香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Dates of hearing: 30 September 2008, 29 November 2008 and 19 December 2008
Defendant: Dr TEOH Sim Chuan Timothy (張新村醫生)

1. The charge alleged against the Defendant, Dr TEOH Sim Chuan Timothy, is that:

> "In or about October 2003 he, being a registered medical practitioner, issued 4 vouchers to BUPA Health Net for claiming consultation fees, dated 14 October 2003, 21 October 2003, 24 October 2003 and 27 October 2003 respectively, 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.
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> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

2. On 8 October 2003, the patient consulted the Defendant. The patient had a medical insurance policy, under which he was entitled to free consultation and medicine in accordance with the terms of the policy. Each time he was only required to give the doctor his insurance card for imprinting of a voucher and to sign on the voucher. The doctor would also fill in the diagnosis and sign the voucher. The voucher would then be submitted by the doctor to the insurance company for claiming reimbursement of the prescribed fees. We shall first set out the evidence of the patient, and then deal with the Defendant's evidence.

3. The patient returned for a second consultation on 11 October 2003. During that consultation, the patient requested the Defendant to dispense more medicine to him. The Defendant explained to him that for each consultation only 3 days'

supply of medicine would be covered under the insurance policy. The Defendant suggested that 6 days' supply of medicine could be dispensed by imprinting an additional voucher. The patient agreed. Therefore 2 vouchers were imprinted and 6 days' supply of medicine was dispensed. One of the vouchers was dated 11 October 2003, and the other voucher was left blank when the patient signed them. The member's copy of the dated voucher was given to the patient, but not the undated voucher.

4. On 17 October 2003, the patient went back to consult the Defendant. When the patient again requested for more medicine, the Defendant suggested that 2 weeks' supply of medicine could be dispensed but altogether 4 vouchers would have to be imprinted. The patient agreed. Therefore 4 vouchers were imprinted and 2 weeks' supply of medicine was dispensed. One of the vouchers was dated 17 October 2003, and the other 3 vouchers were left blank when the patient signed all of them. The member's copy of the dated voucher was provided to the patient, but not the undated vouchers.

5. On 4 November 2003, the patient went back to consult the Defendant. He raised concern about the practice of imprinting several vouchers each time in order to get more medicine, as under the insurance policy there was an annual quota of 30 consultations and the quota would be exhausted soon if the practice continued. The Defendant suggested that he could pay separately for the medicine. The Defendant would sell the anti-depressant to him, and would give a prescription for him to purchase the tranquilizer from pharmacies. In this regard, the Defendant told him that the anti-depressant was from Germany which was only available from his clinic. The patient agreed. From then on, the new arrangement came into use, and the patient would have medicine to last through 1 month before consulting the Defendant again.

6. From 4 November 2003 onwards, the patient consulted the Defendant roughly on a monthly basis. This went on until 21 September 2004 when the Defendant told the patient that the anti-depressant which was exclusively available from his clinic was no longer available. The patient then intended to consult another doctor and asked for a medical report and copies of the medical record. The Defendant agreed to provide a medical report at a fee but refused to provide the medical record.

7. When the patient got the medical report on 22 September 2004, he went back to

the clinic complaining that it was too short and the cost too expensive. On 24 September 2004, he demanded a copy of the medical record in accordance with the statutory right under the Personal Data (Privacy) Ordinance. The Defendant immediately complied and provided a photocopy of the medical record to the patient.

8. On 24 September 2004, the patient read in the newspaper a report of an inquiry by the Medical Council in which a doctor was found guilty of professional misconduct for imprinting several insurance vouchers in the same consultation and then presented the vouchers to the insurance company to claim reimbursement as if there were consultations on different dates. Noting that the case was very similar to the situation in his dealings with the Defendant, the patient discovered that it was a case of professional misconduct. He then telephoned the insurance company to check on which dates the Defendant has claimed reimbursement. Double checking the dates provided by the insurance company against the photocopy of the medical record, he found that the Defendant had submitted vouchers in respect of 4 dates on which there was no consultation. The dates were 14th, 21st, 24th and 27th of October 2003. He then made a complaint to the Medical Council on 28 September 2004.

9. The Defendant gave a different version of what happened.

10. According to the Defendant, he never imprinted more than one voucher for each consultation. The patient always turned up at the clinic without appointment. On some occasions the patient turned up while the Defendant was away, he reacted strongly and insisted on getting the medicines. The clinic assistant eventually called up the Defendant and he spoke to the patient over the telephone. Having been satisfied from the telephone consultation that it was suitable to prescribe further medicines to the patient, he then told the clinic assistant to dispense the same medicines to the patient. The clinic assistant would then dispense the medicines, including dangerous drugs, to the patient and imprint one voucher for the telephone consultation. He would return to the clinic in the evening, check the register of dangerous drugs to ensure that it was accurate and correct, and also fill in the medical record the prescriptions he had given over the telephone.

11. The Defendant said that the dangerous drugs were kept in a locked cabinet in accordance with the statutory requirement under the Dangerous Drugs Ordinance. The clinic assistant was able to dispense dangerous drugs to the patient in his

absence because she had the key to the locked cabinet. To allow persons who are not authorized by the Ordinance to have access to the dangerous drugs is a criminal offence under section 23(4) and (6) of the Ordinance. While it is not for us to consider whether the Defendant had committed an offence, it is a factor in considering whether the Defendant would run the risk of criminal prosecution by leaving the key to the clinic assistant, and therefore the credibility of the Defendant's evidence.

12. The Defendant also produced a book recording the dangerous drugs dispensed to patients to support the fact that the dangerous drugs were dispensed to the patient on the dates stated in the vouchers. According to the evidence of the Defendant and the clinic assistant, the book was filled in by the clinic assistant at the time of dispensing, and then copied to the statutory dangerous drugs register the next day. There was no explanation as to the reason for this unusual and redundant practice, as it would only add unnecessary work and increase the chance of mistakes when the information was copied from the book to the various dangerous drugs registers. In this respect it must be noted that it is a statutory requirement to keep separate registers in respect of separate dangerous drugs. The practice of keeping a separate record of dangerous drugs dispensed in addition to the statutory registers is unheard of in the medical community. While we cannot rule out the possibility of the Defendant adopting such an unusual practice, it is also a factor for us to consider in relation to credibility of the Defendant's evidence, in particular that no explanation was given by the Defendant for such a practice.

13. The photocopied medical record provided to the patient on 24 September 2003 is the best evidence of what actually happened. The Defendant admitted that it was a contemporaneous record. In the medical record, there was record of all the consultations with the patient except the 4 dates in question, namely, 14th, 21st, 24th ad 27th October 2003. The Defendant explained that the consultations on those 4 days were reflected by the symbols "x2" in the entry dated 11 October 2003 and "x4" in the entry dated 17 October 2003. These symbols indicated that the same medicines on 11 October 2003 were repeated on another date, and the same drugs on 17 October 2003 were repeated on 3 other dates. When questioned about how he made the entries in respect of the telephone consultations, the Defendant said that when he returned to the clinic in the evening he would make the entry. When asked why he did not make the entries "x2", "x3" and "x4" in the entry dated 17 October 2003 according to the practice he described, he said that he was too busy on the first two days (i.e. 21st and 24th

October 2003) and so on 27 October 2003 he simply wrote down “x4” to record that the same medicine was also dispensed on two previous days.

14. We find the explanation of the Defendant unacceptable. If he had time to check that the dangerous drugs registers were accurate, which would involve much more work in counting the stock of dangerous drugs and verifying the figures on the various registers against the book maintained by the clinic assistant, he could not be short of time to simply write down the symbol “x2” on 21 October 2003 and the symbol “x3” on 24 October 2003. In any case, on those two days he could not have anticipated that there would be similar dispensing on a subsequent day so that he could leave the record to be taken care of on 27 October 2003. Furthermore, as the Defendant accepted that the medical record was an important record for the continued treatment of the patient, there was no reason that he did not write down at least the date on which the medicines were repeated and the symptoms of the patient. The only inference is that the symbol “x2” was written on 11 October to indicate that two times the usual medicines were dispensed, and “x4” was written on 17 October to indicate that four times the usual medicines were dispensed on the relevant day.

15. We have also seen the original medical record. There was significant difference between the original record and the photocopy. In the original record there were the entries “14/10 – Repeat drugs”, “21/10”, “24/10” and “27/10”. These entries were missing from the photocopy provided to the patient on 24 September 2004 immediately upon the patient producing the personal data access request form. It is also noteworthy that in the receipt signed by the patient on 24 September 2004 acknowledging receipt of copies of the medical record, the 4 days in question were missing while all the other days were carefully listed out. Therefore, these 4 entries must have been added after the photocopy has been provided to the patient.

16. It is obvious that in the original medical record there were adhesive marks over the 4 subsequently added entries, showing that they have been covered at some stage. The Defendant explained that he wrote the 4 entries on the original after he was notified by the Preliminary Investigation Committee of the complaint in order to help him remember that there were 4 consultations which were not recorded. He then gave the original to his former legal representatives. He could not give any explanation for the adhesive marks, as he did not know what the former legal representatives did to the original. In effect the Defendant was

suggesting that the former legal representatives tampered with the original medical record. While it is not for us to speculate what actually happened, we must take into consideration that the Defendant by his own admission made alterations to the original medical record on matters which are of direct relevance to the complaint. As it is the professional duty of all registered medical practitioners to keep proper contemporaneous medical records of all consultations, the Defendant must have known that the medical record was a crucial piece of evidence when he made the alteration by adding those 4 crucial entries.

17. On the other hand, the Defendant's meticulous efforts in making the redundant record of dangerous drugs dispensed is in stark contrast to the perfunctory manner in which the Defendant kept the record of the telephone consultations. If he was so careful in record keeping, he would not have omitted even writing down simply the dates of the telephone consultations.

18. We must also point out that both the Defendant and the clinic assistant were able to give evidence about every minute detail on the relevant occasions when there was no record whatsoever, and they had no reason to recall the matters until more than 2 years later in January 2005 when the Defendant was notified of the complaint by the Preliminary Investigation Committee. If according to the clinic assistant that she had particular memory of the events because of the disorderly and aggressive behaviour of the patient, it was unreasonable that no note about those occasions were made at all in the medical record. In this respect, it is relevant to note that the Defendant on 24 September 2004 made a note in the medical record about the patient's complaint about the medical report being too short and demanded reduction of the cost of the medical report.

19. For the fore-going reasons, we reject the evidence of the Defendant and the clinic assistant.

20. Having considered the evidence carefully, we accept the evidence of the patient in respect of how the vouchers in question came into being and that there was no consultation on the 4 dates in question. We note that under the cross-examination of the Defence Counsel there were inconsistencies between the patient's evidence on exactly what happened on each consultation and what was recorded in the medical record. However, this is a matter which took place 5 years ago and it is unrealistic to expect a patient to remember each and every matter, especially

matters which were of little significance to a layman patient. The patient's evidence is corroborated by the indisputable documentary evidence, in particular the medical record. We accept his evidence that he was asked to imprint and sign 2 vouchers on 11 October 2003 and 4 vouchers on 17 October 2003, and twice the usual amount of medicines were dispensed to him on 11 October 2003 and four times the usual amount of medicines on 17 October 2003. We also accept that the patient did not go to the Defendant's clinic nor spoke to the Defendant on the telephone on the 4 days in question.

21. It is not disputed that the Defendant had presented the 4 vouchers in question to the insurance company to claim reimbursement.

22. We are satisfied that the Defendant had by the vouchers falsely represented that he was consulted on the 4 dates in question. As integrity and honesty is of paramount importance in the medical profession, the Defendant's conduct has clearly fallen below the standard expected amongst registered medical practitioners. We are satisfied that this constitutes professional misconduct. We find him guilty as charged.

Sentencing

23. The Defendant was previously convicted in 1986 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. Although the conviction was 22 years ago, that disciplinary offence of dishonesty is similar in nature to the present case. That causes us concern that he has not rehabilitated from that act of dishonesty.

24. We give him credit for having performed some community service.

25. With regard to the mitigation that the financial gain from the offence was small, we must point out that it is the ethical conduct rather than the gain which is of significance. As we have said earlier, honesty and integrity are of paramount importance for the medical profession. The fact that the gain was small is of no relevance.

26. Having regard to his previous record, the gravity of the case and the mitigation, we order that the Defendant's name be removed from the General Register for

a period of 6 months. We are of the view that this is not a suitable case for suspension of the order.

27. If and when the Defendant applies for restoration to the General Register, we recommend that the Council should consider requiring the Defendant to have satisfactorily completed a course of continuing medical education in medical ethics approved by the Council in advance.

28. We note that the Defendant's name is included in the Specialist Register under the specialty of urology. While it is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration, we are of the view that his dishonest conduct which warrants removal from the General Register also justifies removal from the Specialist Register.

Dr. Kin CHOI
Temporary Chairman, Medical Council