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21 October 2014

PRESS RELEASE

DISCIPLINARY COMMITTEE INQUIRY FOR DR TEH TZE CHEN KEVIN

1. The Singapore Medical Council ("**SMC**") held a Disciplinary Committee ("**DC**") inquiry for Dr Teh Tze Chen Kevin ("**Dr Teh**"), age 40, on 18 to 19 July, 26 August and 20 December 2013, 23 to 24 January, 9 July and 19 August 2014.

2. Dr Teh is a registered medical practitioner practising at Singapore Lipo, Body & Face Centre ("**the Clinic**") located at 10 Sinaran Drive #08-05/06 Novena Medical Center at the material time.

3. Dr Teh contested all six charges alleging professional misconduct under Section 45(1)(d) of the MRA in relation to the care and management of one of his patients ("**Patient**"). The six charges faced by Dr Teh alleged as follows:

   a) That Dr Teh was in wilful neglect of his duties to the Patient when he prescribed and thereby allowed the Patient to consume Augmentin, a medication containing Amoxycillin which the Patient was allergic to ("**First Charge**").

   b) That Dr Teh failed to act in the best interests of the Patient when he proceeded with the Vaser LipoSelection treatment ("**Procedure**") on the Patient after he realised that the Patient had consumed Augmentin ("**Second Charge**").

c) That Dr Teh had failed to disclose to the Patient that he was going to administer Promethazine to treat a potential allergic reaction to Amoxycillin ("**Third Charge**").

d) That Dr Teh had grossly mismanaged the care of the Patient after he performed the Procedure on the Patient ("**Fourth Charge**").

e) That Dr Teh falsified or caused to be falsified the Patient's medical records by stating that the Promethazine administered to the Patient at the start of the Procedure was diluted, when it was in fact undiluted ("**Fifth Charge**").

f) That Dr Teh falsified or caused to be falsified the Patient's medical records by stating that the Patient's allergy to Amoxycillin was ascertained at the consultation on 12 March 2009, when the Patient's allergy to Amoxycillin was in fact only ascertained on the date of the Procedure on 17 March 2009 ("**Sixth Charge**").

4. At the conclusion of the Inquiry, the DC convicted Dr Teh on the First to Third Charges and the Sixth Charge. The DC acquitted Dr Teh of the Fourth and Fifth Charges.

5. In relation to the **First Charge**, the DC found that Dr Teh did not, at the consultation on 12 March 2009, take a proper medical history recording the Patient's allergy to Amoxycillin. No instructions were given to the nurses prior to or on 17 March 2009 with respect to prescribing an alternative medication to Amoxycillin.

6. The DC noted that while there was also a series of process errors on the part of the Clinic staff and nurses, Dr Teh, as the presiding doctor, was not released from overall responsibility and had the responsibility to design and implement an effective system and protocol for administering medicines that would safeguard the health and safety of his patients. The DC was of the view that Dr Teh failed to live up to this standard required of him.

7. Accordingly, while the DC found that while Dr Teh was not solely to blame, his omissions materially contributed to the Patient being prescribed Augmentin, and convicted him on the First Charge.

8. In relation to the **Second Charge**, it was not disputed that Dr Teh did not tell the Patient that he had been given Augmentin, and chose instead to observe the Patient for any signs or symptoms of allergy. After the observation, Dr Teh administered Promethazine to counteract any possible allergic reaction the Patient might have. Given that the Procedure was elective and cosmetic in nature, Dr Teh ought to have refrained from taking any risk.

9. The DC was of the opinion that Dr Teh's failure to disclose that Augmentin had been given, to advise the Patient of the risk factors associated with continuing with the Procedure and to give the Patient an informed choice about continuing with the Procedure amounted to professional misconduct and duly convicted him of the Second Charge.

10. The **Third Charge** was related to the Second Charge because they formed part of the same sequence of events, insofar as the administration of Promethazine was due to the consumption of Augmentin. It was not in dispute that Dr Teh did not inform the Patient that "*Promethazine*" would be given. The DC found that the crux of the matter was that Dr Teh had failed to inform the Patient about the administration of both Augmentin and Promethazine. This was a critical issue of informed consent, which was expected to be notated in the case notes, and Dr Teh's failure to make this disclosure amounted to professional misconduct and Dr Teh was accordingly guilty of the Third Charge.

11. In relation to the **Fourth Charge,** the DC found that Dr Teh had taken follow up steps when the Patient attended a consultation on the next day following the Procedure. Dr Teh had also instructed his nursing staff to regularly follow up with the Patient, and the Patient had given some indication that the situation was under control. Although it was possible to say that Dr Teh's follow up was not entirely satisfactory, the DC dismissed the Fourth Charge as it was unable

to conclude beyond a reasonable doubt that Dr Teh had grossly mismanaged the care of the Patient.

12. On the evidence available to the DC in relation to the **Fifth Charge**, while the DC noted that Dr Teh's record-keeping left a lot to be desired, there was a certain amount of uncertainty surrounding Dr Teh's administration of the undiluted Promethazine. In the circumstances, the DC dismissed the Fifth Charge as it was unable to conclude beyond a reasonable doubt that Dr Teh had falsified or caused to be falsified the Patient's medical records in respect of this issue.

13. In relation to the **Sixth Charge**, the DC found that Dr Teh had tampered with the case notes by recording the Patient's allergy history without making it clear that it was only written on 17 March 2009 (or such other date), thereby causing the case notes to reflect that the Patient's allergy to Amoxycillin had been ascertained on 12 March 2009 when it had only been discovered later. As such, it was to that extent, misleading.

14. The DC found that Dr Teh's failure to annotate exactly when the allergy was recorded was blameworthy, as his action in attempting to create the impression that he made the entry on 12 March 2009 was part of the cover-up and plan to divert the blame to the nurses. The retrospective insertion of the Patient's allergy history gave the erroneous impression that it was written contemporaneously at the initial consultation on 12 March 2009 when it was not. This inaccuracy was deliberately perpetrated as part of Dr Teh's strategy of self-preservation and blame-shifting, and the DC found Dr Teh guilty of professional misconduct under the Sixth Charge.

15. On the matter of sentence, the DC noted that although Dr Teh had made a series of misjudgements which ultimately culminated in him dishonestly trying to cover his tracks, on the specific facts of the case, leniency ought to be shown in view of the compelling mitigating factors that were presented to the DC. Accordingly, taking all the circumstances into consideration, including Dr Teh's mitigation plea, the DC ordered that Dr Teh:

(a) be fined the sum of **$10,000**;

(b) be censured;

(c) give a written undertaking to the SMC to abstain in future from the conduct complained of in the Sixth Charge or any similar conduct; and

(d) pay 70% of the costs of, and incidental to, the disciplinary proceedings, including the costs of counsel to the SMC and the Legal Assessor.

16. The DC also ordered that its Grounds of Decision be published.

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