IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2026] SMCDT 3

Between

Singapore Medical Council

And

Dr Teo Sek Khee

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional misconduct – Suspension from Register of Medical Practitioners

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Singapore Medical Council
v
Dr Teo Sek Khee

[2026] SMCDT 3

Disciplinary Tribunal – DT Inquiry No. 3 of 2026
Prof Ho Lai Yun (Chairman), Clinical A/Prof Tee Kim Huat Augustine, Mr Marvin Bay (Judicial Service Officer)
21 to 23 October 2025, 27 to 29 October 2025, 16 March 2026

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional conduct – Suspension from Register of Medical Practitioners

18 March 2026

GROUNDS OF DECISION

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

Introduction

1 The Respondent is Dr Teo Sek Khee ("**Dr Teo**"). He has been a medical practitioner since 1985 and a registered specialist in geriatric medicine since 1998. At all material times in August to September 2013, he was practising as a geriatrician at Raffles Hospital.

2 After six days of contested hearings, Dr Teo communicated his intention to plead guilty to a charge under section 53(1)*(d)* of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("**MRA**") for professional misconduct, namely failing to provide competent and appropriate care to his patient, C (the "**Patient**"), by failing to take the necessary steps to detect and identify gastrointestinal bleeding and to manage the Patient's condition

appropriately during his admission to Raffles Hospital from 24 August 2013 to 2 September 2013.

The Charge

3 The charge against Dr Teo, as set out in the Re-Amended Notice of Inquiry dated 6 January 2026, reads as follows:

> "That you, DR TEO SEK KHEE, a registered medical practitioner under the Medical Registration Act (Cap 174, 2004 Rev Ed) ("MRA"), are charged that, from 22 August 2013 to 2 September 2013, whilst practising as a doctor specializing in Geriatric Medicine at the Raffles Hospital located at 585 North Bridge Road Singapore 188770, in breach of Guideline 4.1.1.5 of the 2002 Edition of the Singapore Medical Council's ("SMC's") Ethical Code and Ethical Guidelines ("2002 ECEG"), you failed to provide competent and appropriate care to your patient, one [C] (the "Patient"), by failing to take the necessary steps to detect and identify gastrointestinal bleeding and to manage the Patient's condition appropriately.
>
> PARTICULARS
>
> (a) The Patient was 72 years of age as of August 2013 and had been under your care since on or around 13 July 1998.
> (b) On 22 August 2013, the Patient visited you at your clinic in Raffles Hospital due to noticeable oedema (i.e. water retention) in his ankles and you provided medical treatment to him before sending him home.
> (c) On 24 August 2013, the Patient visited you at your clinic again and you admitted the Patient to Raffles Hospital as the ankle oedema did not subside.
> (d) You were aware that based on the Patient's medical history, he had multiple risk factors for gastrointestinal bleeding:
> (i) The Patient suffered from diabetes since 1977;
> (ii) The Patient has been prescribed and was on warfarin since 2007;
> (iii) The Patient's Glycated Hemoglobin (HbA1C) trend suggested that the patient's diabetic control from 26 April 2011 to admission was not optimally controlled; and
> (iv) The Patient's haemoglobin count in the 2 years preceding his admission on 24 August 2013 was fluctuating. His haemoglobin count was 9.6 g/dl at its lowest on 17 January 2012 and 12.8 g/dL at its highest on 20 March 2013. The fluctuating haemoglobin count could have been the result of gastrointestinal bleeding.
> (e) On 26 August 2013, the CT scan of the Patient's abdomen which you ordered included findings of gastro-oesophageal varices and features suspicious of portal hypertension.
> (f) On 26 August 2013, the Patient's haemoglobin count was 10.4g/dl. On 31 August 2013, the haemoglobin count fell to 7.8g/dl.
> (g) At all material times, as a registered medical practitioner, you were required to comply with Guideline 4.1.1.5 of the 2002 ECEG which states that *"[a] doctor shall provide competent, compassionate and appropriate care to his patient. This 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."

(h) In breach of Guideline 4.1.1.5 of the 2002 ECEG, you failed to provide competent and appropriate care to the Patient by not taking the following steps, at the latest by 31 August 2013, to detect and identify gastrointestinal bleeding in light of the particulars at (d), (e), and (f) above, and to manage the Patient's condition appropriately:
  (i) performed a digital rectal examination;
  (ii) ordered an INR test;
  (iii) group-and-matched blood for transfusion standby;
  (iv) referred the Patient to a gastroenterologist and/or surgeon for endoscopic evaluation of the gastrointestinal tract; and
  (v) withheld the discharge.

(i) Instead, you discharged the Patient on 2 September 2013.

(j) The Patient was subsequently admitted to Hospital B on 5 September 2013. On 6 September 2013 at Hospital B, he was diagnosed with upper gastrointestinal bleeding secondary to bleeding gastric varices, and coagulopathy secondary to warfarin.

and your aforesaid conduct amounts to such serious negligence that it objectively constitutes an abuse of the privileges of being registered as a medical practitioner, and that in relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)*(d)* of the MRA."

4 Dr Teo pleaded guilty to this charge without qualification and admitted to the Statement of Agreed Facts[1] without reservation. It would be salient however, to re-iterate that the decision to plead guilty was notified to this tribunal ***after*** the conclusion of a six-day trial, and before the rendition of the tribunal's verdict on liability.

Background Facts

The Patient's medical history and risk profile

5 The Patient was 72 years old at the material time and had been under Dr Teo's care intermittently from July 1998 to September 2001, and again from around 2006 until 2 September 2013. He presented with multiple significant risk factors for gastrointestinal bleeding that should have heightened clinical vigilance:

(a) ***Diabetes mellitus*** since 1977 with suboptimal control, evidenced by HbA1C levels ranging from 6.9% to 8.0% over the preceding years;

(b) ***Hypertension*** since 1994, managed with antihypertensive medications;

[1] The signed ASOF is dated 16 January 2026, with the plea taken on 10 March 2026.

(c) ***Splenomegaly*** first diagnosed in 2000, which can be associated with portal hypertension and increased bleeding risk;

(d) ***Chronic anaemia*** since 2000 with persistently fluctuating haemoglobin levels, a pattern that should have raised concerns about occult bleeding;

(e) ***Atrial fibrillation*** since June 2004, treated with warfarin anticoagulation since April 2007, significantly increasing bleeding risk; and

(f) ***Fluctuating haemoglobin*** levels in the two years preceding admission, ranging from 9.6 g/dL to 12.8 g/dL, demonstrating an unstable haematological profile.

6 The Patient's medical history was particularly concerning given the combination of anticoagulation therapy, chronic anaemia, and splenomegaly. These factors collectively created a high-risk profile for gastrointestinal bleeding that required careful monitoring and prompt investigation of any concerning symptoms or laboratory findings.

The August 2013 admission and clinical course

7 On 22 August 2013, the Patient consulted Dr Teo due to bilateral ankle oedema that had developed over the preceding weeks. Initial investigations revealed *hypoalbuminaemia* (albumin level of 25 g/L, normal range 35-50 g/L) as the likely cause of the oedema. Dr Teo appropriately identified this as requiring inpatient management.

8 On 24 August 2013, the Patient was admitted to Raffles Hospital for intravenous treatment with frusemide and albumin infusion. The admission was initially straightforward, with the Patient responding well to diuretic therapy and albumin replacement.

9 During the nine-day admission, however, several concerning developments occurred that should have triggered a systematic evaluation for gastrointestinal bleeding:

10 These developments included:

(a) ***Persistent low-grade fever***: From 24 August 2013, the Patient developed a persistent low-grade fever ranging from 37.2°C to 38.1°C. Dr Teo appropriately ordered multiple investigations including blood cultures, urine cultures, and chest X-rays to identify the source of infection.

(b) ***Computed Tomography ("CT") scan findings***: A CT scan[2] performed on 26 August 2013 revealed gastroesophageal varices[3] and features suspicious of portal hypertension. This was a critical finding that significantly elevated the Patient's risk of variceal bleeding, particularly given his anticoagulation status.

(c) ***Progressive anaemia***: The Patient's haemoglobin levels showed a concerning downward trend, dropping significantly by 25% over 5 days, from 10.4 g/dL on 26 August to 7.8 g/dL on 31 August 2013. This represented a substantial decline that warranted urgent investigation.

(d) ***Laboratory investigations***: Dr Teo ordered a number of investigations to determine the cause of fever, including multiple blood cultures, inflammatory markers, and imaging studies. It was ***however*** the case that he did not order ***specific*** tests to investigate potential gastrointestinal bleeding despite the concerning haemoglobin trend.

The "red flags" in this case

11 The clinical picture during admission presented several metaphorical ***red flags*** that should have prompted immediate action:

(a) The combination of known gastroesophageal varices (from CT scan) with declining haemoglobin levels.

[2] It is an important qualification that the CT scan was ordered to investigate for ***fever*** and not predicated upon any concerns connected with suspected ***internal bleeding***.

[3] The presence of ***varices*** (abnormally swollen, dilated or twisted blood vessels) was a new finding upon which the tribunal holds that Dr Teo should have regarded with due suspicion and apprehension, and further investigation on an urgent basis, given they portended a bleeding risk, and in the background of the Patients warfarin therapy.

(b) The Patient's high-risk profile due to warfarin therapy and chronic liver-related complications.

(c) The unexplained nature of the haemoglobin drop in the absence of obvious external bleeding.

(d) The Patient's age and multiple comorbidities making him particularly vulnerable to complications.

Critical Omissions in Clinical Management

12 Despite these warning signs, the admitted facts show Dr Teo failed to take several fundamental steps that constitute standard care for a patient with suspected gastrointestinal bleeding:

(a) Digital rectal examination ("**DRE**"): This basic clinical examination was not performed[4] despite being essential for detecting melaena or other signs of gastrointestinal bleeding. The examination is particularly important in elderly patients on anticoagulation with declining haemoglobin levels.

(b) International Normalised Ratio ("**INR**") monitoring: Despite the Patient being on warfarin therapy and showing signs of potential bleeding, Dr Teo failed to order an INR test to assess the degree of anticoagulation. This was a critical omission given that over-anticoagulation significantly increases bleeding risk and may require urgent reversal.

(c) Blood grouping and cross-matching: With haemoglobin levels dropping to 7.8 g/dL (approaching transfusion threshold), Dr Teo failed to group-and-match blood for

[4] The tribunal notes Dr Teo's point that patients might have reservations and experience potential discomfort from an ostensibly intrusive digital rectal examination, but the tribunal's view was that the DRE was ***critical*** in the light of the hitherto inexplicable declining haemoglobin levels, and Dr Teo should at the very least have offered to perform this procedure, and give the Patient a chance to make an informed choice to either agree or decline.

potential transfusion standby, leaving the Patient vulnerable if urgent transfusion became necessary.

(d) Gastroenterology referral: Given the CT findings of gastroesophageal varices and the concerning haemoglobin trend, Dr Teo should have referred the Patient to a gastroenterologist for urgent endoscopic evaluation. Early endoscopy is crucial in suspected variceal bleeding for both diagnostic and therapeutic purposes.

(e) Discharge decision: Most critically, Dr Teo proceeded with discharge on 2 September 2013 despite the Patient's haemoglobin level of 7.8 g/dL[5] and the constellation of concerning findings. This decision exposed the Patient to significant risk outside the hospital environment.

Failure to follow through on FOBT ordered

13 A faecal occult blood test ("**FOBT**") was ordered on 31 August 2013, but the sample was only collected on the day of discharge (2 September 2013). The test subsequently returned positive with a result ***of 248 ng/ml***, confirming the presence of gastrointestinal bleeding. However, this result was not available at the time of discharge, and the timing of the test collection was suboptimal. This failure was unfortunately complete in the sense that **no arrangements** were made for Dr Teo to be notified once the test results were ready, and Dr Teo never demonstrated any intention to look for the result. Indeed, the tribunal's impression is that the fact of this pending test result seems to have only returned to Dr Teo's consciousness ***after*** the Patient's fall, and warding in a different hospital, which will be covered in the subsequent paragraphs of these grounds.

Post-Discharge Events and Consequences

14 We stress again how Dr Teo's plan to see the Patient only two weeks after discharge was irreconcilable with responsible or acceptable treatment of a patient at risk of an internal bleeding episode. As matters transpired, the consequences of the delayed diagnosis

[5] Simply stated, this reading was the ***lowest*** in the Patient's history with Dr Teo, and the tribunal's observation that Dr Teo has made the call to order a home discharge and only sought to be the patient two weeks thereafter suggested that this concerning reading was not seriously taken.

became apparent shortly after discharge. On 5 September 2013, just ***three*** days after leaving Raffles Hospital, the Patient experienced dizziness and weakness while at home. From a medical perspective, these symptoms appear directly attributable to ongoing blood loss and anaemia.

15 While attempting to move around his home, the Patient fell in his bathroom, sustaining a significant head injury. The fall was a direct consequence of the dizziness and weakness caused by his undiagnosed and untreated gastrointestinal bleeding. He was immediately taken by ambulance to Hospital B.

16 At Hospital B, the Patient's condition was rapidly assessed and the diagnosis of upper gastrointestinal bleeding was immediately established:

(a) His INR was found to be dangerously elevated above 10, indicating severe over-anticoagulation that had contributed to the bleeding severity;

(b) His haemoglobin had further dropped to 6.4 g/dL, representing severe anaemia requiring urgent intervention;

(c) Clinical examination and investigations confirmed active upper gastrointestinal bleeding.

17 The Patient underwent urgent endoscopy on 6 September 2013, which revealed a bleeding gastric varix. The bleeding was successfully controlled using *histoacryl* injection, a standard therapeutic intervention for variceal bleeding. He received multiple blood transfusions to correct his severe anaemia and was discharged from Hospital B on 11 September 2013 after seven days of intensive treatment.

18 We pause at this point to observe that notwithstanding the span of some 12 years between the narrated events in 2013 and the present, there have been no significant changes in the applicable standard of care between the two periods, and the yardstick of acceptable and sound patient management practices essentially remain the same.

Reported sequalae

19 It was unfortunately the case that the Patient's ordeal did not end there. He continued to experience recurrent episodes of upper gastrointestinal bleeding over the subsequent months, requiring ongoing specialist gastroenterological care. The bleeding episodes were sufficiently severe and recurrent that he ultimately required splenectomy on 26 July 2014, nearly a year after the initial incident. This major surgical intervention was necessary to address the underlying portal hypertension and prevent further life-threatening bleeding episodes.

Expert Medical Opinion

20 The case was reviewed by independent medical experts who provided clear opinions on the standard of care expected in such circumstances. The expert evidence established that:

(a) The combination of gastroesophageal varices (identified on CT scan), declining haemoglobin levels, and warfarin therapy created a high-risk scenario requiring urgent investigation and management;

(b) The failure to perform basic investigations such as digital rectal examination and INR testing fell below acceptable standards of care;

(c) The decision to discharge the Patient with a haemoglobin level of 7.8 g/dL without addressing the underlying cause of anaemia was inappropriate;

(d) Variceal bleeding carries significant morbidity and mortality risks, with studies showing a 25% incidence rate and 20% mortality risk at six weeks if not promptly diagnosed and treated.

Procedural Timeline and Delays

21 As a major mitigatory point, the procedural history of this case does show a series of delays that may have caused a degree of prejudice to Dr Teo. For convenient reference, the significant events are set out below:

Date	**Event**
5 November 2013	The Patient's complaint received by the Singapore Medical Council ("**SMC**").
4 April 2014	SMC issued Notice of Complaint to Dr Teo.
10 April 2014	Dr Teo provided written explanation[6].
23 June 2015	The Complaints Committee ("**CC**") issued a letter of advice.
15 July 2015	The Patient lodged appeal to the Minister for Health.
5 September 2017	The Ministry of Health ("**MOH**") directed CC to provide detailed reasons for decision.
19 September 2018	CC provided Grounds of Decision to Patient.
8 October 2018	The Patient confirmed intention to continue appeal. *[3-year gap]*
13 October 2021	MOH directed SMC to appoint Disciplinary Tribunal.
7 November 2024	SMC issued Notice of Inquiry.
21 to 29 October 2025	Evidence was heard over six days.
6 January 2026	SMC issued Re-Amended Notice of Inquiry.
16 January 2026	Dr Teo decided to plead guilty to amended charge.

Prolongation of proceedings

22 The Respondent's Counsel ("**RC**") has noted that the total period from complaint to resolution spans over 12 years and 2 months, and flagged several aspects of this timeline for notice:

(a) There being a three-year gap between October 2018 and October 2021 with no apparent activity or explanation.

[6] Please see ASOF at [4].

(b) There being an additional three-year period from the MOH direction in October 2021 to the issuance of the Notice of Inquiry in November 2024;

(c) Their contention of there having been a lack of any satisfactory explanation for these delays in the proceedings.

23 RC has identified these delays to have caused Dr Teo a not insubstantial degree of adversity, including prolonged uncertainty about his professional standing, difficulty in reconstructing events after such a long period, and the development of serious health issues during the proceedings.

Sentencing Recommendations

24 Ms Chang, Prosecuting Counsel ("**PC**") for the SMC, submitted that Dr Teo ought to face a suspension of 18 months, or alternatively a minimum of nine (9) months if a discount for delay were applied, together with the usual ancillary orders. SMC's position was that the case involved moderate harm and medium culpability, warranting a substantial suspension to reflect the seriousness of the failures and maintain public confidence in the medical profession.

25 The RC, Ms Koh, submitted on Dr Teo's behalf, that the appropriate sentence should be a fine, censure, written undertaking and costs. RC argued for a finding of slight harm and low culpability, emphasising that no actual harm was intended, the Patient ultimately recovered, and there were substantial mitigating factors including Dr Teo's unblemished 40-year career and the extraordinary delays in prosecution spanning over 12 years.

Our Decision

26 Having considered the submissions of both parties, the Agreed Statement of Facts, expert medical evidence, and the applicable sentencing principles, we impose a suspension of seven (7) months together with the usual ancillary orders. We now explain the basis:

Applicable Sentencing Framework

27 The applicable sentencing framework is well-established following *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("***Wong Meng Hang***") and the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals (July 2020 Edition) ("**Sentencing Guidelines**").

28 The Court of Three Judges in *Wong Meng Hang* established a structured four-step analysis that requires disciplinary tribunals to:

(a) Evaluate the seriousness of the offence with reference to harm and culpability;

(b) Identify the applicable indicative sentencing range using the harm-culpability matrix;

(c) Identify the appropriate starting point within the indicative sentencing range; and

(d) Adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

29 This framework ensures consistency in sentencing while allowing for appropriate consideration of the specific circumstances of each case. The harm-culpability matrix provides indicative sentencing ranges that serve as a starting point for analysis, but the ultimate sentence must reflect the totality of circumstances. We start by setting out the harm/culpability matrix[7] referenced by the High Court panel in *Wong Meng Hang*:

[7] The ellipse marks the range derived after our analysis.

Harm / Culpability	Slight	Moderate	Severe
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

Step 1: Harm and Culpability Assessment

Harm: Moderate

30 We assess the level of harm as ***moderate*** for the following reasons:

31 ***Actual harm*** suffered: The Patient experienced significant ***actual*** harm as a direct consequence of Dr Teo's failures:

(a) The Patient suffered weakness and dizziness for two to three days following discharge, symptoms that were distressing and limited his daily activities;

(b) The Patient suffered a fall resulting in a head injury on 5 September 2013, which was directly attributable to the dizziness caused by undiagnosed anaemia;

(c) The Patient required emergency hospitalisation at Hospital B for seven days, involving urgent endoscopic intervention and blood transfusions;

(d) The Patient continued to suffer recurrent episodes of upper gastrointestinal bleeding over the subsequent months, requiring ongoing specialist care and ultimately major surgery (splenectomy) in July 2014.

32 ***Potential harm***: The medical evidence established that the ***potential*** consequences of Dr Teo's failures ***could*** have been rather severe:

(a) Variceal bleeding carries a 25% incidence rate and 20% mortality risk at 6 weeks according to medical literature;

(b) Given the Patient's age at the material time (72 years) and multiple comorbidities including diabetes mellitus, hypertension, and cardiac issues, he belonged to a particularly vulnerable group where delayed diagnosis could have been catastrophic;

(c) The Patient's INR level above 10 at presentation to Hospital B demonstrated dangerous over-anticoagulation that could have resulted in life-threatening bleeding via *inter alia*, a head injury consequent upon a fall;

(d) The delay in diagnosis and treatment could have resulted in exsanguination or other serious complications. This being especially so in the light of Dr Teo's actual knowledge of the Patient's varices which left him vulnerable to a catastrophic bleed.

33 ***Lost opportunities***: Dr Teo's failures resulted in missed opportunities for earlier detection and intervention during the nine-day admission period, when the Patient was under close hospital supervision with daily medical review. Early intervention could have prevented the subsequent complications and the need for emergency treatment.

34 ***Impact on public confidence***: The failures occurred in a hospital setting involving a senior geriatrician treating an elderly patient with multiple comorbidities. These are circumstances where the public reasonably expects comprehensive monitoring, appropriate specialist care, and prompt recognition of deteriorating clinical conditions.

Culpability: Medium

35 We assess Dr Teo's culpability as falling in the ***lower end*** of the ***medium*** range for the following reasons:

36 Significant departures from standards: Dr Teo's management involved several significant departures from accepted standards of care:

(a) ***Failure to perform digital rectal examination***: This basic clinical examination is fundamental when investigating potential gastrointestinal bleeding and should have been performed given the Patient's risk factors and declining haemoglobin;

(b) ***Failure to monitor INR***: Despite the Patient being on warfarin therapy and showing signs of potential bleeding, the failure to check INR levels was a serious omission that left a critical parameter unmonitored;

(c) ***Failure to arrange blood products***: With haemoglobin levels approaching transfusion threshold, the failure to group-and-match blood demonstrated inadequate preparation for potential complications.

(d) ***Failure to seek specialist input***: The combination of CT findings showing varices and declining haemoglobin warranted urgent gastroenterology consultation for endoscopic evaluation; We note too that from the in-patient hospital setting, such a referral would have been a particularly uncomplicated process to expedite.

(e) ***Inappropriate discharge decision***: This would be the most consequential breach, as the decision to discharge with unresolved anaemia and concerning clinical findings exposed the Patient to unnecessary risk.

Ignoring multiple warning signs

37 Multiple warning signs: The Patient presented with numerous clear indicators of potential gastrointestinal bleeding that should have triggered systematic investigation:

(a) Known gastroesophageal varices identified on CT scan;
(b) 25% drop in haemoglobin over 5 days (10.4 to 7.8 g/dL);
(c) Multiple risk factors including diabetes mellitus, warfarin therapy, and fluctuating haemoglobin levels;
(d) Haemoglobin level of 7.8 g/dL approaching transfusion threshold;

(e) Positive faecal occult blood test (though result available after discharge).

Factors reducing culpability

38 In addressing factors that could justify a reduction in culpability, RC raised several factors seeking to reduce Dr Teo's culpability and distinguish this case from more serious instances of professional misconduct. We recognise a degree of validity in ***some*** of these submissions which had potential mitigatory value. The tribunal makes no comment on (a), (b), (c) and (e), but presents its observation to (d):

(a) Good faith clinical reasoning: Dr Teo acted throughout with genuine belief in the Patient's best interests. His clinical reasoning, while ultimately flawed, involved complex risk-benefit analysis regarding the competing dangers of bleeding versus thromboembolism in a patient with atrial fibrillation[8];

(b) Active clinical engagement: Dr Teo did conduct daily examinations and ordered investigations to identify the cause of the Patient's fever and clinical deterioration. His approach did demonstrate a degree of ongoing clinical engagement;

(c) Isolated incident: This was an isolated incident in an otherwise unblemished 40-year career, suggesting that it represented an error in judgment rather than a pattern of substandard care;

(d) Erroneous analysis rather than recklessness: The faults in Dr Teo's management were more in terms of erroneous clinical judgment rather than recklessness, indifference, or deliberate disregard for patient safety; In this regard the tribunal notes that Dr Teo's management amounted more to a ***confluence of consecutive erroneous clinical judgments*** that compounded into misconduct as they constituted a series of serious lapses in the context of the respondent's knowledge of risk factors for bleeding arising from his training and experience as a specialist geriatrician.

[8] As elucidated in *Respondent's Sentencing Submissions* at [37].

(e) Complex clinical scenario: The Patient presented with multiple medical issues requiring simultaneous management, and the clinical picture was complicated by the need to balance anticoagulation risks with bleeding risks.

Step 2: Indicative sentencing range

39 Based on our assessment of moderate harm and medium culpability (at the lower range), we now refer to the harm-culpability matrix established in *Wong Meng Hang*. The indicative sentencing range for moderate harm and medium culpability falls within one to two years' suspension. Given our assessment that this stood in the lower range of medium culpability, we considered a term in excess of one year's suspension but well short of the maximum of two years' suspension to be the most appropriate.

Step 3: Starting point

40 Considering the precedent cases involving similar clinical failures and the specific circumstances of this case, we adopted a starting point of ***12 months*** suspension, which was enhanced to ***14 months'*** suspension after considering the major aggravating factor of Dr Teo's seniority. This starting point reflects the seriousness of the clinical failures while acknowledging certain factors that reduced Dr Teo's culpability.

41 In reaching this starting point, we have considered similar cases involving failures to diagnose and manage medical emergencies, while noting that each case must be assessed on its own facts and circumstances. Of the four precedent cases flagged for our attention for sentencing, this tribunal found that the case of *Singapore Medical Council* v *Khoo Boo Peng* [2025] SMCT1 *("**Khoo Boo Peng**")* to have the closest parallels to the instant case. The offending doctor in *Khoo Boo Peng* received an initial 12-month suspension, which was reduced to seven-and-a-half months' suspension to account for inordinate delays, in respect of the charge[9] most congruent to sentencing considerations for this case.

[9] This related to the second charge for failure to carry out close monitoring of the patient and management of the patient's side effects after starting the latter on the drug *Azathioprine*.

Step 4: Aggravating and mitigating factors

Aggravating Factors

42 Seniority and Experience: Dr Teo was a senior practitioner with 28 years' experience at the material time and held specialist qualifications in geriatric medicine. As established in *Ang Yong Guan v Singapore Medical Council* [2025] 3 SLR 135, seniority necessarily attracts heightened expectations from patients and the public. Senior practitioners are expected to demonstrate higher standards of clinical judgment and are held to correspondingly higher standards of accountability when failures occur. The impact on public confidence is also greater when senior practitioners are found to have fallen short of expected standards. This tribunal saw fit to add an additional ***two months' suspension*** to the initial point of 12 months' suspension, after considering the aggravating effect brought on by Dr Teo's seniority, counterbalanced with the mitigating factors referenced below, to derive a disqualification period of ***14 months'*** disqualification.

Mitigating Factors

43 Guilty Plea: Dr Teo's guilty plea was entered relatively late in the proceedings (after a six-day hearing). The tribunal observes and finds that in the course of this trial, Dr Teo made various attempts to elide from taking responsibility by putting up a range of implausible reasons in an ostensible bid to explain away the series of omissions that culminated with the Patient's collapse at home, after the plainly wrong decision to discharge the latter despite concerning signs that all was not well.

44 Dr Teo, for example, attempted to explain the Patent's worrying readings to be attributable to "*haemodilution*". It is also notable that his own expert witness was demonstrably ambivalent in supporting Dr Teo's own defence theory.

Limited discount for belated guilty plea

45 While Dr Teo would not deserve the full discount accorded to a respondent tendering an *ab initio* or early pre-trial guilty plea, his decision to plead guilty, when it finally came, nonetheless demonstrated Dr Teo acceptance of responsibility and that, while somewhat belated, has saved ***some*** judicial time and resources.

46 We hence accord his taking this course only the ***mildest*** mitigatory weight, recognising that the plea obviated the need for this tribunal to parse and analyse the entire body of the contested hearing transcripts of the six-day trial, to rule on his liability amid the competing factual testimonies and expert evidence.

Unblemished career and occurrence should be seen as an uncharacteristic aberration

47 Dr Teo's 40-year career without any prior disciplinary action does stand as a valid consideration in mitigation. RC characterised the event as an isolated error in judgment and an uncharacteristic aberration, and not part of any pattern of misconduct. She stressed that Dr Teo has had no prior disciplinary issues in 28 years before the instant incident and no problems in the 12 years since. RC closed with an assurance that "*Dr Teo has accepted his error and learnt from it. The risk of Dr Teo re-offending is extremely low*"[10]. To that, the tribunal would also observe that Dr Teo's offence is rather more the nature of an unfortunate series of ***omissions*** in failing to properly analyse the Patient's condition, and making the fateful choice to discharge him, than any ***active*** and ***overt*** acts of malpractice.

Extraordinary delay

48 The most cogent mitigating factor in this case is the inordinate delay in prosecution spanning over 12 years from complaint to its disposition. We recognise that the delay was not contributed to by Dr Teo and has caused him substantial prejudice. We agree with points (a), (b) and (d), and explain our rejection of (c) as causally speculative and medically unproven:

(a) Prolonged uncertainty: Dr Teo has lived with uncertainty about his professional standing for ***10 years and 7 months*** between the Notice of Complaint issued to Dr Teo on 4 April 2014 and the issuance of the NOI on 7 November 2024, and over

[10] *Respondent's Sentencing Submissions* and *Plea-in-Mitigation* at [51].

12 years to final disposition, causing ongoing anxiety and stress. In this regard, RC states[11]:

> "There was a significant delay in the present matter. At the outset, it is noted that there was a period of above 10 years and 7 months between the Notice of Complaint issued to Dr Teo on 4 April 2014 and the issuance of the NOI on 7 November 2024. Even though the absolute length of a delay in and of itself is not an indicator or proxy for whether the delay has been inordinate for the purposes of sentencing discounts (Ang Yong Guan at [63]), there was evidently inordinate delay in the investigation and prosecution of the case against Dr Teo. This is seen in:
>
> (1) the gap of 1 year and 2 months between Dr Teo providing his written explanation on 10 April 2014 and the decision by the CC on 23 June 2015 to issue Dr Teo with a letter of advice rather than refer the matter to a DT.
>
> (2) the gap of 5 years and 11 months between the CC's decision on 23 June 2015 to Dr Teo being notified on 28 May 2021 of the Complainant's appeal of the CC's decision. This included
>
> (i) a period of 2 years and 1 month between the Complainant lodging his appeal on 15 July 2015 and the MOH's direction to the CC on 5 September 2017 to provide detailed reasons for its decision;
>
> (ii) over a further year more for the CC to provide its grounds of decision on 19 September 2018; and
>
> (iii) another 2 years and 7 months between the Complainant confirming that he wanted to proceed with the appeal on 8 October 2018, and Dr Teo being notified of the Complainant's appeal on 28 May 2021.
>
> (3) the gap of close to 3 years and 1 month between the MOH's letter on 13 October 2021 notifying the Complainant and Dr Teo of the Minster's decision to refer the matter to a DT and the issuance of the NOI on 7 November 2024. This included
>
> (i) a period of 2 years and 1 month for the SMC to obtain PE's expert report on 16 November 2023; and
>
> (ii) a period of about 1 year between the issuance of PE's expert report on 16 November 2023 and the issuance of the NOI on 7 November 2024."

(b) Evidential difficulties: The passage of time has made it difficult to reconstruct events and beset Dr Teo with complications appurtenant to the potential difficulties in witnesses' memories fading from the effluxion of time and the need to trawl through archived documents.

(c) Alleged impact on health: Dr Teo was diagnosed with severe coronary artery disease requiring cardiac stenting in 2025, RC has likely ***overstated*** her case by

[11] *Respondent's Sentencing Submissions and Plea-in-Mitigation* at [54].

positing there to be "*a **real possibility** that the prolonged stress of the proceedings hanging over his head **had contributed** to the presence and severity of his coronary artery disease*"[12].

(d) To be clear, this tribunal accepts Dr Teo being unduly subject to prolonged stress but there is no medical evidence of this having any ***causal*** link with the exacerbation of Dr Teo's coronary atherosclerosis. It would be hyperbolic and speculative to suggest any causation, especially in the absence of convincing medical opinion for this attribution. We do, nevertheless accept that Dr Teo experienced a degree of additional stress in managing his medical condition in the shadow of these prolonged proceedings.

(e) False sense of closure[13]: RC pointed out that after the CC issued a letter of advice in 2015, Dr Teo would have reasonably believed the matter was concluded, only to face renewed proceedings years later.

Personal circumstances

49 Ultimately, we recognise that Dr Teo is now in his late 60s and approaching retirement, and that the prolonged proceedings have taken a significant psychological toll during what should have been the concluding years of his medical career.

Discount for Delay

50 Following the principles established in *Ang Peng Tiam* v *Singapore Medical Council* [2017] 5 SLR 356 and *Ling Chia Tien* v *Singapore Medical Council* [2024] 6 SLR 217, this tribunal considered whether the delays in this case warrant a discount in sentence.

51 There was recognition in these two cases that while public interest considerations are paramount in medical disciplinary proceedings, there might come a point where

[12] Please see *Respondent's Sentencing Submissions and Plea-in-Mitigation* at [63](2) [Emphasis added].
[13] *Respondent's Sentencing Submissions and Plea-in-Mitigation* at [59].

inordinate delay could cause such prejudice to the practitioner that it would be unjust not to provide a significant discount in sentencing.

52 In this case, we find that the cumulative delays rose to the level that they should be deemed to be "***inordinate***" and caused real prejudice to Dr Teo:

(a) The total delay the period between SMC's receipt of the Patient's letter of complaint on 5 November 2013 and the issuance of the Notice of Inquiry on 7 November 2024 was 11 years and amounting in all to over 12 years to the date of this case's disposition. This must count as exceptional in comparison with prior cases involving periods of delay;

(b) Dr Teo has suffered a degree of genuine prejudice in terms of ongoing anxiety which, while not necessarily carrying any medically ascertainable ***direct*** health impacts, created considerable and prolonged stresses attendant to having defend himself for such an extended duration;

(c) While public interest considerations are always important, there is also a patent need to counterbalance the prejudice caused by the delay in this particular case to derive a just sentence.

53 After very careful consideration, we apply a discount of 50% to account for this delay, reducing the sentence from ***14 months*** to ***7 months***. This discount reflects the exceptional nature of the delays while still ensuring that the sentence serves the purposes of specific deterrence and maintenance of public confidence in the medical profession.

Conclusion

54 Balancing all factors, we impose the following orders:

(a) Dr Teo is to be suspended from practice for a period of **seven (7) months**.

(b) Dr Teo is to be censured for his professional misconduct.

(c) Dr Teo is to give a written undertaking to SMC that he will not engage in the conduct complained of or any similar conduct in the future.

(d) Dr Teo is to pay the costs and expenses of and incidental to these proceedings, including the costs of counsel to SMC and such reasonable expenses as are necessary for the conduct of these proceedings.

55 It is further ordered that the period of suspension is to commence 40 days after the date of the order herein as this would have taken into account the time frame for parties to appeal and for Dr Teo to settle any outstanding matters before commencing his suspension.

56 This sentence reflects the seriousness of the professional failures while recognising the exceptional circumstances of delay and Dr Teo's otherwise exemplary career. The suspension serves the dual purposes of specific deterrence and maintaining public confidence in the medical profession, while acknowledging the substantial prejudice suffered by Dr Teo by circumstances that were quite distinct from attributable faults in his treatment of the Patient.

General advisory

57 We emphasise that this case serves as a reminder to all medical practitioners of the importance of systematic clinical assessment, particularly when managing high-risk patients with multiple comorbidities. The combination of anticoagulation therapy, declining haemoglobin levels, and radiological evidence of varices should trigger immediate and comprehensive investigation for gastrointestinal bleeding.

58 We order that these Grounds of Decision be published with appropriate redaction of personal particulars where necessary, so that the medical profession and the public may understand the standards expected and the consequences of falling short of those standards.

59 The hearing is hereby concluded with our expression of gratitude to respective counsel for their cogent submissions and assistance to this tribunal.

Coda

60 We would like to communicate our sense that the Patient, who had given his testimony in the first day of hearing, had persisted so long in his complaint as he was genuinely ***seeking answers*** on his treatment and what may have transpired in the sequence of events that eventuated in his collapse at home. As the hearing is concluded, this tribunal extends our encouragement for Dr Teo to reach out to connect with the Patient in a gesture of conciliation and closure.

Prof Ho Lai Yun Chairman	Clinical A/Prof Tee Kim Huat Augustine Member	Mr Marvin Bay Judicial Service Officer

Ms Chang Man Phing and Ms Rachel Chang
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for Singapore Medical Council; and

Ms Koh En Ying and Ms Charlene Tan
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