SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR TEH TZE CHEN KEVIN HELD ON 18 TO 19 JULY, 26 AUGUST AND 20 DECEMBER 2013, 23 TO 24 JANUARY, 9 JULY AND 19 AUGUST 2014

Disciplinary Committee:
Prof Lee Eng Hin - Chairman
Dr Raymond Chua
A/Prof Thng Leong Keng Paul
Mr Chan Kok Way - Lay Member

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GROUNDS OF DECISION OF THE DISCIPLINARY COMMITTEE

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

Introduction and the Notice of Inquiry

1. The Respondent, Dr Teh Tze Chen Kevin ("**Dr Teh**"), is a General Practitioner registered under the Medical Registration Act (Cap. 174) (2004 Ed.) ("**the Act**"). He had 11 years of experience at the material time. Dr Teh faced charges of professional misconduct under section 45(1)(d) of the Act. At all material times, Dr Teh practised at Singapore Lipo, Body & Face Centre ("**the Clinic**").

2. The Notice of Inquiry served on Dr Teh sets out 6 charges as follows:

> "*Notice is hereby given to you that in consequence of a complaint made against you to the Medical Council an inquiry is to be held*

by the Disciplinary Committee into the following charges against you:

*1. That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), on or about 17 March 2009, you were in wilful neglect of your duties to your patient, one Mr P ("**the Patient**"), in that you prescribed and thereby allowed the Patient to consume Augmentin, a medication containing Amoxycillin, to which the Patient had an allergy which you knew or ought to have known, as one of the pre-medications to be given to the Patient.*

Particulars

*(a) On 12 March 2009, the Patient consulted you for Vaser LipoSelection treatment ("**the Procedure**") on his lower back area.*

(b) The Procedure was scheduled to be performed on 17 March 2009.

(c) On or about 17 March 2009, you prescribed Augmentin, a medication containing Amoxycillin, to the Patient as one of the pre-medications to be given to the Patient.

(d) The Patient attended at the clinic on 18 March 2009 around 9.00am. At or about 9.15am, the Patient was given the pre-medications, including Augmentin, which he consumed.

(e) At the material time, the Patient was allergic to Amoxycillin.

(f) You should have ascertained from the Patient prior to the Patient's consumption of the pre-medications, that he was allergic to Amoxycillin, but you failed to do so and that in relation to the facts alleged, you have been guilty of

professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)

("**the First Charge**")

*2. That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), on or about 17 March 2009, you failed to act in the best interests of your Patient, one Mr P (**"the Patient"**), in that you proceeded with Vaser LipoSelection treatment ("**the Procedure**"), even after you realized that the Patient had consumed Augmentin, a medication containing Amoxycillin, which the Patient was allergic to."*

Particulars

(a) On 12 March 2009, the Patient consulted you for the Procedure on his lower back area.

(b) The Procedure was scheduled to be performed on 17 March 2009.

(c) The Patient attended at the Clinic on 17 March 2009 around 9.00am. At or about 9.15am, the patient was given pre-medications, including Augmentin, a medication containing Amoxycillin, which he consumed.

(d) At the material time, the Patient was allergic to Amoxycillin.

(e) At no time did you disclose to the Patient that he had been given a medication containing Amoxycillin.

(f) Notwithstanding the matters stated in (c) to (e) above, you proceeded with the Procedure at or about 10.35am.

(g) You should have postponed the Procedure as there was a possibility of the Patient having an allergic reaction to the Amoxycillin.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)
("**the Second Charge**")

*3. That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), on or about 17 March 2009, you failed to disclose to your patient, one Mr P (**"the Patient"**), that you were going to provide treatment for a potential allergic reaction to Amoxycillin.*

Particulars

(a) You failed to disclose to the Patient that he had been given a medication containing Amoxycillin which he was allergic to.

(b) You failed to disclose to the Patient that you were going to administer to him Promethazine to treat a potential allergic reaction to Amoxycillin.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)
("**the Third Charge**")

*4. That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), between the period 17 March 2009 to 1 April 2009, you grossly mismanaged the care of your Patient, one Mr P*

*(**"the Patient"**) after you performed the Vaser LipoSelection treatment (**"the Procedure"**) on the Patient.*

Particulars

(a) Prior to the Procedure on 17 March 2009, the Patient consumed Augmentin, a medication containing Amoxycillin which he was allergic to.

(b) During the Procedure, you administered, inter alia*, Promethazine and Propofol (collectively known as "**the Medications**") to the Patient.*

(c) During the Procedure, there was extravasation of the Medications.

(d) Swelling of the Patient's right hand was noted during the Procedure.

(e) After the Procedure, you prescribed to the Patient Ciproflaxin, Arcoxia, and Anarex.

(f) In light of the matters stated in (a) to (d) above, you should have closely followed up with the Patient's condition after he was discharged from the Clinic.

(g) At the follow-up consultation on 18 March 2009, you noted that the swelling of the Patient's right hand had not subsided. You further prescribed Arcoxia and Prednisolone. The next follow-up review was scheduled for 25 March 2009.

(h) The swelling of the Patient's right hand persisted on 20 and 23 March 2009 and the Clinic was aware of this.

(i) Despite the Patient not turning up for his follow-up review scheduled for 25 March 2009, you failed to ascertain the Patient's condition.

(j) It was only on 1 April 2009 when the Patient came to the Clinic to obtain a medical report, that you reviewed the Patient's condition.

(k) By 1 April 2009, the Patient's right thumb had turned dusky and there was superficial skin necrosis over the dorsum of his hand.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)
("**the Fourth Charge**")

5. *That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), you did falsify or cause to be falsified the medical records of your Patient, one Mr P ("**the Patient**").*

Particulars

(a) You falsified or cause [sic] *to be falsified the medical records of the Patient by inserting the words*

"IV diluted 5ml N/S } 1038
(over 5 min) } "

*(collectively known as "**the Falsified Words**")*

*beside the words "*IV Promethazine 0.5ml*" on the Anaesthesia Record.*

(b) The Falsified Words were false as the medication Promethazine was in fact undiluted."

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)
("**the Fifth Charge**")

*6. That you **Dr TEH TZE CHEN KEVIN,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Lipo, Body & Face Centre ("**the Clinic**"), you did falsify or cause to be falsified the medical records of your Patient, one Mr P (**"the Patient"**).*

Particulars

(a) You falsified or cause [sic] *to be falsified the medical records of the Patient by circling the printed word "*Yes*" for the heading "*Drug Allergy*", and inserting the words:*

"Amoxycillin → ? skin
Test
- Unknown reaction
- No major reaction"

*(collectively known as "**the Tampered Words**")*

*under the heading "*Drug Allergy*" for the consultation dated "*12/3/09*"."*

(b) The Patient's allergy to Amoxycillin was not ascertained at the consultation on 12 March 2009, but only at the next consultation on 17 March 2009.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.)"
("**the Sixth Charge**")

Preliminary Objections

3. The manner in which this complaint came to the Disciplinary Committee was as follows: The Patient lodged a complaint with the Singapore Medical Council ("**SMC**") by a Statutory Declaration dated 3 July 2009 ("**the Complaint**"). The SMC Complaints Committee wrote to Dr Teh about the complaint on 13 August 2009. Dr Teh responded to the Complaints Committee by way of letter on 17 September 2009. The Complaints Committee decided not to refer the matter to the Disciplinary Committee. The Patient, aggrieved at this outcome, appealed to the Minister under section 41(7) of the Act. The Minister, in light of the appeal, referred the matter to this Disciplinary Committee by way of letter dated 5 May 2011 pursuant to section 41(8)(b) of the Act.[1]

Dr Teh's preliminary objections

4. Dr Teh objected to Charges 1, 2 and 3 arguing that these charges were outside the scope of the Patient's complaint. Dr Teh also objected to these charges on the basis that he was not given notice that the Complaints Committee was inquiring into the matters that are the subject of these charges, contrary to section 40(9) of the Act.

5. Section 40(9) of the Act states:

> "*Where, in the course of its inquiry, a Complaints Committee receives information touching on or evidence of the conduct or physical or mental fitness of the registered medical practitioner concerned which may give rise to proceedings under this Part, the Complaints Committee may, after giving notice to him, decide on its own motion to inquire into that matter.*"

6. Dr Teh's argument was that the Complaints Committee had to give him notice before inquiring into any matter—because such notice would have allowed him the opportunity to be heard.[2] The failure to give notice was a breach of natural justice.

[1] Letter from the Ministry of Health to the SMC, dated 5 May 2011
[2] Respondent's Submission for his objection to Charges Nos. 1, 2 and 3 at [11], [14] and [19]

7. The first three charges all concerned various aspects of the Procedure relating to the Patient's consumption of Augmentin, a medication containing Amoxycillin, that the Patient was allergic to:

7.1. The First Charge related to the prescription of Augmentin notwithstanding the Patient's allergy to Amoxycillin.

7.2. The Second Charge related to continuing with the Procedure even though Augmentin (with contained Amoxycillin) had been administered.

7.3. The Third Charge related to the non-disclosure of treatment for the potential allergic reaction to Amoxycillin i.e. the prescription of Promethazine.

Dr Teh's objection was that the Patient's complaint did not raise the foregoing. The Complaint made no reference to Amoxycillin, Augmentin or Promethazine. As such Dr Teh claimed he did not address them in his letter of explanation to the Complaints Committee dated 17 September 2009.

8. Dr Teh also objected to the fact that he was not able to address the Minister on the subject matter of the 3 Charges prior to the Minister referring the matter to the Disciplinary Committee.

The Prosecution's submissions[3]

The 3 Charges are not inconsistent with the Complaint

9. The Prosecution submitted that the 3 Charges were not inconsistent with the Complaint and corresponded with both the subject matter and scope of the Complaint. The Prosecution's argument was that the factual essence of the Complaint included the substance of the 3 Charges. Just because "*Amoxycillin*" did not expressly appear on the face of the Complaint did not preclude it from being within the scope of the substantive charge.

[3] SMC's Skeletal Arguments on Preliminary Objections at [4]-[9]

10. The Prosecution also argued that Dr Teh deliberately suppressed the prescription of Augmentin from the Patient and subsequently, Promethazine to treat the Patient's allergic reaction to Augmentin. He could not now object that the Patient did not refer to information that had been hidden from him.

11. If there was a "*clear linkage*" between the charge and the conduct of the doctor, the conduct would fall within the purview of the charge. The Prosecution urged the Disciplinary Committee to take a "*broad-based*", as opposed to a semantic, approach.

Dr Teh does not have a right to be heard in an appeal to the Minister

12. The Prosecution also submitted that Dr Teh had no right to be heard in an appeal to the Minister.

13. Sections 41(7) and (8) of the Act state:

> "(7) *Where the person who has made the complaint ... to the Medical Council is dissatisfied with any order of a Complaints Committee ... he may ... appeal to the Minister* **whose decision shall be final**.
>
> *(8) The Minister may make –*
>
> *...*
>
> *(b) an order directing the Medical Council to immediately appoint a Disciplinary Committee to hear and investigate the complaint or matter[.]*" (emphasis added)

The Disciplinary Committee's decision

14. Section 40(9) of the Act is not applicable because the 3 Charges did not originate from the Complaints Committee's own motion—but from the Minister allowing the Patient's appeal. The Minister issued an order directing the Inquiry. The Complaints Committee was not in a position to give notice.

15. Further, the administration of Augmentin (which contains Amoxycillin) and Promethazine to the Patient was referenced in documents that Dr Teh himself

had disclosed in his explanation to the Complaints Committee. The Minister reviewed these documents. The Minister also made it clear in his letter of 5 May 2011 what the grounds of the referral to the Disciplinary Committee were—they expressly mentioned Augmentin and Promethazine:

> "*The Minister … has taken note … [that] The CC may not have fully considered the circumstances arising from Dr Teh's administration of Augmentin: … i. Dr Teh may not have informed [the Patient] that he had been mistakenly administered Augmentin; ii. The reason for Dr Teh's administration of IV Promethazine is unknown. It may have been done as a precautionary measure in response to the mistaken administration of Augmentin. … iv. Knowing the possible harmful side effects of IV Promethazine, Dr Teh should have been more careful in attending to [the Patient's] injury post-operation.*"[4]

16. While it is correct that Dr Teh did not have an opportunity to address the Minister on these issues, no mechanism is provided for this under the Act. In any event, he had ample opportunity to defend himself in relation to the First to Third Charges at the Inquiry. The appropriate forum to be heard is the Inquiry before the Disciplinary Committee; that is where natural justice must be extended to any Respondent. As such, there is no merit in the breach of natural justice argument raised by Dr Teh.

17. We are also of the view that the Charges arise from the Complaint. We agree that a broad based approach is more appropriate than being overly technical and semantic. The Complaint was aimed at exploring any and all relevant facts that could explain the Patient's ultimate condition. The Patient had asked the Complaints Committee to investigate in wide terms. He wrote:

> "*I would like to request that the Singapore Medical Council investigate the conduct of Dr Kevin Teh ... specifically to determine what took place during the procedure he gave me on the 17th*

[4] Letter from the Ministry of Health to the SMC, dated 5 May 2011

> *March 2009, and the* **manner in which he provided treatment** *and follow-up care and* **record-taking***.*"[5] (emphasis added)

18. We are of the view that the First Charge comes within the ambit of "*record taking*" while the Second and Third Charges relate to the "*manner in which he provided treatment*".

19. The Patient was at pains to detail his experiences in the Complaint. It is clear that his grievances arose from the condition of his right hand. His Complaint was based on incomplete information, and his invitation to the Complaints Committee was precisely to investigate the situation and find answers.

20. In fact, the Patient was specifically worried about the effects of the intravenous medications that were given to him. In his Statutory Declaration he states:

> "*I was in fact very worried about whatever drugs or chemicals that were injected[.]*"[6]

and

> "*I remain disturbed as to how any injection performed on my hand could have effected such a serious complication. I am concerned as to what really took place in Dr Teh's clinic that day that could have resulted in radial arterial thrombosis[.]*"[7]

21. At the end of the day, both the Complaint and the charges are premised on Dr Teh's treatment and care of the Patient. It all potentially arose from the mistaken administration of Augmentin. However, the Patient cannot be expected to refer to Augmentin and Promethazine when he did not even know that these were given to him.

22. The Minister issued an order directing the SMC to appoint a Disciplinary Committee to hear and investigate the Complaint. There is no mechanism provided in the Act to appeal the Minister's order—section 41(7) provides that

[5] Mr P's Statutory Declaration, dated 3 July 2009 at [33]
[6] Mr P's Statutory Declaration, dated 3 July 2009 at [24]
[7] Mr P's Statutory Declaration, dated 3 July 2009 at [27]

the Minister's decision is final. Thus, Dr Teh did not have a right be heard before the Minister as to whether the Complaint should or should not be brought before this Disciplinary Committee. As stated in paragraph 16 above, this does not mean that Dr Teh has been deprived of his rights under natural justice.

23. Finally, Dr Teh's objections against the Minister's referral is effectively a 'back-door' attempt to judicially review the Minister's decision. Dr Teh did not challenge the Minister's referral at the time in the Courts and is precluded from doing so before the Disciplinary Committee.

24. We therefore dismissed Dr Teh's preliminary objections. The Inquiry continued based on the 6 Charges set out above.

The Law of Professional Misconduct

25. Section 45(1) of the Medical Registration Act enables the Disciplinary Committee to find a practitioner guilty of "*professional misconduct*" or "*such improper act or conduct which … brings disrepute to [the practitioner's] profession.*" Paragraph 5.4 of the SMC's Ethical Code and Ethical Guidelines ("**ECEG**") states:

> "*Whether the conduct complained of amounts to professional misconduct is to be determined by the rules and standards of the medical profession. Professional misconduct is akin to the expression 'infamous conduct in a professional respect'. …*
>
> > *'If it is shown that a medical man in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency … he has been guilty of infamous conduct in a professional respect.'*
>
> *The Ethical Code and Ethical Guidelines provide a guide as to what types of conduct could amount to professional misconduct.*"

26. The Court of Three Judges in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 the Court said that whether a particular course of conduct will be regarded as misconduct is to be determined from the nature of the conduct and not from its consequences. Professional misconduct is more than negligence. It exists where there is any departure from the generally accepted standards that a medical practitioner would be deemed to be aware of. Professional misconduct requires a deliberate departure from these standards or negligence of such a degree that it belies an indifference to the known standards.

27. While the ECEG is not an exhaustive code, it does represent the fundamental tenets of conduct and behaviour expected of doctors (see *Lim Mey Lee Susan v Singapore Medical Council* [2013] SGHC 122).

The Facts which give rise to the Charges

28. We set out what in the course of the proceedings appear to be the undisputed facts:

Events before the Procedure

29. On 12 March 2009, the Patient came to the Clinic as a new patient seeking Vaser LipoSelection treatment for his lower back, to remove his "*love handles*". The first person who dealt with him was Ms P1, the Clinic Manager. The Patient completed a Patient Registration Form. Crucially, the Patient stated, under the heading "*Medical History*", that he had an allergy to "*Amoxycillin*"—a member of the penicillin drug family.

30. Ms A entered the information from the Patient Registration Form into the Clinic's computer system. Unfortunately, Ms P1 erred in capturing the Patient's data. It was not clear whether she failed to make any entry at all for the Patient's drug allergy, or whether she mistakenly inputted the word "*nil*". In either event, the Patient's allergy was not recorded.

31. Next, as per the normal workflow, Ms P1 printed out stickers to be attached to the Patient's records ("**the Casenotes**"). These stickers were generated by the

Clinic's computer system and the words "*Allergy: Nil*" were printed on the sticker along with the Patient's name and postal address.

32. These Casenotes were subsequently used by both Dr Teh and the nurses in their dealings with the Patient. This erroneous sticker was also affixed to documents other than the Casenotes e.g. (i) the "*Pre-operative Nursing Record*", (ii) the "*Anaesthesia Record*" and (iii) the "*Reviews and Measurements*" sheet.

33. Ms P1 brought the Patient to Dr Teh's room for a consultation. No nurses were present at this first consultation. Dr Teh quoted fees of $1,800.00 and scheduled the Procedure for 17 March 2009.

The day of the Procedure

34. The Patient arrived at the Clinic on 17 March 2009 at about 9am for the Procedure. He was met by the Clinic's nursing staff, changed into a gown and given a copy of the Clinic's standard consent form to read. Next, at about 9.15am, one of the Clinic nurses, Ms P2 administered certain pre-operative medications to the Patient. The Patient was not told what they were.[8]

35. One of the pre-medications given to the Patient by Ms P2 was Augmentin, an antibiotic containing Amoxycillin (which the Patient said he was allergic to during the first consult). After consuming the pre-operative medications, he then went into Dr Teh's consultation room.

36. When Dr Teh realised that the Patient had been given Augmentin which contained Amoxycillin, he came out of the consultation room and scolded the nurses. After which, Dr Teh observed the Patient for just over one hour. Following this observation, Dr Teh continued with the Procedure as planned.

37. The initial intravenous line proved difficult to insert and it took Dr Teh two attempts. Over and above the usual sedative and anaesthetic medications, Dr Teh intravenously administered an anti-histamine called Promethazine as a

[8] Mr P's Statutory Declaration, dated 3 July 2009 at [5]

prophylaxis to counteract any allergic reaction that the Patient's consumption of Augmentin might have caused.

38. After the Procedure, the Patient was taken to a recovery room. When he came round, his right hand was painful, swollen and numb.[9] He was given post-operative medications such as Arcoxia and Anarex (for pain), and Maxolon (for nausea) and Imovane (for sleep). The Patient was told to return the next day on 18 March 2009, which he did. The Patient was also given the antibiotic Ciproflaxacin—which does not contain Amoxycillin.

Events after the Procedure

39. The events after the Procedure are briefly set out below:

39.1. At the 18 March 2009 consultation with Dr Teh, the Patient's hand was "*moderately swollen*". The Patient had minimal pain with no discolouration. Dr Teh did not tell the Patient that there was any cause for alarm. Nonetheless, Dr Teh told the Patient to call him if further problems developed. A date of 25 March 2009 was set for the next consultation.

39.2. Pending the next consultation, Dr Teh instructed his nursing staff to regularly follow up with the Patient. On 20 March 2009, Ms P3 ascertained over the phone that the Patient still had some swelling but had movement in the fingers. On 22 March 2009, the Patient cancelled the 25 March 2009 appointment. On 23 March 2009, Ms P1 spoke to the Patient who informed her that his hand looked "*horrible*" but was "*ok*".

39.3. The swelling however, soon extended to his lower arm. Shortly thereafter, the pain drastically increased in his right hand.[10] On 25 March 2009, the Patient was in significant pain, and called the Clinic's after hours number. He was not able to reach anyone.

[9] Mr P's Statutory Declaration, dated 3 July 2009 at [8]
[10] Mr P's Statutory Declaration, dated 3 July 2009 at [12]-[13]

39.4. At 2.30am on 26 March 2009, the Patient was admitted to Tan Tock Seng Hospital ("**TTSH**"), where he was advised that the possibility of a thrombosis—and therefore potential amputation of the thumb—existed.

39.5. On 26 March 2009, a scan showed a 13cm right radial artery thrombosis. Fortunately, the Patient responded favourably to treatment and was discharged the next day.

39.6. On 1 April 2009, the Patient went to the Clinic to obtain his medical reports. Dr Teh removed his stitches at this point and gave the Patient some medical reports. At this consultation, the right thumb was "*dusky*" with "*superficial necrosis over dorsum of hand*". Dr Teh told the Patient that he could call him at any time.

39.7. On 2 April 2009 the Patient had further consultations at TTSH and on 3 April 2009, the Patient underwent a thrombectomy to remove the thrombosis.

39.8. On 17 April 2009, Dr Teh received a letter from the Patient's lawyers' requesting any medical records that were held by Dr Teh.

39.9. The following day on 18 April 2009, Dr Teh had a meeting about the incident with nurses Ms P3 and Ms P2.[11] On other occasions Dr Teh had at least two private meetings with Ms P2, who secretly audio-recorded these conversations.

39.10. At about this time, Dr Teh also reported the incident to his superior Mr D1, the Executive Chairman of the Singapore Medical Group.

39.11. The Patient swore a Statutory Declaration on 3 July 2009 making an official complaint with the SMC against Dr Teh.

39.12. We also note that,[12] the Patient has sustained permanent compromise to his hand's blood circulation, while some of his right hand thenar muscles have wasted away. Significantly, the circulation of the Patient's right

[11] Ms P2's Witness Statement at [13] & [19]
[12] Mr P's Statutory Declaration, dated 3 July 2009 at [21] & Dr P4's Witness Statement at [15]

hand is now entirely dependent on the ulnar artery, as opposed to both the ulnar and radial arteries. The Patient was thus advised to change his career as a rescue swimmer with the US Navy.[13]

The First Charge—Prescribing and allowing the Patient to consume Augmentin which contained Amoxycillin

40. The critical question for this Disciplinary Committee to consider is this: Did Dr Teh, during the 12 March 2009 consultation, take a proper medical history recording the Patient's allergy to Amoxycillin? Many other conclusions and/or inferences flow from this finding.

41. Based on the evidence, there are three possible factual scenarios:

    41.1. First, Dr Teh did not ascertain that the Patient was allergic to Amoxycillin on 12 March 2009 and only first came to know of this on 17 March 2009. This was the Prosecution's primary position.

    41.2. Second, Dr Teh did ascertain the Patient's allergy to Amoxycilin on 12 March 2009, but failed to write this into his Casenotes on that day. They were only written subsequently on or after 17 March 2009. This appeared to be the Prosecution's alternative position.

    41.3. Third, Dr Teh did ascertain the Patient's allergy to Amoxycillin on 12 March 2009 and did that same day write it in the Casenotes. This was Dr Teh's position. He said that he asked about drug allergies, general medical history and current medications.

42. According to Dr Teh, he did not prescribe Augmentin to the Patient and the real blame lay with Ms P2, who had made the following two errors:

    42.1. First, one of her duties as a trained nurse was to check with the patient whether the patient had any drug allergies before administering the medication. Ms P2 failed to do this. This fact is not disputed.

[13] Dr P4's Witness Statement at [19]

42.2. Secondly, Ms P2 did not consult the Casenotes in the course of administering the pre-medications. The Casenote described the Amoxycillin allergy from the 12 March 2009 consultation. Ms P2 failed to refer to it when she worked her way through the standard pre-operative checklist with the Patient.

43. On the other hand, Ms P2 asserted that the Casenotes she received from Dr Teh were not properly filled out—and the drug allergy section, in particular, was blank.[14] Believing that the blank section was further evidence of what was printed on the sticker—"*Allergy: Nil*"—she summarily concluded that the Patient had no drug allergies. From this point, she proceeded to complete the standard "*Pre-operative Nursing Record*" dated 17 March 2009 ("**the Checklist**") that was meant to be used as part of her routine.

44. Ms P2 candidly admitted that she did not ask the Patient on 17 March 2009 whether he had any allergies before administering the medication. The Disciplinary Committee accepts that she failed in her responsibilities to ascertain from the Patient—for herself—whether he had any drug allergies or not.

45. As it stands, the following entry appears on the face of the 12 March 2009 Casenote:

> "*Drug Allergy: Nil* *Yes* [circled]
>
> *Amoxycillin → ? skin*
> *Test*
> - *Unknown reaction*
> - *No major reaction*"

The Casenote therefore indicates that in the 12 March 2009 consultation, Dr Teh recorded—in the course of having taken the Patient's history—that the Patient was allergic to Amoxycillin.

[14] P2's Witness Statement at [8]

46. Dr Teh insisted that he wrote the word "*Amoxycillin*" during the 12 March consultation. Dr Teh also maintained that the Patient told him that he did not know exactly what the allergy was because he had not personally experienced it; and he only knew of it because his mother told him about it—and that he might have had a skin test done when he was younger. It was for this reason that Dr Teh asserted that he wrote the words: *"Amoxycillin —> ? skin test – Unknown reaction"* into the Casenote on 12 March 2009.[15]

47. However, the Prosecution argued that even taking Dr Teh's case at the highest he should have changed the prescription of pre-operative medication (that the nurses would subsequently administer on the day of the Procedure). In short, Dr Teh failed to actively bring the allergies to the attention of the nurses prior to the standard pre-operative medication being administered.

48. It was not only Ms P2 who claimed that Dr Teh's Casenotes were blank. Ms P3, Ms P2's co-nurse, said the same thing. Ms P3 similarly concluded that the incomplete Casenote was because Dr Teh had failed to take a proper history from the Patient at the first consultation.[16]

49. As for the words "*No major reaction*", Dr Teh initially maintained that he subsequently wrote this phrase on the day of the Procedure, 17 March 2009.[17] This was because he had personally observed that the Patient exhibited no major reaction to Amoxycillin. There was evidence to suggest (exhibit P1 which was a copy of the Patient's Casenotes procured by Ms P2 on 17 April 2009) that the words "*No major reaction*" were entirely absent from the Casenote as at 17 April 2009. Subsequently, Dr Teh under cross-examination conceded that these words were written in *after* 17 April 2009, and not on 17 March 2009.

<u>Ms P2 and the Checklist</u>

50. Ms P2 also gave evidence that at that point of time (March 2009) the standard operating procedure as to how the Checklist ought to have been filled out had not been finalised and was in draft version. Ms P3 also gave evidence that there

[15] Respondent's Closing Submissions at [48]-[49]
[16] Ms P3's Witness Statement at [3], [5], [7]-[8], [16] and email from Ms P3 to Ms P2, dated 26 April 2009
[17] Respondent's Closing Submissions at [15]

was no standard protocol to filing out the Checklist—to the extent that it could even be completed after an operation. These points were rejected by Dr Teh. Ms D2 evidence appeared to contradict Ms P2 and Ms P3 (see below). However, nothing turns on this as Ms P2 would, regardless of any checklist or clinic standard operating procedure, still have a responsibility to ask the Patient if he had any allergies prior to administering any medication.

51. Notwithstanding this, while a nurse may have certain responsibilities, it is also clear that prior to 17 March 2009, Dr Teh did not bring the allergy to the attention of the nurses, nor did he take steps to prescribe an alternative medication to Augmentin.

52. After consuming the pre-operative medications by Ms P2, the Patient was brought into Dr Teh's consultation room. It was during this consultation—the second meeting between Dr Teh and the Patient—that Dr Teh discovered one of two things: Either

    (i) the Patient had just consumed a drug he was allergic to (where Dr Teh already had prior knowledge that the Patient was allergic to it); or
    (ii) the Patient was allergic to Amoxycillin *and* it had just been administered to him as part of the standard pre-operative medications.

    In either event, Dr Teh excused himself from the consultation with the Patient and proceeded to scold Ms P2, Ms P3 and Ms D2 at the reception desk for the medication error.

Nurses' Evidence

53. Ms D2 gave evidence that at during the scolding she looked at the 12 March 2009 Casenote that was lying on the reception counter and saw the words "*Amoxycillin*" written there. She testified that she also saw the erroneous sticker indicating "*Allergy: NIL*" as well as the phrase "→ *?skin test*" next to the word "*Amoxycillin*" on the Casenote as well as seeing the word "*Yes*" circled with an asterisk next to the words "*Drug Allergy*".

54. Ms D2 took a red pen and cancelled the word "*NIL*" on the sticker and wrote the word "*Yes*" in its place. She then instructed Ms P2 and Ms P3 to stamp all the Casenotes with the word "*ALLERGY*".

55. Ms P3's evidence was that the wording

> "*Amoxycillin →* *? skin*
> *Test*
> - *Unknown reaction*
> - *No major reaction*"

was written "**after** *the pre-medication was given to Mr P*"[18] (emphasis added). In other words, these words were not written in the 12 March 2009 consultation—a fact corroborated by Ms P2. The words "*No major reaction*" were definitely written no earlier than 17 March 2009 (by Dr Teh's own admission in oral evidence) and were probably written sometime after 17 March 2009.

56. Ms D2's evidence is not necessarily inconsistent with Ms P2 and Ms P3. Ms D2 had sight of the Casenote *after* the second consultation (one would expect that Dr Teh would have had the Casenote with him during both his consultations). Ms P2 would have looked at the Casenote before administering the pre-operative medications, so it would have been *before* the second consultation. If Dr Teh had written in the words

> "*Amoxycillin →* *? skin*
> *Test*
> - *Unknown reaction*"

at the consultation, this may explain the discrepancy in the evidence.

57. We now turn to the recorded conversations held between Ms P2 and Dr Teh. As a result of the Patient's lawyers' letter of 17 April 2009 to obtain his records from Dr Teh, the doctor had several informal discussions with Ms P2 and Ms P3—Ms P2 recorded these conversations without Dr Teh's knowledge.

[18] Ms P3's Witness Statement at [8]

58. In the course of these conversations, Ms P2—consistent with her evidence—repeatedly refers to the fact that Dr Teh (i) did not properly ascertain the Patient's history, and (ii) did not fill in the drug allergy section on the 12 March 2009 Casenote.

59. At no point in these conversations did Dr Teh deny or contradict Ms P2's assertions. On the contrary, Dr Teh appears to accept that he, at the very least, failed to fill out the Casenote on 12 March 2009 on the drug allergy.

60. We quote from the transcripts of these conversations:[19]

> Dr Teh: "*If for example, Pearl(?) is at fault for not entering into the system that she saw that he had allergy or* **if I didn't write down there that he had an allergy[.]** *... even if the case notes say no allergy, we still ask*" (Emphasis added)
>
> ...
>
> Ms P2: *But even back then we didn't know that he had an allergy what.*
>
> Dr Teh: **I wouldn't know unless I served the medicine** *...* **it doesn't matter whether it's written or not***, even if you don't have a case sheet at all, when you see a patient ... you always ask them whether you had allergy as the back-up.* (Emphasis added)
>
> ...
>
> Dr Teh: *So they said that it's a series of work process errors?*
>
> Ms P2: *Mm-hm.*
>
> Dr Teh: *Starting from what?*
>
> Ms P2: *Everybody.*
>
> Dr Teh: *Okay, okay. So, from Pearl, you,* **me***, Dawn.*
>
> Ms P2: *Yah*
>
> Dr Teh: *Uh-huh. And what did they — what did you — you — you know this is — what did you ask them specifically?* (Emphasis added)

[19] P2 Transcript of conversation DW-D0111 at pgs 4, 10, 16-17 and 20-21

...

Ms P2: *The fault is not totally at the nurse, that what [the NBS] say.*

Dr Teh: *Why is the fault not at the nurse, at least for the initial part, well, the registration was — was not done properly.*

Ms P2*: Mm-hm.*

Dr Teh: *Is that one of the issues? Registration was not done properly.*

Ms P2: *Yay,* **and your history taking was incomplete also what**.

Dr Teh: *Er, which part?* **The — the drug history part. But I didn't circle whether it was — it was a drug allergy or no drug allergy***.*

Ms P2: *Yah,* **so it's still incomplete***.*

Dr Teh: **Okay***. But still that's not the — that's not the point. The point — the points is —* **in fact you are supposed to ask so that you can settle** —

Ms P2: *If you had —* **if you had asked***, then we would have changed the pre-op medication also what, then we would have noted also.*

Dr Teh: **Okay***. But you know — you know — you know the — the — asking drug allergy is not specifically the doctor's, er —*

Ms P2: *But on that day of consultation, we weren't present, as we were both inside the OT.*

Dr Teh: *Okay*.

Ms P2: *Which I remember very, very clearly*. (Emphasis added)

61. Dr Teh did not at any point refute Ms P2's suggestions that he did not properly obtain a history from the Patient at the 12 March 2009 consultation; or even if he did, he did not record the allergy to Amoxycillin that day. Dr Teh's point in the conversation was that Ms P2 ought to have, as part of her duties and responsibilities, independently asked the Patient if he had allergies. His point was that even if he had not, for whatever reason, recorded the Amoxycillin allergy, Ms P2 should still have asked the Patient, and that would have prevented the situation from arising. Ms P2 has already admitted that she was in error. In fact, there is direct evidence that strongly points to Dr Teh admitting that he did not take the Patient's history on 12 March 2009 in the following excerpt:

Ms P2: *But no allergies was known.*

Dr Teh: *That's because the — the label wrote "Nil".*

Ms P2: *That's why it was —* **it wasn't known to you also***, and then you have to get the consent form what. ... then you have to do the consent form taking and* **then you have to ask him at that point of time**.

Dr Teh: **Correct***[.] ...*

Ms P2: *But I mean on that day we were not part of — we were not involved in the consultation*.

Dr Teh: *Yes, I know,* **doesn't matter, that's consultation part, so that consultation part, er, I didn't write in the — the allergies or not***,* **but on the day of the — the procedure***, you have to ask before you give medicine or same thing,* **I happened to also ask because it was time to — time to complete the thing***.* (Emphasis added)

The last sentence suggests that Dr Teh only asked about the Patient's allergies on 17 March 2009.

62. We accept the transcripts of these conversations as credible evidence. Dr Teh's explanation that he was merely playing the devil's advocate in these conversations to elicit answers from Ms P2 seems inherently unlikely and would unnaturally strain the tenor and flow of the conversations as transcribed. Simply put, Dr Teh did not have to play devil's advocate to make the point that Ms P2 had to independently ascertain if the Patient was allergic to anything before administering the pre-operative medications.

Other Factors

63. Critically, no mention was made in Dr Teh's Casenotes that Augmentin had been administered to the Patient. Nor was there any indication that the nurses had made an error. The Casenotes were also silent on the corrective steps (i.e. prescription of Promethazine) that Dr Teh took in response to the errors that had been made. This suggests that Dr Teh was conscious that he had done

something, or failed to do something which could implicate himself—in this case, the omission to ascertain the allergy or to record it at the first consultation.

64. Only Dr Teh had the ability to prescribe the pre-operative medications. It is surprising to us that Dr Teh did not issue instructions about alternative pre-operative medications if he had either (i) known about or (ii) notated the Patient's drug allergy in the 12 March 2009 Casenotes. If a patient had an allergy to any of the pre-medications it would have been up to Dr Teh to prescribe an alternative medication and inform the nurses ahead of time. Such an alternate prescription prior to the Procedure was conspicuous by its absence. Dr Teh also did not write into the Casenotes or anywhere else that the Patient's pre-medications would have to be changed from Augmentin to another suitable drug. We believe that if a proper medical history had been taken on 12 March 2009, there would be some evidence prior to 17 March 2009 of an alternative prescription to replace Augmentin.

Finding for the First Charge

65. We are therefore of the view and find that:

65.1. Dr Teh failed to take a proper medical history on 12 March. As such, we find that as at 12 March, the section of the Casenote dealing with allergies was not filled in. In this respect, we accept the evidence of Ms P2 and Ms P3. It is consistent with the transcript, as well as the circumstances leading to the administration of Augmentin on 17 March 2009.

65.2. No instructions were given to the nurses prior to or on 17 March 2009 with respect to prescribing an alternative medication to Amoxycillin.

65.3. On 17 March, the Patient was served Augmentin. There was nothing in the Clinic's records at that point (save for the initial Patient Registration Form) that suggested that he had allergies. However, as we have stated earlier, Ms P2 also failed in her responsibilities to ask the Patient if he had any allergies.

65.4. Dr Teh only found out about the Patient's allergy on 17 March during his pre-operation consultation. This is why he rushed out to scold the nurses as he must have realised that the Patient had already taken Augmentin, as he had not, up to that point, prescribed an alternative.

65.5. What occurred was a series of process errors which included:

65.5.1. The wrong information being entered into the Clinic's system by Ms P1 on 12 March;

65.5.2. Dr Teh failing to take a history at the first consultation on 12 March;

65.5.3. The failure to prescribe an alternative medication to Augmentin between 12 and 17 March; and

65.5.4. Ms P2 failing to ask the Patient if he had allergies on 17 March.

66. In light of these findings, and taking Dr Teh's case at its highest, can he rely on Ms P2's own duty to check whether the Patient had allergies as well as the implementation of a clinic checklist to be absolved of liability?

67. Dr Teh's responsibilities as the presiding doctor were not delegable. He bore responsibility for taking the Patient's history which he failed to do. The ECEG sets out a clear requirement of what constitutes a standard of care and treatment that a medical practitioner should provide. Paragraph 4.1.1.1 requires medical practitioners to perform an adequate clinical evaluation of their patients and to only provide medical care "*after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination*" has been conducted. Dr Teh failed to do this.

68. Dr Teh was also responsible for the prescription and administration of all pre-medications that the Clinic gave to the Patient. The various errors of Ms P1, at the data entry stage, and Ms P2, at the pre-operative drugs administration stage, do nothing to relieve Dr Teh from this responsibility. Even if, on 12 March 2009, Dr Teh inquired about the Patient's allergies, he took no action to inform his staff or prescribe an alternative.

69. While paragraph 4.1.1.4 of the ECEG permits the doctor to delegate his duties, the doctor is not released from overall responsibility. It was incumbent on Dr Teh to ensure the effective supervision of his duties. As the clinic doctor he had the responsibility for designing and implementing an effective system and protocol for administering medicines that would safeguard the health and safety of his patients. In our view, Dr Teh failed to live up to this standard required of him.

70. While Dr Teh is not solely to blame, his omissions materially contributed to the Patient being prescribed Augmentin and we therefore find him guilty of professional misconduct in respect of the First Charge.

The Second Charge—Non-disclosure of the Administration of Amoxycillin and the Continuation of the Procedure

71. It is not disputed that Dr Teh did not tell the Patient that he had been given Augmentin, choosing instead to observe the Patient for just over an hour for any signs or symptoms of allergy. After the observation, Dr Teh administered Promethazine to counteract any possible allergic reaction the Patient might have. Dr Teh's case when giving oral evidence was that he

> "*explained to the Patient that he had been given a medication that may not be suitable for him and that he would be giving him medication to prevent allergies.*"[20]

72. The crux of the Second Charge was that Dr Teh failed to act in the best interests of the Patient in two ways: First, Dr Teh continued with the Procedure, even though there was a risk that the Patient could have an allergic reaction to the Augmentin. Secondly, Dr Teh failed to disclose to the Patient that he had consumed Augmentin, which contained Amoxycillin which the Patient was allergic to. The Patient was therefore unable to give informed consent to the continuation of the Procedure.

[20] Respondent's Closing Submissions at [103]

73. After the observation the Patient had no rash nor any sign of allergic reaction. Dr Teh stated that the Patient was

> "*clinically extremely well and showed no signs of symptoms or allergies. ... There was no rash, periorbital nor perioral oedema, no shortness of breath and no physical discomfort.*"[21]

74. In fact, Dr Teh's case was that his "*clinical judgment of the Patient's reaction ... [was] that the Patient was not, in fact, allergic to Augmentin.*"[22]

75. There was some disagreement about whether the Patient did in fact develop a rash. There was also a suggestion from the Prosecution that Dr Teh had decided from the outset—even before the observation period had begun—that he was going to administer Promethazine and proceed with the Procedure.[23] In our view, the evidence on both these points is not convincing either way. That said, we also believe that a finding can be made on this Charge without having to make a determination on these two points.

76. The Prosecution's expert witness, Dr PE testified that she would not have continued with a procedure the moment a patient had consumed medication he was allergic to.[24] On the other hand, Dr DE, Dr Teh's witness said an approach of weighing the situation and then making a clinical judgment call would have been acceptable. His view was that even if a rash appeared after injecting Augmentin, a procedure could continue so long as: (1) it was not life threatening, and (2) the patient had been observed for an hour or so.[25]

77. The Prosecution asserted that regardless of whether a reaction materialised or not the risk remained that a reaction could have occurred. Just because no allergic reaction materialised in one hour did not mean there was no risk. The existence of a risk made it imprudent for Dr Teh to have carried on in light of the

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[21] Email from Dr Teh to Singapore Medical Group, dated 1 June 2009, attaching his "Incident Report"
[22] Dr Teh's Opening Statement at [9]
[23] SMC's Closing Submissions at [113]-[114]
[24] Dr PE's Report, dated 22 June 2012
[25] Cross-examination of Dr DE, 24 January 2014

fact that this was an elective procedure that could have continued on another day.[26]

78. The administration of Promethazine was Dr Teh's likely attempt to treat a potential allergic reaction to the Augmentin.[27] The administration of a prophylactic under such circumstances suggests that in Dr Teh's mind there was at least a risk of an allergic reaction at this stage—a view in direct contrast with Dr Teh's stated case that in his clinical judgement, the Patient was not allergic to Augmentin.[28] It could, alternatively, in fairness, be read as an abundance of caution on Dr Teh's part. Both experts also concurred that the possibility of an allergic reaction manifesting after 85 minutes was not out of the question.[29]

Finding for the Second Charge

79. Our view is that Dr Teh should have disclosed that the Patient had taken Augmentin. It was not enough to tell the Patient that the medicine he had been given was "*not suitable*" for him and that it would be replaced with more appropriate medicine. In cross-examination, Dr Teh explained the vagueness of this disclosure by saying that he decided against informing the Patient of the "*nitty-gritty*" of the medications as the Patient did not need to know this level of detail.[30] That fact may be true for some patients. However, in this specific case the Patient had been given the very medication that he said he was allergic to. He knew exactly what Amoxycillin was.

80. Given that the Procedure was an elective and cosmetic procedure, we are of the view that the correct thing to do would have been:

(a) Tell the Patient that he had been given Augmentin, a medication containing Amoxycillin, by mistake;

[26] SMC's Closing Submissions at [88]
[27] Dr DE's Witness Statement at [13]
[28] Respondent's Closing Submissions at [10]
[29] Cross-examination of Dr PE, 20 December 2013; Cross-examination of Dr DE, 24 January 2014
[30] Cross-examination of Dr Teh, 23 January 2014

(b) Explain that other medication could be given to counteract the effect of Augmentin;

(c) Give the Patient the choice to either continue with the Procedure (after an observation period), or reschedule the procedure for another day; and

(d) Explain the risks (or lack thereof) associated with either option.

81. By failing to do the above, Dr Teh deprived the Patient the ability to make an informed decision. In not disclosing that Augmentin had been administered, Dr Teh should not have continued with the Procedure. The fact that the Procedure was an elective, cosmetic one meant that Dr Teh ought to have refrained from taking any risk.

82. Paragraph 4.1.3 of the ECEG sets out the requirements of the proper standard of care with regard to a medical practitioner's duty in relation to the prescription of medicine. It is clear from the ECEG that the doctor should inform his patient "*about the purpose of the prescribed medicines, contraindications and possible side effects.*" Likewise, paragraph 4.2.2 states that a medical practitioner shall ensure that "*a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment*". Paragraph 4.2.4.1 also requires the doctor to "*provide adequate information to a patient so that he can make informed choices about his further medical management".* The ECEG also makes it clear that every doctor is expected to "*be an advocate for patients' care and well being and endeavour to ensure that patients suffer no harm*" and "*treat patients with honesty, dignity, respect and consideration, upholding their right to be adequately informed and their right to self-determination.*"

83. In *Low Cze Hong v Singapore Medical Council* (above), professional misconduct was seen as including those instances where a doctor does not offer other treatment options to his patient and where there is no balanced discussion of risk as against benefit in the case—which are the basic requirements of informed consent. The case of *Eu Kong Weng v Singapore Medical Council* [2011] 2 SLR 1089 further establishes that the doctor's duty to obtain informed consent is a serious one because it constitutes one of the foundational pillars of the doctor-patient relationship of trust.

84. We should add that Dr Teh's Casenotes do not reflect that the Patient had consumed Augmentin. The Casenotes do not even reflect that Dr Teh had told the Patient that he had been given a medication that was "*not suitable*" for him. This is at odds with paragraph 4.1.2 of the ECEG which states that "*Medical records kept by doctors shall be clear [and] accurate … All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented.*" It also suggests that Dr Teh may not have actually told the Patient that he had been given medications that were "*not suitable*" for him. However, there is no need to come to any conclusion on this in respect of this Charge, because Dr Teh's case—even at its highest (that he disclosed that the Patient had been given medicines that were "*not suitable*")—falls short of the required ethical standard.

85. In our opinion, by reason of Dr Teh's failure to: Disclose that Augmentin had been given; advise the Patient of the risk factors associated with continuing with the Procedure; and give the Patient an informed choice about continuing with the Procedure, the Disciplinary Committee finds him guilty of professional misconduct under the Second Charge.

The Third Charge—Failure to Disclose the Administration of Promethazine as a Treatment for a Potential Allergic Reaction to Augmentin

86. The Third Charge flows directly from the Second Charge because the administration of Promethazine was due to the consumption of Augmentin, and is therefore part of the same sequence of events.

87. As discussed under the Second Charge, Dr Teh claimed that he told the Patient that he had been given unsuitable medicines but that he would give him a medicine to counteract this. The critical issue was that Dr Teh failed to specifically disclose that Augmentin was administered.

88. It was not in dispute that Dr Teh did not inform the Patient that "*Promethazine*" would be given.[31] The fact that Dr Teh did not specify "*Promethazine*" is not necessarily objectionable. In all probability, the Patient would not know what

[31] Agreed Statement of Facts at [5]

Promethazine was and what its medicinal properties were. However, the crux of the matter is that Dr Teh had failed to inform the Patient about the administration of the *Augmentin.*

89. In cross-examination, Dr Teh said that the Patient responded to his alleged disclosure by saying, "*Fine—carry on*". Dr Teh's apparent disclosure is not recorded in his Casenotes—a point he conceded in cross-examination.[32] We would expect that such a critical issue of informed consent would be included in the Casenotes. There is no indication in the evidence that the Patient remembers this disclosure—the TTSH medical records suggest that the Patient was never aware that he had been given either Amoxycillin or Promethazine.

90. Dr Teh's explanation for this was that the Patient had retrograde amnesia from the drugs used in the Procedure and would not necessarily recall his disclosure. Yet, Dr Teh did not rely on any witness to corroborate his story. We also find it surprising that the Patient in the light of this alleged disclosure did not ask the doctor any questions—as Dr Teh's version would have us believe.

91. The Prosecution also highlighted that Dr Teh's case concerning the disclosure of prophylactic treatment evolved over time. Initially—in his Incident Report, Opening Statement and oral submissions—Dr Teh asserted that he had told the Patient that he had given him medicine that was not suitable for him and that it would be replaced with something more appropriate *upon discharge*. However, in oral evidence, Dr Teh—for the first time—asserted that he had informed the Patient that he had put into the IV line medication to prevent allergies.

92. We find it doubtful that Dr Teh made the disclosure to the Patient as he claimed. The evidence, including the shifting story, points to his story being contrived after the fact. It is significant that there is no mention of his disclosure in the Casenotes, and his version of events is wholly uncorroborated.

93. Again, we do not have to come to a conclusive view of this. Even if Dr Teh's version is to be believed, and his case is taken at its highest, the fact remains that Dr Teh did not make any disclosure about *both* Augmentin and Promethazine—which is the crux of the issue. This alone is sufficient to make a

[32] Cross-examination of Dr Teh, 23 January 2014

finding of professional misconduct in respect of the Third Charge and we duly find Dr Teh guilty.

The Fourth Charge—Failure to Follow up Adequately

94. The Prosecution asserted that in light of the consumption of Augmentin and the administration of Promethazine that led to a swelling of the Patient's hand, Dr Teh should have closely followed up with the Patient but failed to do so. The Prosecution claimed that Dr Teh was guilty of neglect of the Patient's condition mounting to professional misconduct.

The Follow Up Steps Taken

95. There was a follow up the next day. At the 18 March 2009 consultation with Dr Teh, the Patient's hand was "*moderately swollen*".[33] Dr Teh wrote in the Patient's 18 March 2009 Casenotes concerning this consultation:

> "*Well, minimal pain in back. R hand moderately swollen from IV leak but no bruising / skin necrosis / vascular[.]*"

96. Dr Teh advised the Patient that there was no cause for undue concern. There was no discolouration.[34] Dr Teh also prescribed medication for pain relief, antacids and Prednisolone for the treatment of inflammatory conditions. During this review, Dr Teh told the Patient to call him should he experience any further problems, specifically if his hand started to get more painful or more swollen.[35] A follow-up appointment was scheduled for 25 March 2009.

97. Dr Teh also instructed his nursing staff to regularly follow up with the Patient. This appears not to have been standard practice at the Clinic and represented something of an extraordinary measure by the doctor.[36] Two days later on 20 March 2009, Ms P3 followed up with the Patient by way of telephone call, where the Patient informed her that the "*swelling [was] still there, but he [had] regained movement in his fingers.*"[37] Inconsistent with this, the Patient later said in his

[33] Agreed Statement of Facts at [8]
[34] Dr Teh's letter to the Complaints Committee, dated 17 September 2009
[35] Dr Teh's letter to the Complaints Committee, dated 17 September 2009
[36] Ms P3's Witness Statement at [11]
[37] Agreed Statement of Facts at [11]

Statutory Declaration that by this stage the swelling had extended to his lower arm.[38]

98. On 22 March 2009, the Patient emailed the Clinic advising them that he would not be able to attend the proposed 25 March 2009 appointment due to a trip to Indonesia that he had planned. On 23 March 2009, Ms P1 contacted the Patient where he informed her that his hand was still swollen, but that he did not feel any pain and could use his fingers without a problem, saying that it "*looks horrible ... [but] hand is ok*". Dr Teh did not give the Patient further advice to return for a review.[39] From this point, Dr Teh only heard from the Patient some 9 days later on 1 April 2009.

99. Around about this time, things began to deteriorate for the Patient. Shortly thereafter, the Patient cancelled the trip to Indonesia because of an increase in the severity of the pain in his right hand. By 25 March 2009, the Patient's hand took another turn for the worse. That night his hand had become so painful that he called the Clinic. There was no answer as it was after hours, but he left a message. Dr Teh said that the Clinic never received the message.

100. At 2.30am on 26 March 2009, the Patient was admitted to TTSH. A vascular surgeon, Prof P5, advised him that if there was a significant thrombosis the possibility existed that the thumb would need to be amputated. On 26 March 2009, Dr P6, a vascular surgeon, noted that the Patient had "*(a) Dusky right thumb with distal half of the thumb pulp showing deep cyanosis; (b) Index finger was dusky over the dorsum; and (c) An absent radial pulse.*"[40] On the same day, a scan showed that the Patient's right radial artery was thrombosed for 13cm from the mid forearm to the palmar arch. He was again told that an amputation of digits was possible. Fortunately, after responding well to treatment, the Patient was discharged from TTSH on 27 March 2009.

101. On 1 April 2009, the Patient went to the Clinic without an appointment. Evidently, he returned to the Clinic only to obtain medical reports that he needed for his consultations at TTSH. He consulted with Dr Teh, who also removed his stitches. The Patient's hand was no longer swollen but the right

[38] Mr P's Statutory Declaration, dated 3 July 2009 at [12]
[39] Agreed Statement of Facts at [13]
[40] Dr P4's Witness Statement at [5]

thumb was "*dusky*" with "*superficial necrosis over dorsum of hand*".[41] The Patient requested for medical reports from Dr Teh to be used for a consultation at TTSH. In this appointment, Dr Teh told the Patient that he could call him at any time, giving him his personal handphone number.

102. On 2 April 2009 the Patient was examined by Dr P7 a Registrar at TTSH, where an "*ultrasound scan revealed that his subclavian artery, axillary and brachial arteries were all patent.*"[42] The Patient had further consultations on 2 April 2009 with Dr P8 (Hand and Microsurgery Section) and Dr P4, the Head of Vascular Surgery at TTSH. Dr P4 diagnosed the patient as having "*a thrombosed right radial artery with digital eschemia*" where the thrombi extended 13cm from the wrist.[43] Dr Teh called the Patient on 2 April 2009.

103. On 3 April 2009, the Patient underwent a thrombectomy performed by Dr P4 to repair the vessel damage where the thrombosis was removed. Dr Teh visited him twice after his thrombectomy on 3 April 2009 telling him that he could call him at any time on his personal handphone number.

104. On 8 April 2009, Dr Teh unsuccessfully tried to call the Patient but could not get through to him.

<u>Did Dr Teh Fail to Adequately Follow the Patient Up?</u>

105. The Prosecution's case was that as the situation developed, Dr Teh was not adequately responsive, and that the steps that Dr Teh did eventually take were a case of "too little, too late".

106. At the outset, we wish to make a preliminary point. It was put to Dr Teh by counsel in the cross-examination that he should have personally followed the Patient up, without deputising this responsibility to his nurses. This view was reinforced by Dr PE who testified that since Dr Teh had considered the possibility of compartment syndrome, he should have followed up personally with the Patient instead of delegating it to the nurses. We do not necessarily agree. As Dr DE pointed out in his Evidence-in-Chief, if something like

[41] Agreed Statement of Facts at [14]
[42] Letter from Dr P5, dated 8 April 2009
[43] Letter from Dr P9, dated 13 April 2009

Compartment's Syndrome is feared, the vascular supply to the digits must be closely monitored, but not necessarily by the doctor personally.[44] In this regard, overall responsibility remains with the doctor, and he is free to delegate and organize his staff accordingly.

107. Dr Teh's general response to the Prosecution's charge can be summed up from extracts from his letter to the Complaints Committee:[45]

> "*If I been* [sic] *informed by the Patient of the condition of his hand and had been allowed to be involved in his care before I saw him on 1 April 2009, I am confident I could have assisted in speeding up his treatment[.]*"

108. Dr Teh went further to assert that the Patient was not willing to be followed up on. In the same letter he stated that he had made it abundantly clear to the Patient that he was to notify the doctor should pain or swelling persist:

> "*During the review* [18 March 2009]*, I asked Mr P to give us a call if he had any further problems. Specifically, I asked him to let me know if his hand started to get more painful or more swollen[.]* ... "*I asked him several times, when I saw him on 18 March 2009, to come back to see me or contact the clinic if his hand worsened in any way".*"

109. Dr Teh argued that at various points in the post-operative phase the Patient had created the impression that the situation was not serious. For example, Dr Teh pointed to the Patient's email of 22 March 2009:

> "*Based on his e-mail to us on 22 March 2009, Mr P did not mention any problem with his hand, and gave the impression that there were no issues with it.*"[46]

110. The Prosecution argued that Dr Teh did not bother to schedule any follow up consultations when the Patient cancelled the 25 March 2009 consultation, even

[44] Evidence-in-chief of Dr DE, 24 January 2014
[45] Dr Teh's letter to the Complaints Committee, dated 17 September
[46] Dr Teh's letter to the Complaints Committee, dated 17 September

though he knew of the swelling of the hand. The Prosecution pointed to the fact that by 23 March the Patient's swelling had persisted for six days, and despite this, Dr Teh had not arranged for any follow-up reviews. According to the Prosecution, the Patient was not in fact getting better—but had convinced himself that he was, only because he was relying on Dr Teh's reassurances that he would get better. The Prosecution also took issue with Dr Teh's defence that it was the Patient's responsibility to identify if he needed follow up or not, especially when he had been given medications that were not disclosed to him.

111. The thrust of the Prosecution's point was that Dr Teh was aware that the Patient's condition could deteriorate into a far more severe condition (i.e. compartment syndrome). However, Dr Teh chose to downplay this when he should have followed up personally. Further, the failure of the nurses and/or staff to recognise that the Patient's thumb had turned cyanotic showed how important it was that that Dr Teh personally follow-up.

112. In support of the Prosecution's charge, Dr P4 stated in his Witness Statement:

> "*Mr P's situation was dire. He should have been referred to a specialist* **soon after** *the swelling in his right hand occurred and persisted. I advised him that he needed immediate revascularisation to try and save his right thumb and index finger. If not, there would be a high risk of amputation of both digits.*"[47] (Emphasis added)

113. Dr P4, the Prosecution's witness, also stated that two weeks was too long to have allowed the Patient's condition to have continued for without being referred for more specialist treatment. Once all was said and done, Dr P4's overall assessment was that the Patient was extremely "*fortunate*" for his condition the way it ended, albeit that the Patient is still faced with permanent damage and a career change.

<u>Conclusion to the Fourth Charge</u>

[47] Dr P4's Witness Statement at [10]

114. Paragraph 4.1.1.5 of the ECEG states that the duty of care expected of medical practitioners includes "*making necessary and timely visits, arranging appropriate and timely investigations and ensuring that results of tests are communicated to the patient and the most appropriate management is expeditiously provided.*" We do not agree with the Prosecution that it was beyond a reasonable doubt that Dr Teh fell short of this requirement. Dr Teh had taken follow up steps, as detailed above. He had taken the step of tasking his staff to follow up with the Patient. The Patient had cancelled the scheduled follow up appointment and had given some indication that the situation was under control. While the Patient's condition seemed to dramatically turn for the worse we cannot say beyond a reasonable doubt that Dr Teh had "*grossly mismanaged the care of [the] Patient*".

115. This is not to say that Dr Teh could not have done more. But this is with the benefit of hindsight. It would not have been remiss of him to have personally called the Patient knowing that the swelling in his hand had not subsided, especially in light of the administration of Promethazine. He could have advised the Patient to reschedule the review when the Patient cancelled the review on 25 March 2009. So while it is possible to say that Dr Teh's follow up was not entirely satisfactory, it is not safe to say that it constituted, beyond reasonable doubt, professional misconduct.

116. We therefore dismiss the Fourth Charge.

The Fifth Charge—Falsification of Medical Records (purporting to represent that diluted Promethazine was administered)

117. The crux of the Fifth Charge was that Dr Teh administered *undiluted* Promethazine to the Patient, and when it later transpired that the Patient suffered certain complications from the Procedure—possibly due to the administration of the said *undiluted* Promethazine—Dr Teh deliberately entered false information into the Casenotes. Specifically, the Prosecution charged, Dr Teh inserted the words

> *"IV* **diluted** *5ml N/S } 1038*
> *(over 5 min) } "* (emphasis added)

beside the words "*IV Promethazine 0.5ml*" on the Anaesthesia Record—an act of deliberate falsification. These words were referred to as "**the Falsified Words**". If *undiluted* Promethazine had been used, the Falsified Words would amount to a falsification of the Casenotes, which would have been a breach of the ethical standard to maintain accurate and honest medical records. The fact to be determined is therefore this: Was diluted or undiluted Promethazine administered?

Evidence that Undiluted Promethazine was used

118. The first suggestion that undiluted Promethazine was used was the Patient's own reaction to the injection. Promethazine is known to be highly caustic to the intima and it is not uncommon for Promethazine to cause pain when it is injected—especially where it is undiluted.[48] It was agreed by the experts that Promethazine, when undiluted, would cause severe and "*immediate*" sharp, burning pain.[49]

119. The Patient's evidence was that when Dr Teh injected medicines including Promethazine, he suffered a sensation of extreme heat in his hand. The Patient immediately said, "*Hot hot, very hot!*" [50] The Prosecution asserted that this reaction from the Patient was indicative that Dr Teh had used undiluted Promethazine.

120. Secondly, at the site of the injection the Patient had evidence of a "*chemical burn*" on his hand such that he had two scabs on the skin—an "*eschar measuring about 1.5cm to 2.2cm long*".[51] The Prosecution concluded that such burn marks could only have been caused if undiluted Promethazine had been used. However, Dr Teh's Casenotes stated that there was no skin bruising or obvious skin necrosis.[52]

121. These observations were also part of the Prosecution's argument that there was a connection between the administration of the Promethazine and the Patient's thrombosis such that it could be inferred that the Promethazine caused the

[48] Dr PE's letter to WongPartnership, dated 16 June 2012
[49] See the cross-examination of Dr DE, 24 January 2014
[50] Mr P's Statutory Declaration, dated 3 July 2009 at [6]
[51] Dr P4's Witness Statement at [8]
[52] Dr Teh's letter to the Complaints Committee, dated 17 September 2009

thrombosis. The Prosecution argued that this could only have been caused by the administration of undiluted Promethazine. However, whatever the validity of the Prosecution's argument may be, there was no charge linking the Promethazine to the thrombosis and it was not something that we were asked to make a finding on.

Other Evidence

122. In the aftermath of the scolding they received from Dr Teh on 17 March, Ms P2 and Ms P3 had not expected the Procedure to get off the ground. In fact, they arrived late at the Operating Theatre having wrongly assumed that the Procedure was to be called off. By the time Ms P2 went into the Operating Theatre, the intravenous medications had already been administered by Dr Teh.[53] At this point she observed some broken ampoules on the IV tray. She had no actual knowledge of what had been administered to the Patient.[54]

123. Notwithstanding the fact that Ms P2 was not present when these medications were given to the Patient, it was Ms P2 who filled out the Anaesthesia Record. She relied on Dr Teh to provide her with the relevant information.

124. Dr Teh's evidence was that he personally diluted and therefore administered *diluted* Promethazine to the Patient. No one was able to directly contradict Dr Teh on this point.

125. To undermine Dr Teh's version of events, the Prosecution placed reliance on a comparison of the anaesthetic record obtained by Ms P2 on or about 17 April 2009[55] as against the one provided by Dr Teh in his 17 September 2009 letter to the Complaints Committee. The two documents are different. The later version contains the Falsified Words whereas the earlier version does not. This anomaly leads to the conclusion that the entry was inserted sometime after 17 April 2009. Dr Teh conceded this point under cross-examination stating that the Casenotes were only filled in six weeks later.[56] However, it does not throw light on whether undiluted Promethazine was administered.

[53] Email from Ms P3 to Ms P2, dated 26 April 2009
[54] Ms P2's Witness Statement at [13]
[55] Exhibit P1, at pg 17
[56] Cross-examination of Dr Teh, 23 January 2014

126. The Prosecution also made much of an apparent admission made by Dr Teh that he had used undiluted Promethazine. Ms P2 alleged that at a meeting on 18 April 2009 Dr Teh admitted that he administered *undiluted* Promethazine to the Patient.[57] Ms P2 claimed that Dr Teh had said in the meeting that he had given Promethazine in "*bolus form*" to the Patient. Ms P2 took the phrase *"bolus form*" to mean in "*undiluted*" form.

127. Dr Teh vigorously refuted Ms P2's account on two grounds. First, he denied he ever said this. Second, he argued that even if he had said "*bolus form*" it does not necessarily mean 'concentrated form'. On the latter point we agree with Dr Teh. We accept that "*bolus form*" can plausibly be used as an expression to describe that a single shot was given to the Patient whether in diluted or undiluted form. The phrase does not necessarily imply that it was given in an undiluted form.

128. Ms P3, the other nurse involved in the meeting, makes no mention of Dr Teh's alleged admission in her Witness Statement. Nor is there any mention of this purported admission in two emails—that specifically discussed the contents of the 18 April 2009 meeting—between Ms P2 and Ms P3 that were sent after the meeting. The first one was sent two days later on 20 April 2009.[58] Ms P2's initial email is two pages long and is relatively detailed. It is headed "*reflection of what happened on April 18 2009 at SLBFC 1330hrs.*" Ms P3 replied on 26 April 2009. Neither nurse made any mention of undiluted Promethazine being administered.

Conclusion to the Fifth Charge

129. We cannot safely conclude that Dr Teh administered undiluted Promethazine. We do not believe that the Patient's testimony of "*Hot hot, very hot!*" and the apparent burn marks on his skin are in and of themselves sufficient to reach the conclusion beyond a reasonable doubt that undiluted Promethazine was used. Something more definitive is required. No one observed what Dr Teh injected into the Patient. The Prosecution's reliance on a supposed admission made by Dr Teh on 18 April 2009, even if true, was at best a misunderstanding on Ms P2's part.

[57] Ms P2's Witness Statement at [13] and [24]
[58] Email from Ms P3 to Ms P2, dated 26 April 2009 enclosing Ms P3's email dated 20 April 2009

130. It may well be that Dr Teh did use undiluted Promethazine. A certain amount of uncertainty surrounds his administration of the Promethazine. In Dr Teh's letter to the Complaints Committee, he made no mention of the Falsified Words or the administration of Promethazine whatsoever. Nor was mention made in Dr Teh's typed medical records dated 1 April 2009 to TTSH of Promethazine, nor is any reference to it (other than the Anaesthesia Record) to be found in his Casenotes. However, that may have been referable to the larger episode of taking the Patient's medical history properly and therefore a desire to minimise or suppress references to Augmentin and Promethazine. Ultimately, on the evidence available to us, we cannot say beyond a reasonable doubt that he used undiluted Promethazine.

131. As such, the Fifth Charge is dismissed.

132. Before moving to the next Charge, we make mention that Dr Teh's record-keeping left a lot to be desired. The entry about the Promethazine was only filled into the anaesthesia records some six weeks after the Procedure when the files were retrieved from storage. To set this in context, for at least six weeks the Patient's physicians were in the dark about the administration of the Promethazine and this could have potentially impacted the diagnosis and health of his thumb. Having said that, a late entry is not necessarily a false entry.

133. Paragraph 4.1.2 of the ECEG commands doctors to adhere to an exacting standard of record-keeping: "*Medical records kept by doctors shall be clear, accurate … and shall be made at the time that a consultation takes place. … All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented*". However, the ambit of the Fifth Charge was to determine whether the entry was a *falsified* entry.

The Sixth Charge—Tampering with the Medical Records (the insertion of particulars relating to the Amoxycillin Allergy)

134. The Prosecution's charge was that Dr Teh falsified or caused to be falsified the 12 March 2009 Casenote by circling the printed word "*Yes*" for the heading "*Drug Allergy*" and by inserting the words

"*Amoxycillin →* *? skin*
Test
- *Unknown reaction*
- *No major reaction*" ("**the Tampered Words**")

Dr Teh denied that he tampered with the Casenotes.

135. We have already found under the First Charge that Dr Teh did not take a history on 12 March. It follows that Dr Teh failed to record the Patient's allergy history (as encapsulated by the Tampered Words) in the Casenotes on 12 March 2009. We find that Dr Teh annotated the history portion of the Casenote at some point *after* 12 March 2009.

136. On its own, the completion of the Casenotes at a later date does not necessarily amount to professional misconduct. However, the gravamen of the Sixth Charge is that the doctor passed this entry off as being written on 12 March 2009. If Dr Teh had annotated the entry to reflect that it was filled in on 17 March it would not, in our view, amount to a tampering of the Casenotes. It is the context of this case that makes the failure to annotate exactly when the allergy was recorded blameworthy. Dr Teh's action in attempting to create the impression that he made the entry on 12 March was part of the cover-up. It diverted the blame to the nurses and cast them in a bad light.

137. Given our findings under the First Charge, we conclude that Dr Teh tampered with the Casenotes by writing the Tampered Words without making it clear that the words were only written on 17 March 2009 (or such other date as they may have been written) thereby causing the Casenotes to reflect that the allergy to Amoxycillin had been ascertained on 12 March when it had only been discovered later. As such, it was to that extent, misleading.

138. Paragraph 4.1.2 of the ECEG states that "*Medical records kept by doctors shall be clear, accurate … and shall be made at the time that a consultation takes place. … All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented.*" The Tampered Words did not meet this standard. They gave the

erroneous impression that they were written contemporaneously with the initial consultation when they were not. Their inaccuracy was deliberately perpetrated as part of Dr Teh's strategy of self-preservation and blame-shifting. We therefore find Dr Teh guilty of professional misconduct under the Sixth Charge.

Sentencing and Mitigation

139. After having considered the parties respective submissions on sentencing and mitigation, and taking into account the totality of Dr Teh's conduct, the Disciplinary Committee makes the following orders:

(a) That Dr Teh be fined **$10,000**;

(b) That Dr Teh be censured;

(c) That Dr Teh 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) That Dr Teh pay 70% of the costs of, and incidental to, these proceedings, including the costs of counsel to the SMC and the Legal Assessor.

140. We made a choice to be lenient with Dr Teh. We wish to briefly explain our reasons.

141. We do not regard the first three Charges, (*viz*. administering a drug to the Patient that he was allergic to; the failure to take a proper history; the non-disclosure of the administration of the drug the Patient had an allergy to; and the continuation of the Procedure) as sufficiently serious in the context of the surrounding circumstances to justify a suspension from practice. However, the same cannot necessarily be said for the Sixth Charge. A charge of tampering with medical records is a violation of the doctor-patient relationship and is ultimately an offence which connotes some dishonesty. The medical fraternity should be at pains to take a dim view of such conduct. This case, in our view, was on the borderline. Dr Teh's tampering of the Casenotes was in essence a late insertion of information which had the appearance of contemporaneity

which—in the absence of further explanation—would have misled anyone who read them. The information entered in the Casenotes was not in and of itself inaccurate. While it was Dr Teh's intention to avoid scrutiny of his conduct, we distinguish this situation from other tampering of medical records, such as outright forgeries or falsifications.

142. In determining the sentence, we have also given consideration to the fact that Dr Teh, in response to this incident with the Patient, has reformed much of the Clinic's standard operating procedures with regard to the administration of medications. In the first place, Dr Teh changed the way that pre-operative medications are dispensed. The nurses no longer dispense the pre-operative medications as this is now the duty of the doctor. Secondly, Dr Teh engages an anaesthetist as part of the surgical team when the administration of IV medication is required. These changes point towards Dr Teh having learned from his mistakes.

143. In consideration of mitigation of sentence, we took into account several references that Dr Teh produced commending his character and competence as a doctor. Some of these references were written by eminent and respected members of the medical profession and we gave them due weight. These doctors would not have given these references lightly. In addition, we take notice of the fact that Dr Teh has no other disciplinary antecedents.

144. In light of the above, we consider that as a young doctor just starting out in private practice, Dr Teh made a clinical mistake which caused him to panic. This, in turn, led to Dr Teh making a series of misjudgements which ultimately culminated in him dishonestly trying to cover his tracks. While none of these actions are excusable, it is our view that on the specific facts of this case, the sentence should fall more leniently than harshly. While we were initially inclined to impose the minimum suspension of 3 months, we felt that the mitigating factors were compelling and we are satisfied that the sentence as set out in paragraph 139 above strikes the correct balance.

Publication of decision

145. We hereby order that the Grounds of Decision be published.

146. The hearing is hereby concluded.

Dated this 19th day of August 2014.