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11 February 2016

PRESS RELEASE

DISCIPLINARY TRIBUNAL INQUIRY FOR DR TEH TZE CHEN KEVIN

1. The Singapore Medical Council ("**SMC**") held a Disciplinary Tribunal ("**DT**") inquiry for Dr Teh Tze Chen Kevin from 18 to 22 May 2015 and 20 November 2015.

2. Dr Teh is a general practitioner who was practising at Singapore Lipo, Body & Face Centre ("**the Clinic**") at the material time.

3. The inquiry arose from a complaint made to the SMC on 7 September 2012.

4. The events involved a Vaser Liposelection treatment ("**Procedure**") performed by Dr Teh on a patient ("**the Patient**") on 14 October 2010 which was to be carried out under tumescent local anaesthesia and twilight sedation. Both the Procedure and the administration of the sedation were carried out by Dr Teh.

5. After the Procedure, the Patient was transferred to the recovery room. When she woke up, she was lying on a bed warmer. The Patient informed the nurse that she felt discomfort. After the Patient returned home on 14 October 2010, the pain did not subside. Dr Teh attended to the Patient at her home on the same night and gave her an injection of 30 mg of IM Pethidine to relieve the pain.

6. On the morning of 15 October 2010 (1st Post-Operative Day), the Patient returned to the Clinic for her follow-up appointment with Dr Teh. During the consultation, Dr Teh noted that the Patient had fluid-filled blisters on the back of both thighs that were not present the day before, and some swelling and bruising on the Patient's thighs. There were moderate redness and tenderness around the blisters. The Patient's wounds were treated with chlorhexidine wash, bactroban antibiotic cream, bactigras dressings, gamgee and gauze. Dr Teh asked the Patient to return to the Clinic daily

for review of her blisters and liposelection results. She was instructed to continue with the medication she was given, which included an antibiotic.

7. The next morning, on 16 October 2010 (2nd Post-Operative Day), the Patient returned to the Clinic. The Patient reported pain in her thighs and Dr Teh noted that the Patient's condition remained largely the same. The Patient's dressings were changed again.

8. Between 17 October and 20 October 2010, the Patient was seen daily by Dr Teh and his nurses for wound cleansing and dressing.

9. On the night of 21 October 2010 (the 7th Post-Operative Day), Dr Teh and his nurses went to the Patient's house. The Patient reported feeling chills that evening. Upon taking the Patient's temperature at about 2000 hours, it was noted that the Patient had developed a fever of 39.1°C. Dr Teh also observed, among other things, swelling and bruising on the bilateral thighs with more erythema and areas of purple blotchiness extending 1 to 2 cm from the blister edges. The Patient was brought to the Accident & Emergency Department of the Singapore General Hospital ("**SGH**") where she was admitted to the Burns Unit and scheduled to undergo skin graft surgery the next morning. The Patient was admitted in SGH from 22 October 2010 to 8 November 2010.

10. Three charges were preferred against Dr Teh for professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap. 174) in relation to the treatment and management of the Patient. The three charges faced by Dr Teh were:
    (a) Between 14 October 2010 to 21 October 2010, Dr Teh failed to refer the Patient to a specialist for proper evaluation and treatment of her condition in a timeous manner, despite the seriousness of the Patient's condition ("**First Charge**");
    (b) During the Procedure, Dr Teh, who was performing the Procedure, failed to ensure that the sedation was safely and appropriately administered to the Patient, ("**Second Charge**"); and
    (c) Dr Teh failed to ensure proper and adequate documentation of the sedation given to the Patient during the Procedure ("**Third Charge**").

11. Dr Teh claimed trial. At the conclusion of the Inquiry, Dr Teh was found guilty of the First and Second Charges. The DT acquitted Dr Teh of the Third Charge.

12. In relation to the First Charge, the DT found that there was clear medical evidence from the experts for both sides that Dr Teh should have referred the Patient much earlier, rather than only after high fever and infection had set in on the 7th Post-Operative day (21 October 2010). The DT rejected Dr Teh's contention that prior to the 7th Post-Operative day, the Patient's condition was stable and improving as there was no evidence to support this contention. The DT noted that Dr Teh's alleged clinical impression that the Patient's condition was stable and improving was not documented in the case notes, and was also contradicted by the evidence of Dr Teh's nurse that the wounds were not improving. 2 of the 3 plastic surgery experts agreed that they would both have referred the Patient to a specialist Burns Centre by the 2nd Post-Operative day, whilst the 3rd expert agreed that burns could evolve over time and there was a need for close observation.

13. Therefore, the DT found that Dr Teh's failure to refer the Patient in a timeous manner amounted to professional misconduct and convicted him of the First Charge.

14. For the Second Charge, it was not disputed that:
    (a) Dr Teh was not aware of the 'Guidelines for Safe Sedation Practice for Investigation and Intervention Procedures' issued by the Academy of Medicine in December 2002 ("**2002 Guidelines**"); and
    (b) The amount of Propofol administered by Dr Teh exceeded the manufacturer's recommended dosage.

15. The DT stated that Dr Teh's conduct as set out in paragraph 14 above was particularly troubling since it would be incumbent on any doctor, who has the intention to conduct his own sedation, to ensure that he is familiar with the prevailing guidelines and something as basic as a recommended dosage.

16. The DT further rejected Dr Teh's contentions. The DT found that Dr Teh's attempt to explain away his conduct was totally unacceptable and demonstrated his cavalier attitude towards patient safety and his duty as a medical practitioner.

17. Therefore, the DT found that Dr Teh had departed from established guidelines and recommended dosages on his own accord, without basis, especially since he was neither a trained anaesthetist nor intensivist. In so doing, Dr Teh had totally disregarded the potency of Propofol and the need for greater care, which was

reflected in the manufacturer's guidelines in the product insert that Propofol was to be administered only by anaesthetists or intensivists. This disregard was reinforced by Dr Teh's failure to have in place a system to monitor the Patient after the Procedure ended.

18. Additionally, the DT found that Dr Teh's failure to give supplemental oxygen to the Patient during the sedation was contrary to the 2002 Guidelines and the expert evidence from both sides.

19. Accordingly, the DT concluded that Dr Teh's failure to ensure that the sedation was safely and appropriately carried out amounted to professional misconduct and convicted Dr Teh of the Second Charge.

20. The DT acquitted Dr Teh of the Third Charge relating to his alleged failure to keep proper and adequate documentation of the sedation given to the Patient during the Procedure. The DT noted that Dr Teh only recorded the quantity of Dormicum administered to the Patient, and not the dosage. There was evidence before the DT that the dosage could be calculated because Dr Teh's clinic only stocked Dormicum of one concentration and Dr Teh's nurse had taken responsibility for this omission. Further there was expert evidence that non-recording of the dosage did not affect patient safety. Therefore although the DT found that Dr Teh's conduct was not ideal, the DT was satisfied that it did not amount to professional misconduct. The DT also did not find fault with the frequency of the recording as it noted that Dr Teh's recording at 15-minute intervals was consistent with prevailing practice in the private sector and the specific interval was not mandated by the 2002 Guidelines.

21. In coming to the appropriate sentence, the DT took into account the following mitigation factors:
    (a) Dr Teh's voluntary service;
    (b) The strong testimonials on his behalf from other members of the medical profession, his staff and patients;
    (c) Dr Teh was a relatively young doctor in 2010 pursuing his interest in aesthetic medicine; and
    (d) Dr Teh has since changed his practice and would engage an anaesthetist to undertake the sedation for his aesthetic procedures.

22. The DT was of the view that given the gravity of Dr Teh's offences under the First and Second Charges, anything less than a suspension of 4 months would not be adequate to register the seriousness of the conduct or punish Dr Teh, nor would it deter such lapses or preserve public confidence in the medical profession. This was particularly since the safety of the Patient had been put at risk.

23. Accordingly, the DT ordered that Dr Teh:
    (a) be suspended for 4 months;
    (b) be censured; and
    (c) gives a written undertaking to the SMC that he will not engage in the conduct complained of and any similar conduct; and

24. The DT also ordered Dr Teh to bear the costs and expenses of and incidental to these proceedings, including the costs of SMC's solicitors. Although Dr Teh was acquitted of the Third Charge, the DT considered the overlap in work and the common witnesses for the Second and Third Charges, and exercised its discretion not to order any apportionment of costs.

25. The DT also ordered that its Grounds of Decision be published.

26. Dr Teh's 4-month suspension took effect on 12 January 2016 and will run to 11 May 2016 (both dates inclusive).

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