G.N. 3526

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF THE MEDICAL COUNCIL OF HONG KONG

DR TEOH SIM CHUAN TIMOTHY (REGISTRATION NO.: M01798)

It is hereby notified that after due inquiry held on 20 June 2022 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong ('Inquiry Panel') found Dr TEOH Sim Chuan Timothy (Registration No.: M01798) guilty of the following disciplinary charges:—

'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.'

Dr TEOH was at all material times and still is included in the General Register and still is included in the Specialist Register under the Specialty of Urology.

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.

On 4 February 2019, the Patient consulted Dr TEOH for left renal tumour. Dr TEOH 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, Dr TEOH wrote his diagnosis as *'L lower pole renal tumour'* but left blank the column 'name or description of operation/invasive procedure of the patient'.

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

(a) at 17.50 p.m., 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'*.

On the day of the scheduled operation on 25 March 2019, according to the anaesthetist's record, the Patient was anaesthetized at 09.35 a.m. and the anaesthesia finished at 14.46 p.m.. 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 p.m..

In the operation record, Dr TEOH 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'*.

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'*.

In the inpatient clinical record of 25 March 2019, at 15.45 p.m., Dr TEOH wrote *'post L nephrectomy under GA'*. He also wrote some instructions to nurses about immediate post-operative care for the Patient.

Dr TEOH visited the Patient at the ward at 19.30 p.m. on 25 March 2019. Dr TEOH 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 Dr TEOH 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.

On 27 March 2019 at about 15.00 p.m., Dr TEOH visited the Patient at the ward. Dr TEOH 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 Dr TEOH 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, Dr TEOH wanted to schedule the 2nd Operation to take place that night. The Patient's husband queried why the hurry. Dr TEOH 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.

As regards documentation, on 27 March 2019:—

(a) According to the MEWS Observation Chart for Adult, at 1.15 a.m., 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 p.m., Dr TEOH 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'*.

On 28 March 2019, at around 11.45 am, Dr TEOH visited the Patient at the ward. Dr TEOH 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. Dr TEOH said he had cancelled the 2nd Operation and would re-schedule it some 6 weeks later.

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 Dr TEOH 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.

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

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) Dr TEOH 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 Dr TEOH 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, Dr TEOH 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 9.00 a.m., 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 38.2° Celsius at 10.00 pm.

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.

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

On 3 April 2019, hospital files documented the following actions by Dr TEOH:—

(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'*. Dr TEOH 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 p.m. with Dr TEOH's signature next to the word *'splenectomy'*.

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

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

Dr TEOH did not contest the factual particulars of all the disciplinary charges against him.

Charge (i)

The Inquiry Panel adopted as the 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.'

On 4 February 2019, when the Patient consulted Dr TEOH for her left renal tumour, what Dr TEOH 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.

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.

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'*.

The Inquiry Panel was satisfied that performing splenectomy on the Patient was without proper justification and informed consent. In the view of the Inquiry Panel, Dr TEOH's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (i).

Charge (ii)

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.

Dr TEOH wrote in his first operation record the words *'L nephrectomy (video-assisted)'*.

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

The specimen handover record signed by Dr TEOH stated in the column *'name of specimen'* that the specimen was *'left kidney tumour'*.

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

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

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

Further, judging from the video recording of the 1st Operation, the Secretary's expert came to the view that Dr TEOH 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.

The Inquiry Panel was satisfied that Dr TEOH had failed to recognize the difference in anatomy between the spleen and the kidney during the 1st Operation. In the view of the Inquiry Panel, Dr TEOH's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (ii).

Charge (iii)

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

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.

The Inquiry Panel agreed with the Secretary's expert that pancreatic injury is known to be the most common morbidity associated with laparoscopic splenectomy. Dr TEOH 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.

However, despite all these findings, Dr TEOH's instructions to nurses on 3 April 2019 was *'keep observation*' and *'change drain dressing'*. There was no documentation in the inpatient record that Dr TEOH 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 p.m. that the antibiotics Augmentin was changed to intravenous Meropenem (a stronger antibiotics) and vaccination was prescribed for pneumococcal, meningococcal and *Haemophilus influenzae*.

The Inquiry Panel was satisfied that Dr TEOH 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.

In the view of the Inquiry Panel, Dr TEOH's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (iii).

Charge (iv)

On 28 March 2019, Dr TEOH 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.'*

In the inpatient clinical record, Dr TEOH 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 9.00 a.m., 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.'*

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.

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 Dr TEOH 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 Dr TEOH tell her that the 'ouch' sound was pain, which required further explorations at the 1st Operation. There was no consent given that Dr TEOH could do whatever was necessary at the 1st Operation.

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'*.

The Inquiry Panel was satisfied that Dr TEOH ex-post facto attempted to rationalize splenectomy on the Patient when there was no such indication and/or finding in the histopathology report. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (iv).

Charge (v)

The Inquiry Panel agreed 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.

In fact, the Patient started running a fever at 01.15 a.m. 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.

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.

The Inquiry Panel was satisfied that Dr TEOH unjustifiably rushed to solicit the Patient to undergo a further operation for 'exploration of left kidney + nephrectomy +/- frozen section' after the 1st Operation. In the view of the Inquiry Panel, Dr TEOH's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (v).

Charge (vi)

As said above, on 28 March 2019, Dr TEOH 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.'*

On 3 April 2019, hospital files documented the following actions by Dr TEOH:—

(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 p.m. with the Defendant's signature next to the word *'splenectomy'*.

It was clear to the Inquiry Panel that Dr TEOH altered the contemporaneous operation records and other medical records with the view to cover up his error of mistakenly resecting the spleen.

The Inquiry Panel was satisfied that Dr TEOH had wrongfully altered contemporaneous operating records and/or other medical records. In the view of the Inquiry Panel, Dr TEOH's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel found Dr TEOH guilty of misconduct in a professional respect under Charge (vi).

The Inquiry Panel took a very serious view against Dr TEOH's wrongful alteration of the contemporaneous operation and medical records. Furthermore, the Inquiry Panel considered it very dangerous that Dr TEOH failed to recognize the anatomy between the spleen and the kidney. This was a very elemental and grievous failure.

Having regard to the gravity of the case and the mitigation advanced on Dr TEOH's behalf, the Inquiry Panel made a global order that in respect of Charges (i) to (vi), Dr TEOH's name be removed from the General Register for a period of 18 months. The Inquiry Panel further ordered that pursuant to section 21(1)(iva) of the Medical Registration Ordinance that the above removal order shall take effect upon publication in the *Gazette*.

Pursuant to the Inquiry Panel's orders, Dr TEOH's name has been removed from the General Register on 8 July 2022; and pursuant to section 19(B)(1) of the Medical Registration Ordinance, Dr TEOH's name has also been removed from the Specialist Register on the same day.

The order is published in the *Gazette* in accordance with section 21(5A) of the Medical Registration Ordinance. The full decision of the Inquiry Panel of the Medical Council is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*