# 香 港 醫 務 委 員 會
# The Medical Council of Hong Kong

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## DISCIPLINARY INQUIRY
## MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TEOH Sim Chuan Timothy (張新村醫生) (Reg. No.: M01798)

Date of hearing: 20 June 2022 (Monday)

Present at the hearing

Council Members/Assessors: Dr HO Pak-leung, JP (Chairperson of the Inquiry Panel)
Dr LUNG David Christopher
Prof. LUI Cho-ze, Joseph
Mr HUNG Hin-ching, Joseph
Mr LAM Ho-yan, Mike

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by Messrs. Mayer Brown

Senior Government Counsel (Ag.) representing the Secretary: Mr Edward CHIK

1. The charges against the Defendant, Dr TEOH Sim Chuan Timothy, are:

"The particulars of the complaint are that in or about March 2019, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ("the Patient") in that he:

(i) performed splenectomy on the Patient without proper justification and/ or without informed consent instead of the planned left partial nephrectomy operation ("the 1st Operation");

(ii) failed to recognize the difference in anatomy between the spleen and the kidney during the 1st Operation;

(iii) failed to recognize pancreatic injury in the post-operative period and/or failed to provide proper care and/or advice to the Patient on the pancreatic injury in the post-operative period;

(iv) ex-post facto attempted to rationalize splenectomy on the Patient when there was no such indication and/or finding in the histopathology report;

(v) unjustifiably rushed to solicit the Patient to undergo a further operation for "exploration of left kidney + nephrectomy +/- frozen section" ("the 2nd Operation") after the 1st Operation; and

(vi) wrongfully altered contemporaneous operating records and/or other medical records.

In relation to the facts alleged, either singularly or cumulatively, he has been guilty of misconduct in a professional respect."

**Facts of the case**

2. The name of the Defendant was at all material times and still is included in the General Register and the Specialist Register under the Specialty of Urology.

3. On 20 December 2018, the Patient underwent a body checkup at St Paul's Hospital ("SPH"). An ultrasound of the abdomen was performed and revealed normal ultrasound of both kidneys but a 1.5 cm lesion. A subsequent computerized tomogram ("CT") of the abdomen performed on 24 January 2019 revealed an exophytic lesion measuring 1.8 cm x 2.5 cm x 2.2 cm in the anteromedial aspect of the mid/lower pole of left kidney.

4. On 4 February 2019, the Patient consulted the Defendant for left renal tumour. The Defendant advised to perform left partial nephrectomy. The Patient agreed to undergo the operation. She signed a consent form for the operation. In the consent form, the Defendant wrote his diagnosis as *"L lower pole renal tumour"* but left blank the column "name or description of operation/invasive procedure of the patient".

5. On 24 March 2019, the Patient was admitted to SPH. The Defendant made two written entries in the Patient's hospital records on that day:

(a) at 17:50 pm, he wrote in the inpatient clinical record that he planned to perform *"L Partial nephrectomy (under video-assisted) under GA"* on the patient; and

(b) in the Patient's consent form dated 4 February 2019 under the column "name or description of operation/invasive procedure of the patient" which was previously left blank, he wrote *"Left partial nephrectomy (video-assisted) +/- nephrectomy + frozen section"*.

6. On the day of the scheduled operation on 25 March 2019, according to the anaesthetist's record, the Patient was anaesthetized at 09:35 am and the anaesthesia

finished at 14:46 pm. The anaesthetist noted in his record that the operation was performed with the Patient placed in the right lateral position and that *"left nephrectomy"* was performed. The amount of blood loss was not recorded. The Patient was transferred to the post-anaesthetic care unit at 14:50 pm.

7. In the operation record, the Defendant wrote, *inter alia:*

   (a) the words *"L renal mass as shown"*, together with a sketch drawing of a left kidney with the tip of its base shaded;

   (b) the words *"L nephrectomy done"*; and

   (c) the words *"Blood loss 1 litre"*.

8. A specimen handover record dated 25 March 2019 recorded that the specimen was collected in operating theatre 9 and in the column "name of specimen", it was written as *"L kidney tumour"*. In the column operation, it was written as *"Lap L (video assisted) nephrectomy"*.

9. In the inpatient clinical record of 25 March 2019, at 15:45 pm, the Defendant wrote *"post L nephrectomy under GA"*. He also wrote some instructions to nurses about immediate post-operative care for the Patient.

10. The Defendant visited the Patient at the ward at 19:30 pm on 25 March 2019. The Defendant told the Patient that her spleen was removed as it was "very ugly and contained something bad" [transliteration] (個脾臟好核突，有啲好唔好嘅嘢). He said the spleen ought to be removed and by doing that he saved her life. The Patient said the Defendant did not tell her what was wrong with her spleen. He also did not mention about the renal tumour. The Patient was shocked to be told that her spleen was removed but thought that was an incidental finding at the operation that her spleen was bad.

11. On 27 March 2019 at about 15:00 pm, the Defendant visited the Patient at the ward. The Defendant told her that he only removed the spleen in the operation but he did not remove the kidney tumour. Therefore, she must underwent a 2nd Operation to remove the tumour as it would be life-threatening should she fail to do so. Since the Defendant kept saying the 2nd Operation was vital and failing which life-threatening, the Patient said she had no choice but to agree to the 2nd Operation. At first, the Defendant wanted to schedule the 2nd Operation to take place that night. The Patient's husband queried why the hurry. The Defendant then re-scheduled it to the late afternoon the next day on 28 March 2019. The Patient thought she had no choice and therefore agreed to the 2nd Operation.

12. As regards documentation, on 27 March 2019:

(a) According to the MEWS Observation Chart for Adult, at 01:15 am, the Patient developed a fever and her body temperature was 38.2º Celsius.

(b) According to the inpatient clinical record, exact time not written down, the Defendant wrote *"ppp x exploration of L Kidney + nephrectomy + frozen section under GA …"*.

(c) According to the inpatient clinical record at 3:30 pm, the Defendant wrote that:

- he had informed the Patient that the resected specimen was the spleen;
- the Patient *"had pain over the 12th rib and was tender on palpation on the day of admission";*
- *"the situation was explained to the patient and her husband and they agreed to exploration of left kidney + nephrectomy +/- frozen section or partial nephrectomy under GA".*

13. On 28 March 2019, at around 11:45 am, the Defendant visited the Patient at the ward. The Defendant said he was advised by SPH that he should not proceed with the 2nd Operation as the Patient should recover first before the 2nd Operation. The Defendant said he had cancelled the 2nd Operation and would re-schedule it some 6 weeks later.

14. A while later, the Superintendent, Head of Nursing, and a nurse of SPH came to visit the Patient in the ward and told her that she should not undergo the 2nd Operation right away. They also told the Patient that the Defendant had removed her spleen instead of the renal tumour and they had already reported the incident to the Department of Health. The Patient requested to see a gastrointestinal doctor as she suffered from abdominal distention and pain since the surgery.

15. Further, the Patient said she began to have abdominal pain almost immediately after the surgery. She said she had kept complaining abdominal pain to the Defendant and the nurses. No explanation was given and no further investigation was done by the Defendant to address her abdominal pain. She also said her wound kept oozing since the surgery. There was no regular cleaning of the wound by the nurses as the Defendant only allowed the change of dressing to be done by himself. On 28 March 2019, her wound oozing became heavy but the Defendant only ordered an outer pad to be added and no change of dressing was allowed.

16. As regards documentation, on 28 March 2019:

(a) According to a histopathology report by a Dr LEE dated 28 March 2019, the specimen received was described as a *"left nephrectomy"* specimen and the pathology diagnosis was *"spleen with no diagnostic abnormalities".*

(b) The Defendant wrote a second, altered operation record comprised partly of the original operation record he wrote on 25 March 2019. This second, altered operation record dated 28 March 2019 differed from the original one dated 25 March 2019 in that the original page was replaced by a fresh and different page in which the operative diagnosis had been changed to *"bleeding and haemotoma over splenic tear"* and the Defendant wrote that there was a 1.5 inch *"tear at the lower part of spleen. Because of the tear of spleen – spleen was mobilized with difficulty splenectomy done."* Blood loss remained the same, at 1 litre.

(c) In the inpatient clinical record, the Defendant wrote:

> *"On admission on 24/3/19, she c/o pain over L lateral 12$^{th}$ rib region. It was tender on palpation.*
>
> *She offered a history of Chinese massage over the upper left abdomen and loin region – this was forceful massage."*

There was an accompanying sketch drawing of the abdomen, with the word *"tender"* pinpointed at a point on the left side above the navel.

> *"On P/E, the left upper abdomen and L Loin region was tender. No bruising seen. BP was stable.*
>
> *Since she was scheduled for +/- left nephrectomy and frozen section on 25-3.19 at 9:00 am, I told her that the tenderness may not be due to the L renal tumour but something else. She agreed to do what is necessary in addition to the L renal tumour."*

(d) The inpatient clinical report recorded that the Patient complained of fluid coming out from main wound and drain site. Her fever continued and her body temperature was 38.2º Celsius at 10:00 pm.

17. On 29 March 2019, a Dr NG, a gastrointestinal doctor of SPH saw the Patient. Dr NG suggested a CT scan and prescribed antibiotics and pain relief medication.

18. On 30 March 2019, a CT scan was performed which revealed left sub-diaphragmatic fluid collection.

19. On 3 April 2019, hospital files documented the following actions by the Defendant:

(a) he wrote on the operation record against his own 25 March 2019 entry that *"this was a pre-op written OT record which had been amended on 28 March 2019"*. The Defendant signed at the end of this sentence.

(b) according to the inpatient clinical record, the word *"nephrectomy"* in the phrase *"post L nephrectomy…"* written on 25 March 2019 was crossed out and replaced by the word *"splenectomy"* on 3 April 2019 at 6:30 pm with the Defendant's signature next to the word *"splenectomy"*.

20. On 4 April 2019, the Patient was seen by a Dr LO who took over her medical care from the Defendant.

21. By a statutory declaration dated 18 December 2019, the Patient made a complaint against the Defendant to the Medical Council.

**Burden and Standard of Proof**

22. We bear in mind that the burden of proof is always on the Secretary and the Defendant does not have to prove his innocence. We also bear in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

23. There is no doubt that the allegations against the Defendant here are serious. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine the disciplinary charges against him carefully.

**Findings of the Inquiry Panel**

24. The Defendant does not contest the factual particulars of all the disciplinary charges against him but it remains for us to consider and determine on the evidence whether in respect of each of the charges he has been guilty of misconduct in a professional respect.

Charge (i)

25. We gratefully adopt as our guiding principles the following statements of law expounded in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11:

> *"87. … The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.*
>
> …

*90. ... the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible."*

26. On 4 February 2019, when the Patient consulted the Defendant for her left renal tumour, what the Defendant advised her as the planned surgery was left partial nephrectomy and it was on this basis that the Patient signed on the consent form on that day.

27. There was never any discussion with the Patient at any time prior to the 1st Operation on 25 March 2019 that splenectomy would be performed.

28. The histopathology report by Dr LEE dated 28 March 2019 showed that the pathology diagnosis of the resected specimen from the 1st Operation as *"spleen with no diagnostic abnormalities"*.

29. We are satisfied that performing splenectomy on the Patient was without proper justification and informed consent.

30. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (i).

Charge (ii)

31. During the 1st Operation, the Patient was positioned in a right lateral position (right side down, left side up). This was the normal position for partial nephrectomy done in either open or laparoscopic method.

32. The Defendant wrote in his first operation record the words *"L nephrectomy (video-assisted)"*.

33. The anaesthetic record also stated that *"left nephrectomy"* was performed.

34. The specimen handover record signed by the Defendant stated in the column "name of specimen" that the specimen was *"left kidney tumour"*.

35. In the inpatient clinical record, the Defendant wrote down some of post-operative care instruction for nurses and he made reference to *"post left nephrectomy under GA"*.

36. Therefore, it was clearly the case that at the completion of the 1st Operation, the Defendant still believed that a left side nephrectomy had been performed on the Patient.

37. However, it turned out that instead of left kidney tumour, the spleen was resected.

38. Further, judging from the video recording of the 1st Operation, the Secretary's expert came to the view that the Defendant had failed to recognize the difference in anatomy between the spleen and the kidney: location, adjacent organ (kidney is retrocolic and spleen is cranial to splenic flexure of colon and adjacent to the stomach) and presence of ureter in the kidney.

39. We are satisfied that the Defendant had failed to recognize the difference in anatomy between the spleen and the kidney during the 1st Operation.

40. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (ii).

Charge (iii)

41. From the hospital records, the Patient was running a fever soon after operation. According to the Patient, there was heavy wound oozing.

42. CT scan performed on 30 March 2019 (ordered by Dr NG on 29 March 2019) revealed the presence of sub-diaphragmatic fluid collection of 3.48 cm x 4.65 cm x 8.01 cm and a peri-pancreatic fluid collection of 3.96 cm.

43. We agree with the Secretary's expert that pancreatic injury is known to be the most common morbidity associated with laparoscopic splenectomy. The Defendant should have been alerted of the potential pancreatic injury to the Patient after the splenectomy due to the following clinical findings:

    (a) continuous large amount of fluid in the wound dressing despite 8 days after operation;

    (b) on and off fever from Day 2 to Day 6 after operation;

    (c) radiological finding of abnormal intra-abdominal collection on 30 March 2019.

44. However, despite all these findings, the Defendant's instructions to nurses on 3 April 2019 was *"keep observation"* and *"change drain dressing"*. There was no documentation in the inpatient record that the Defendant had explained to the Patient about the possibility of potential pancreatic injury. According to the Active Drug List, the Patient was prescribed oral Augmentin 375mg 3 times daily from 25 to 29 March 2019. It was only after Dr NG had seen the Patient on 29 March 2019 at 9:00 pm that the antibiotics Augmentin was changed to intravenous Meropenem (a stronger antibiotics) and vaccination was prescribed for pneumococcal, meningococcal and

*Haemophilus influenzae*.

45. We are satisfied that the Defendant had failed to recognize pancreatic injury in the post-operative period and/or failed to provide proper care and/or advice to the Patient on the pancreatic injury in the post-operative period.

46. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (iii).

Charge (iv)

47. On 28 March 2019, the Defendant altered his original operation record dated 25 March 2019 by replacing with a fresh and different page in which he changed the operative diagnosis to *"bleeding and haematoma over splenic tear"* and he wrote that there was a 1.5 inch *"tear at the lower part of spleen. Because of tear of spleen – spleen was mobilised with difficulty splenectomy done."*

48. In the inpatient clinical record, the Defendant wrote:

> *"On admission on 24/3/19, she c/o pain over L lateral 12th rib region. It was tender on palpation.*
>
> *She offered a history of Chinese massage over the upper left abdomen and loin region – this was forceful massage."*

There was an accompanying sketch drawing of the abdomen, with the word *"tender"* pinpointed at a point on the left side above the navel.

> *"On P/E, the left upper abdomen and L Loin region was tender. No bruising seen. BP was stable.*
>
> *Since she was scheduled for +/- left nephrectomy and frozen section on 25-3.19 at 9:00am, I told her that the tenderness may not be due to the L renal tumour but something else. She agreed to do what is necessary in addition to the L renal tumour."*

49. However, we note that this additional information on (a) *"forceful Chinese massage"* and (b) Patient's consent *"to do whatever is necessary"* was not documented in the inpatient record on the day of admission on 24 March 2019, nor anywhere else previously.

50. Further, the Patient said she had never complained of pain at her left lateral 12th rib region before the 1st Operation. She said on the evening before the 1st Operation,

when the Defendant saw her, he just examined the area near her left kidney by making a few presses around it. In one of those presses, the Patient made an "ouch" sound and said she was sensitive to touch. At no time did the Defendant tell her that the "ouch" sound was pain, which required further explorations at the 1st Operation. There was no consent given that the Defendant could do whatever was necessary at the 1st Operation.

51. As said above, the histopathology report dated 28 March 2019 stated that the pathology diagnosis of the dissected specimen was *"spleen with no diagnostic abnormalities"*.

52. We are satisfied that the Defendant ex-post facto attempted to rationalize splenectomy on the Patient when there was no such indication and/or finding in the histopathology report.

53. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (iv).

Charge (v)

54. We agree with the Secretary's expert that a small renal mass was not normally an immediately life threatening condition. The Patient had displayed no clinical condition that would justify a partial nephrectomy to be performed shortly after the 1st Operation.

55. In fact, the Patient started running a fever at 01:15 am on 27 March 2019 and this continued onto 28 March 2019. This would have been a contra-indication for further surgical procedures for the Patient.

56. Further, in the immediate post-operative period, the Patient would have displayed substantive active inflammatory reactions, and any dissection shortly after the 1st Operation would have been difficult. According to Secretary's expert, small renal mass had a mean growth rate of 0.28 cm yearly with only 1% of the small renal mass progressing to metastases in a mean follow up of 30 months.

57. We are satisfied that the Defendant unjustifiably rushed to solicit the Patient to undergo a further operation for "exploration of left kidney + nephrectomy +/- frozen section" after the 1st Operation.

58. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (v).

Charge (vi)

59. As said above, on 28 March 2019, the Defendant altered his contemporaneous operation record which he wrote on 25 March 2019 in that he replaced the original page with a fresh and different page in which the operative diagnosis had been changed to *"bleeding and haematoma over splenic tear"* and he wrote that there was a 1.5 inch *"tear at the lower part of spleen. Because of the tear of spleen – spleen was mobilized with difficulty splenectomy done."*

60. On 3 April 2019, hospital files documented the following actions by the Defendant:

(a) he wrote on the operation record against his own 25 March 2019 entry that *"this was a pre-op written OT record which had been amended on 28 March 2019".* The Defendant signed at the end of this sentence.

(b) according to the inpatient clinical record, the word *"nephrectomy"* in the phrase *"post L nephrectomy…"* written on 25 March 2019 was crossed out and replaced by the word *"splenectomy"* on 3 April 2019 at 6:30 pm with the Defendant's signature next to the word *"splenectomy".*

61. It is clear to us that the Defendant altered the contemporaneous operation records and other medical records with the view to cover up his error of mistakenly resecting the spleen.

62. We are satisfied that the Defendant had wrongfully altered contemporaneous operating records and/or other medical records.

63. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under Charge (vi).

**Sentencing**

64. The Defendant was previously convicted in 1985 on a charge of disregarding his professional responsibility in that he provided to a patient a false histopathology report to justify his surgical removal of the patient's testis. He was reprimanded for that conviction.

65. The Defendant was convicted again in 2008 on a charge of issuing 4 vouchers to BUPA Health Net for claiming consultation fees in respect of his patient and by which act he represented or implied that he was consulted by the patient on the said dates when in fact he was not. He was ordered to be removed from the General Register for 6 months.

66. In line with our published policy, we shall give credit to the Defendant in sentencing for his admission and cooperation throughout these disciplinary proceedings. We also bear in mind that the purpose of a disciplinary order is not to punish the Defendant, but to protect the public and to maintain public confidence in the medical profession.

67. We have considered the character reference letters as submitted and the CME courses taken by the Defendant.

68. We take a very serious view against the Defendant's wrongful alteration of the contemporaneous operation and medical records. Having considered the two previous disciplinary records, which also involved integrity and dishonesty, this is the third time the Defendant committed offences of similar nature. The Defendant also lied to the Patient that her spleen was removed as it was "very ugly and contained something bad", which was not true. We do not think the Defendant has rehabilitated from the past offences.

69. Having regard to the gravity of the case and the mitigation advanced on the Defendant's behalf, we make a global order that in respect of Charges (i) to (vi), the name of the Defendant be removed from the General Register for a period of 18 months.

70. We have to consider whether to impose an immediate implementation order under section 21(1)(iva) of the Medical Registration Ordinance ("MRO"). We consider it very dangerous that the Defendant failed to recognize the anatomy between the spleen and the kidney. This was a very elemental and grievous failure. For the protection of the public, allowing the Defendant to continue to practice medicine and to operate on patients would be very dangerous. We further order pursuant to section 21(1)(iva) of the MRO that the above removal order shall take effect upon publication in the Gazette.

**Remark**

71. The name of the Defendant is included in the Specialist Register under the Specialty of Urology. We shall leave it to the Education and Accreditation Committee to decide on whether anything may need to be done to his specialist registration.

Dr HO Pak-leung, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong