 In March 2018, I recall Dr Teo Sze Yang ("Dr Teo") instructing the clinic staff not to submit the ME Report of one Ms Pand to ensure that she returns to the clinic for a follow-up. *As I did not recall coming into contact with Ms P when she came to the clinic, I did not give much thought to The Respondent's instructions.*
>
> 5 … *I believe what had happened was that I had submitted [the Patient's] ME Report without knowing that it was Ms P's ME Report.* I recall that I came across a signed and completed ME Report which did not have any writing on it to indicate that it had been submitted to MOM, indicating that it had not been submitted by any of the clinic staff. *As the results on the ME Report were all negative and it had been signed by The Respondent, I thought that the ME Report*

130 Transcripts for 14 October 2021 at page 176 line 7 – line 9.

131 The Respondent's letter dated 8 October 2020: 1AB at page 439 – 442; The Respondent's written statement dated 24 September 2021 at [12(g)]; DW1's statutory declaration at [3.2] annexed to the Respondent's letter dated 8 October 2021: 1AB at page 444.

132 The Respondent's letter dated 8 October 2021 at [6]: 1AB at page 439.

133 The Respondent's written statement dated 24 September 2021 at [41] and [42].

> *was ready for submission.* I did not read the name stated on the ME Report and therefore did not realise that the form belonged to Ms P and that we were not to submit the form."
> [emphasis added][134]

76 To summarise, our findings on how the Form came to be submitted to MOM are as follows:

(a) On 17 March 2018 when the Patient visited the Clinic, in accordance with usual practice –

(i) the clinic staff had pre-checked the Form to indicate, among others, that the Patient was negative of TB; and

(ii) the Respondent had pre-signed the Form.

(b) On 29 March 2018 –

(i) After the review was over, DW1 had submitted the Form to MOM as a matter of course.

(ii) At the material time, there was nothing to indicate to DW1 that she was not supposed to submit the Form.

Second Charge – Did the Respondent depart from the applicable standards, and if so, was this departure egregious?

What is the applicable standard?

77 The consensus amongst the expert witnesses was as follows:

(a) A doctor must have a clear basis before he could certify the Patient to be negative for TB in the Form, and that basis would be a normal chest X-ray image;

(b) A doctor was responsible for the MOM forms that he signed; and

(c) The expert witnesses themselves would not personally pre-sign MOM forms.[135]

The Respondent departed from the applicable standard

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[134] Ms DW1's statutory declaration at [4] and [5] annexed to The Respondent's letter dated 8 October 2021: 1AB at page 444.

[135] Dr PE2: Transcripts for 11 October 2021 at page 111 line 13 – line 17, page 156 line 22 – page 157 line 18, Dr PE1: Transcripts for 13 October 2021 at page 17 line 17 – page 19 line 7; Dr DE1: Transcripts for 15 October 2021 at page 5 line 10 – page 8 line 11; Dr DE2: Transcripts for 14 October 2021 at page 169 line 7 – page 169 line 12.

78 We found that the Form was pre-checked as being negative for TB, and pre-signed, on 17 March 2018. It was not disputed that this certification was made without the basis of a normal X-ray image. The certification turned out to be wrong, as the 24 March CXR suggested that the Patient might have TB.

79 The Respondent accepted that he should not have pre-signed the MOM forms that his staff should not have pre-checked the boxes before the test results were in.[136]

80 By certifying that the Patient was negative for TB (a) when he had no basis to do so and (b) when she in fact had TB, the Respondent had departed from the standards required of him as a medical practitioner.[137] This is the gravamen of the Second Charge.[138]

The Respondent's departure from the applicable standards was egregious

81 In our view, the Respondent's departure from the standard of the medical profession fell under the Serious Negligent Limb of professional misconduct and was egregious.

(a) The Respondent' misconduct was clearly not of a "formal or technical nature". TB remained a prevalent and highly infectious disease in Asia and could be fatal if not treated properly.[139]

(b) The MOM form is an important measure adopted by the authorities to detect TB among work permit holders.[140] Doctors who conduct MOM medical screenings are at the frontline of our national efforts to manage TB cases. They are expected to exercise this "public health responsibility" vigilantly.[141] By pre-signing a certification that the Patient was negative for TB out of administrative convenience, the Respondent had abdicated the heavy responsibility entrusted to him as a medical practitioner.

(c) In the present case, the pre-signing of the Form was clearly not a "one-off breach". It was undisputed that there was a practice in the Respondent's Clinic

136 The Respondent's Closing Submissions at [142].
137 Prosecution's Closing Submissions at [167].
138 The Respondent's Closing Submissions at [141].
139 https://www.moh.gov.sg/diseases-updates/tuberculosis
140 Dr PE1: Transcripts for 13 October 2021 at page 4 line 10 – line 22.
141 MOH Guidelines at page 37: 1AB at page 72.

whereby he had allowed the staff to pre-check the MOM forms and he would thereafter pre-sign these forms.

(d) The Respondent had failed to do anything to correct the wrongful certification in the Form after receiving the 24 March CXR. It was an undisputed fact that the report contained abnormal findings about the Patient's lungs which suggested to the Respondent that she might have TB.

(e) The Respondent had also failed to take adequate steps to ensure the Form was not submitted until he had verified that the test results were indeed negative.[142] As a result of this failure, the Form was submitted to MOM on 29 March 2018. Due to the wrongful certification in the Form, the authorities did not know that the Patient had TB until several weeks later – when she consulted another doctor and was later admitted to Institution A.

The Respondent could not evade his responsibility by pushing the blame on DW1

82 According to the Respondent, he should not be held liable for professional misconduct because the Form was submitted by DW1.[143]

83 We were unable to agree.

(a) Being the one who had pre-signed the Form, it was disingenuous for the Respondent to suggest that he was not responsible for his own negligence in ensuring that the Form was not submitted to MOM until the Patient's TB test results were available and confirmed to be negative for TB.

(b) The Respondent did not implement an effective system to manage the certification and submission of MOM forms in his Clinic.

(c) It was the consistent opinion of the expert witnesses that once the certification was made on the Form, it was incumbent on the Respondent to ensure the Form was not submitted unless he has subsequently verified that the test results were indeed negative.[144] For instance –

142 Prosecution's Closing Submission at [168] and [178].
143 The Respondent's Closing Submissions at [138] and [141].
144 Prosecution's Closing Submissions at [131].

(i) It was Dr DE1's evidence that when there is pre-checking and pre-signing of the forms, the doctor must "verify" the test results to ensure that they were negative before submission.[145]

(ii) Dr PE2 testified that regardless of whether the Respondent's staff had followed his instructions, the Respondent was responsible for a form that he had pre-signed.[146]

(iii) Dr PE1 has unequivocally stated that as the Respondent signed the Form, ultimately the Respondent bears the responsibility for the submission of the Form.[147]

Conclusion on analysis regarding the Respondent's liability

84 For the above reasons, we found the Respondent guilty on the First Alternative Charge and the Second Alternative Charge.

Sentence

Submissions by the SMC

85 **Overview.** Relying on the sentencing framework laid out in *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("***Wong Meng Hang***"), the SMC submitted for the following:

(a) First Charge: 25 months' suspension.

According to the SMC, (i) the gravity of the offence should be pegged at "*moderate" harm* and "*medium" culpability*, (ii) the starting point sentence should be 22 months' suspension, and (iii) this sentence should be enhanced by an additional three months' suspension in light of aggravating factors.

(b) Second Charge: 27 months' suspension.

According to the SMC, (i) the gravity of the offence should be pegged at "*moderate" harm* and "*medium" to "high" culpability*, (ii) the starting point sentence should be 24 months' suspension, and (iii) this sentence should be enhanced by an additional three months' suspension in light of aggravating factors.[148]

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145 Transcripts for 15 October 2021 at page 7 line 7 – 14.
146 Transcripts for 11 October 2021 at page 110 line 7 – 15, page 157 line 18 – line 19.
147 Transcripts for 13 October 2021 at page 52 line 21 – page 53 line 4.
148 Prosecution's Submissions on Sentencing at [57] and [58].

(c) Both sentences to run consecutively.

The SMC submitted that the sentences should run consecutively because the offending conduct in the First Charge (duty to refer the Patient for further management) and the Second Charge (duty to properly certify whether the Patient had TB) were committed on different occasions and engaged distinct duties.

(d) Given that the maximum period of suspension that may be imposed under section 53(2) of the MRA is 36 months, the suspension period for the Respondent should be capped at 36 months.[149]

(e) An order should be made that the Respondent be censured, give a letter of undertaking to the SMC to abstain in future from the conduct complained of and/or similar conduct, and pay the costs of the counsel and of the Legal Service Officer.

86 **First Charge.** The SMC provided the following basis for its submissions on the First Charge.

(a) The SMC pegged the harm for the offence at "moderate" for the following reasons:[150]

(i) As a result of the Respondent's failure to refer the Patient for further management during the 29 May 2018 review, the Patient did not receive treatment for active TB more than one month later. According to the SMC, "Dr Teo ha[d] caused *direct harm* to the Patient's health and his conduct was the *sole cause* of harm to the Patient" [emphasis added].

(ii) The Respondent's failure to refer the Patient promptly had also caused *potential harm to PW1's family* – by allowing them to continue to be exposed to the risks of contracting TB from the Patient. The SMC highlighted that PW1's brother (who was living in the same household as the Patient) had contracted TB, and that it was highly likely this was from the Patient. That said, the SMC accepted that it is not known whether the contraction of TB by PW1's brother was directly linked to

149 Prosecution's Submissions on Sentencing at [59].
150 Prosecution's Submissions on Sentencing at [13] – [15].

the Respondent's failure to refer the Patient promptly for further management.

(iii) The Respondent's failure to refer the Patient during the 29 May 2018 review meant that she was not isolated promptly. According to the SMC, this had "seriously undermined public health and the safety of the public" – in that the public would have been exposed to a highly contagious disease.

(b) The SMC pegged the Respondent's culpability at "medium" for the following reasons:[151]

(i) The Respondent was solely responsible for the harm caused to the Patient as well as the potential harm to the Patient's household members and the public who were exposed to the risk of contracting TB.

(ii) The Respondent suspected that the Patient might have TB and knew that he had to "act urgently" upon receiving the 24 March CXR. Despite this and the MOH Guidelines which stated unequivocally that persons with abnormal chest X-ray should be evaluated further to rule out active TB, The Respondent "intentionally chose" not to refer the Patient for further management.

(iii) The Respondent's departure from the accepted standard practice was aggravated by his continued failure to refer the Patient even at the 31 March 2018 consultation and when the Patient allegedly defaulted on 5 April 2018.

(iv) The Respondent's failure to refer the Patient for further management demonstrated his indifference to the Patient's welfare.

87 **Second Charge.** The SMC provided the following basis for its submissions on the Second Charge.

(a) The SMC pegged the harm for the offence at "moderate" for the following reasons:[152]

[151] Prosecution's Submissions on Sentencing at [19] – [23].

[152] Prosecution's Submissions on Sentencing at [16] and [17].

(i) The wrongful certification lulled the Patient as well as PW1 and her family into a false sense of security that the Patient was only suffering from a normal respiratory infection which would improve in due course.

(ii) According to the SMC, the considerations for "harm" under the First Charge were applicable to the Second Charge as well.

(b) The SMC pegged the Respondent's culpability at "medium" to "high" for the following reasons:[153]

(i) The Respondent "blatantly certified the Patient negative for TB" when (1) he knew that he did not have any basis to certify the Patient to be negative for TB, and (2) he knew that the 24 March CXR was abnormal.

(ii) The Respondent concocted different accounts regarding how the Form came to be submitted to MOM.

(iii) The Respondent was fully responsible for certifying the Form.

(iv) As a result of failing to ensure that the Patient was negative for TB before certifying it (1) potential harm was caused to the persons residing together with the Patient and the public, (2) the Respondent had abused the trust and confidence of the Patient and PW1, and (3) he had acted in breach of the MOM guidelines and "intentionally and deliberately departed from the applicable standards" of the medical profession.

Submissions by the Respondent

88 The Respondent submitted for a sentence of six months' suspension and a fine. The basis for this submission was as follows:

(a) The level of harm caused by the two offences should be classified as "low".

(i) This classification was consistent with the approach taken in the Sentencing Guidelines published by the SMC at page 33 where harm was classified as (1) "slight" if it was of a temporal nature, (2) "moderate" if it was of a permanent nature, and (3) "severe" if the Patient had died as a result of the offending conduct. According to the Respondent, the harm suffered by the Patient was of a temporal nature.

[153] Prosecution's Submissions on Sentencing at [24] – [27].

(ii) In the present case, there was no evidence that the Respondent's offending conduct had caused harm to other persons. Even if there was such harm, it would have been of a temporal nature.

(b) As for the Respondent's culpability, it was submitted that there was no evidence that he had been dishonest. Regarding the making of retrospective entries to the Patient's case note for the 31 March 2018 consultation, the Respondent highlighted that he did not wrongfully pre-date those entries to 29 March 2018, that the entries correctly reflected the date when they were made (i.e., 31 March 2018), and the purpose of making these entries was simply to help the Respondent in case he forgot what had transpired on 29 March 2018.

(c) The starting point sentence should be a suspension of up to one year. The sentencing precedents showed that where substantial periods of suspension had been imposed, these involved repeat offenders or professional misconduct which were more serious than the Respondent's offences. Given that the Respondent's offences arose out of a "mistake" in one consultation, a sentence of *six months' suspension and fine* would have been appropriate.

(d) The Respondent submitted for both the sentences to run concurrently, on the basis that they were part of the same transaction when he reviewed the Patient's case.

Our sentencing decision

89 **Sentencing framework.** In considering the appropriate sentence, we took guidance from the sentencing framework laid out in *Wong Meng Hang* which we summarise as follows:

Step 1A: Assess the seriousness of the offence base on the following Harm factors (non-exhaustive): *Wong Meng Hang* at [30]	
1	*Actual harm* – The more direct the connection between the specific type of harm that has been occasioned and the misconduct in question, the weightier a consideration this will be. Examples – - Bodily injury, emotional or psychological distress; - Serious economic harm; - Increased predisposition to certain illnesses; - Loss of chance of recuperation or survival; - At the most severe end of the spectrum, death.
2	*Potential* harm that could have resulted from dangerous acts of misconduct, even if it did not actually materialise on the given facts. Potential harm should only be

	taken into account if there was a *sufficient likelihood* of the harm arising; it is not appropriate to consider every remote possibility of harm for the purposes of sentencing.

Step 1B: Assess the seriousness of the offence base on the following Culpability factors (non-exhaustive) *Wong Meng Hang* at [30]	
1	The extent and manner of the offender's involvement in causing the harm.
2	The extent to which the offender's conduct departed from standards reasonably expected of a medical practitioner.
3	The offender's state of mind when committing the offence.
4	All of the circumstances surrounding the commission of the offence.
Note.	
Harm may be caused in a variety of ways, usually ranging in severity from negligent or careless acts, to grossly negligent acts, to knowing incompetence and recklessness. In some situations, it may even include intentional acts.	

Step 2: Identify the the appropriate starting point sentence: *Wong Meng Hang* at [33] and [36]

(Tariffs for – Claim trial cases – First offender)

Harm / Culpability	Slight	Moderate	Severe
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

Step 3: Make adjustments to the starting point sentence to take into account the offender-specific aggravating and mitigating factors which include the following: *Wong Meng Hang* at [43]

Aggravating factors		**Mitigating factors**	
1	Prior instances of professional misconduct, especially where such antecedents bear similarities to the conduct underlying the charge in the case at hand.	1	Guilty plea.
		2	A long unblemished track record.
		3	Good professional standing.
		4	Undue delay in the SMC of the proceedings.

90 **First Charge.** We assessed the gravity of the Respondent's misconduct for the First Charge to be as follows:

(a) *Harm – "moderate"*: Considering the matter in totality, we assessed the level of harm for the First Charge to be "moderate".

(i) **Actual harm.** The actual harm caused was "*low*". We came to this view because it was common ground that the Patient would likely *already have* TB when she saw the Respondent during the 29 March 2018 review. In other words, the Respondent did not cause the Patient to contract TB. Neither was there any medical proof (1) that the Patient's condition got worse after the 29 March 2018 review and (2) that this was caused by the Respondent. If the Patient's condition did get worse after the 29 March 2018 review, this could be due to the natural progression of the TB infection. In the circumstances, we disagreed with the SMC's submission that "Dr Teo ha[d] caused *direct harm* to the Patient's health and his conduct was the *sole cause* of harm to the Patient" [emphasis added]. All that could be said is that because of the Respondent's failure to make the referral promptly, the Patient did not receive treatment for her TB until more than a month later, thus causing her pain and suffering that could have been mitigated. We agreed with the Respondent that in cases where the actual harm caused was of a temporal nature (as in the present case), this would typically be classified as "low" harm.

(ii) **Potential harm**. The level of harm arising from professional misconduct is not assessed solely from the perspective of actual harm caused to the patient. There is also a need to consider whether, and to what extent, the misconduct might cause harm to others. In this regard, we were of the view that the potential harm for the First Charge was "*moderate*". We came to this view because the Respondent's misconduct had public health and safety concerns. The delay in referring the Patient to TBCU (and thus having her isolated) had increased the risk of transmission of TB to members of the public who came into contact with her. We noted that contact screening of the Patient's household members and regular visitors to the household revealed that PW1's brother was diagnosed with multi-drug resistant TB similar to

what the Patient had.[154] On the other hand, we also noted that there was no direct evidence to prove that whether the TB infection of the household member and regular visitor was before or after the 29 March 2018 review. If it was before, then the infection of PW1's brother could not be attributed to the Respondent's default. In the circumstances, we decided to give a benefit of doubt to the Respondent.

(b) *Culpability – "medium"*: For the reasons set out in [87(b)] above, we agreed with the SMC that the level of the Respondent's culpability should be assessed to be "*medium*". We wish to add the following observations:

(i) There was absolutely no reason for the Respondent not to promptly refer the Patient to TBCU or a TB specialist for further assessment and treatment, but instead to take matters into his own hand by attempting to treat the Patient for CAP. This was especially so when he admitted to suspecting that the Patient had TB, and that he did not have the resources and expertise to exclude her for such an infection.

(ii) The Respondent's failure to refer the Patient was all the more serious given that apart from the 29 March 2018 review, there was *another opportunity* for him to make the referral and he failed to do so, again. On 31 March 2018, PW1 had brought the Patient to see him because the Patient was still coughing badly. Instead of making the referral, The Respondent merely prescribed medication for the Patient. Dr DE1, a defence expert witness, testified that the Respondent should in fact have referred the Patient "straightaway" to the hospital if the Patient was still feeling unwell on 31 March 2018.[155]

91 **Second Charge.** We assessed the gravity of the Respondent's misconduct for the Second Charge to be as follows:

(a) *Harm – "moderate"*: We were of the view that the level of harm to be "*moderate*". By wrongfully certifying the Patient to be negative for TB, the authorities were not alerted to her TB condition. This *potentially compromised public health and safety*. While our assessment of the level of harm is the same

[154] ASOF at [28]; PW1's Statutory Declaration dated 24 September 2021 at [37]; PW2's Statutory Declaration dated 24 September 2021 at [20].

[155] Transcripts for 15 October 2021 at page 20 line 10 – line 24.

as the SMC, we wish to highlight that we disagreed with the basis on which SMC arrived at its classification. Specifically, we rejected the SMC's submission that the wrongful certification had lulled the Patient as well as PW1 and her family into a false sense of security that the Patient was only suffering from a normal respiratory infection which would improve in due course. There was no evidence to support this submission. In fact, the evidence showed otherwise. After the 29 March 2018 review, PW1 continued to be concerned about the Patient's condition – to the extent that (1) she brought the Patient to see the Respondent again barely two days after the review and (2) she brought the Patient to see a different doctor (Dr A) on 14 April 2018.

(b) *Culpability – "medium"*: In our view, the level of the Respondent's culpability for the Second Charge is "*medium*". The wrongful certification related to TB, a highly infectious and potentially disease. The very purpose of the Form was specifically for the Respondent to confirm, among others, whether the Patient might have TB. By pre-signing the Form which had been pre-checked to be negative for TB even before the Patient had gone for her X-ray screening, the Respondent had abdicated his duty to sieve out TB cases. We disagreed with the SMC's classification of the Respondent's culpability as between "medium" to "high". Our reasons are as follows:

(i) Most of the SMC's submissions on the Respondent's culpability for the Second Charge are similar to those it had made for the First Charge (where it submitted that the culpability level was medium) – save for two. It is these two submissions that had pushed the Respondent's culpability level to "high".

(ii) The first is the SMC's submission that the Respondent had "blatantly certified the Patient negative for TB" when he knew that the 24 March CXR was abnormal ("**SMC's First Submission**"). This submission was not borne out by our findings. To recap – we found that the Respondent had pre-signed the Form on 17 March 2018 (i.e., the day the Patient first consulted him for the purpose of the MOM form). At the material time, the Respondent would not have any reason to suspect that the Patient might have TB. This is because he saw the Patient's abnormal chest X-ray only eight days *later*, on 25 March 2018. In the circumstances,

SMC's First Submission did not provide a basis for classifying the offending conduct in the Second Charge as "high".

(iii) The second submission that the SMC raised to push the Respondent's culpability to "high" was its contention that the Respondent had concocted different accounts regarding how the Form came to be submitted to MOM ("**SMC's Second Submission**"). It is well-established that such post-offence conduct by an offender demonstrated a *lack of remorse* on his part. This is an *offender*-specific aggravating factor, and not an *offence*-specific aggravating factor: *Neo Ah Luan v Public Prosecutor* [2018] 5 SLR 1153 at [74](c); *Logachev Vladislav v Public Prosecutor* [2018] 4 SLR 609 at [37]; *Huang Ying-Chun v Public Prosecutor* [2019] 3 SLR 606 at [98]; *Tan Song Cheng v Public Prosecutor* [2021] SGHC 138 at [39]; *Kunasekaran s/o Kalimuthu Somasundara v Public Prosecutor* [2018] 4 SLR 580 at [45](c); *Ye Lin Myint v Public Prosecutor* [2019] 5 SLR 1005 at [59]; *Public Prosecutor v Wong Chee Meng* [2020] 5 SLR 807 at [62]; *Public Prosecutor v Su Jiqing Joel* [2021] 3 SLR 1232; *Lee Shing Chan v Public Prosecutor* [2020] 4 SLR 1174 at [36]; *Koo Kah Yee v Public Prosecutor* [2021] 3 SLR 1440 at [66]. For further discussion, see Kow Keng Siong, *Sentencing Principles in Singapore* (Academy Publishing, 2019) ("***Sentencing Principles***") at [20.126] – [20.133] and [20.222] – [20.226]. Another problem with SMC's Second Submission is that the *same* contention is relied upon *again* by the SMC to justify an uplift in the sentence – this time as a "specific aggravating factor".[156] This offends the rule against double counting of sentencing factors: *Sentencing Principles* at [08.080], [08.081], [08.085] – [08.087].

92 **Starting point sentence.** Under the *Wong Meng Hang* sentencing framework, the starting point sentence for a misconduct that falls within "moderate" harm and "medium" culpability is a suspension from practice of between one year to two years.

[156] Prosecution's Submissions on Sentencing at [29] – [36].

93 **Aggravating factors.** During the SMC investigations and at the Inquiry, the Respondent had repeatedly provided false and/or misleading information regarding why he did not refer the Patient to TBCU and how the wrong certification in the Form came to be made and submitted to MOM. We agreed with the SMC that this is an *offender*-specific factor that justified an uplift in sentencing.[157]

94 **Mitigating factors.** Apart from his submission that the present charges related to a one-off "mistake", we found that the Respondent did not raise any factor which could be considered to be mitigating.

95 **Sentencing precedents**. We have reviewed the sentencing precedents cited by the SMC and the Respondent. We did not find them to be particularly useful given that they involved (a) cases with very different factual scenarios, (b) cases decided prior to the guideline judgement in *Wong Meng Hang*, and/or (c) doctors who were repeat offenders.

96 **Deterrent sentence needed.** We agreed with the SMC that there was a need for a deterrent sentence.[158] Medical certification forms such as the MOM forms are in many cases the first (and only) line of defence against a public health threat, and that doctors should take their responsibility seriously when performing the relevant medical screenings and when certifying such forms. Doctors who refuse to do so can expect to receive deterrent sentences.

97 **Orders made.** In light of the above –

(a) We imposed the following sentences:

(i) First Charge: *15 months' suspension*.

(ii) Second Charge: *15 months' suspension.*

(b) We ordered that the sentences for both charges were to run *concurrently*. In other words, the Respondent is to be suspended from practice for a period of **15 months**. In our view, such an order would ensure that the eventual sentence

[157] Prosecution's Submissions on Sentencing at [30] – [36].
[158] Prosecution's Submissions on Sentencing at [37] – [39].

does not offend the rule against double counting and the proportionality/totality principle.

(i) In calibrating the individual sentence for each offence, we had considered a number of sentencing factors which are common to both offences – e.g., potential harm to persons in PW1's household and to the public due to the risk of exposure to the Patient who had TB, and the Respondent's failure to properly screen the Patient. (This is not surprising considering that although the two charges address different legally protected interests (that of the Patient for the First Charge and that of the public for the Second Charge), a substantial number of sentencing considerations between these two charges do overlap.) In such a case, an order that the two sentences are to run consecutively would amount to an unfair double counting aggravating sentencing factors to the Respondent's prejudice: *Mohamed Shouffee bin Adam v Public Prosecutor* [2014] 2 SLR 998 at [78] and [79]; *Chang Kar Meng v Public Prosecutor* [2017] 2 SLR 68 at [27]; *Loo Pei Xiang Alan v Public Prosecutor* [2015] 5 SLR 500 at [39].

(ii) Further, we noted that if we were to order the two sentences to run consecutively, this would lead to an aggregate sentence of 30 months' suspension. Such a sentence is not compatible with those precedents involving far more serious instances of professional misconduct highlighted to us by the parties. See for instance, *SMC v Tan Joong Piang* [2019] SMCDT 9. In that case, an aggregate sentence of 33 months' suspension was considered to be a suitable starting point for the offender who faced *18 charges* for long-term prescription of hypnotics to *six patients* and in the process, failing to provide appropriate care, management and treatment of his patients, failing to maintain medical records of sufficient details and failing to refer his patients to an appropriate specialist for management of his patients' conditions in a timely manner.

(c) We further made the following orders:

(i) That the Respondent be censured,

(ii) That the Respondent provides a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct in the future, and

(iii) That the Respondent pays the costs and expenses of and incidental to the proceedings, including the costs of the Counsel for the SMC.

98 We further ordered that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of persons involved.

99 The hearing is hereby concluded.

Prof Ho Lai Yun Chairman	Dr Andrew Tan Gee Seng	Mr Kow Keng Siong Legal Service Officer

Ms Chang Man Phing, Ms Dynyse Loh (M/s WongPartnership LLP)
for Singapore Medical Council

Mr Daniel Chia, Ms Jeannette Wong (M/s Morgan Lewis Stamford LLC) for
Dr Teo Sze Yang