

TRADITIONAL CHINESE MEDICINE PRACTITIONERS BOARD

GROUND OFS OF DECISION ON THE COMPLAINT AGAINST LIU XUESONG MATTHEW (TXXXXX792H)

A. INTRODUCTION

1. Mr N (the “**Complainant**”) submitted his complaint against the Registered Person, Mr Liu Xuesong (Matthew) (the “**Respondent**”), to the Traditional Chinese Medicine Practitioners Board (“**Board**”) by way of a signed statutory declaration dated 22 November 2022 (“**Complaint**”).
2. The Complaint related to acupuncture treatment that the Complainant had received from the Respondent at Clinic A (“**Clinic**”) on 14 June 2022. The Board referred the matter to IC 2023/5 (“**IC**”) for an inquiry.
3. The IC completed the inquiry proceedings and submitted a report (“**IC Report**”) to the Board for its consideration. The Board then convened a hearing on 5 February 2026.

B. THE BOARD’S DECISION

4. The Board, having read and carefully considered the IC Report and the evidence and documents presented at the IC hearing, accepts the following findings of the IC in relation to the Terms of Reference (“**TOR**”):
 - (1) Finding on TOR 1(a): The Respondent had delegated parts of the Complainant’s treatment to the clinic assistant, Mr W.

- (2) Finding on TOR 1(b): The Respondent's aforesaid delegation of treatment was not in compliance with paragraph 4.1.1(d) of the Ethical Code and Ethical Guidelines for TCM Practitioners (January 2006) ("**ECEG**").
- (3) Finding on TOR 1(c): TOR 1(c) is not applicable.
- (4) Finding on TOR 2(a): The Respondent remained ultimately answerable and responsible for providing the appropriate treatment to and management of the Complainant.
- (5) Finding on TOR 2(b): The Respondent failed to manage the care of the Complainant appropriately, in breach of paragraph 4.1.1(e) of the ECEG, and paragraphs 9.1 and 9.3 of the General Advisory on Acupuncture and Other Related Treatment (June 2021) ("**GAA**").
- (6) Finding on TOR 3: There is insufficient evidence to prove that the Complainant suffered injury as a result of Mr W's administering of treatments to the Complainant.
- (7) Finding on TOR 4: The Respondent did not provide appropriate post-treatment care to the Complainant.
- (8) Finding on TOR 5(a): The Respondent did not comply with all standards of professional conduct and ethics determined by the Board as he had breached paragraphs 4.1.1(d) and 4.1.1(e) of the ECEG.
- (9) Finding on TOR 5(b): The Respondent did not comply with all pronouncements on professional matters issued by the Board as he had breached paragraphs 9.1, 9.3 and 9.4 of the GAA.
- (10) The Respondent's aforesaid conduct would amount to a breach of **section 19(1)(f)** of the Traditional Chinese Medicine Practitioners Act 2000 ("**Act**") read with Regulation 2(2)(a) of the Traditional Chinese Medicine Practitioners (Practice, Conduct and Ethics) Regulations ("**Regulations**") [for breaching paragraphs 4.1.1(d) and 4.1.1(e) of the ECEG]; and also read with

Regulation 2(2)(b) of the Regulations [for breaching paragraphs 9.1, 9.3 and 9.4 of the GAA].

- (11) The Respondent's conduct would amount to professional misconduct under **section 19(1)(i)** of the Act.

5. Arising from the findings in paragraph 4 above, the IC had recommended to the Board to take the following measures in respect of the Respondent:

- (1) Suspend the registration of the Respondent as a TCM practitioner for a period of 5 months.
- (2) The Respondent be fined \$1,000.
- (3) The Respondent be censured.
- (4) The Respondent is to give an undertaking, on such terms as the Board thinks fit, to abstain from the conduct that is the subject of the complaint against him.

6. Having considered the IC's findings and recommendation, the Board has decided to impose the following measures on the Respondent pursuant to sections 19(2) and 20 of the Act:

- (1) That the Respondent's registration as a TCM practitioner be suspended for 4 months;
- (2) That the Respondent be censured;
- (3) That the Respondent gives an undertaking, on such terms as the Board thinks fit, to abstain from the conduct that is the subject of the complaint against him; and
- (4) That the Respondent shall pay the costs and expenses of or incidental to the inquiry against him.

C. ELABORATION OF THE BOARD'S DECISION

C.1 Undisputed Facts

7. The main facts were set out in the Agreed Statement of Facts dated 7 September 2023 ("**ASOF**"). The salient agreed facts are set out below.
8. The Complainant had visited the Clinic (where the Respondent was working at) on the morning of 14 June 2022 for acupuncture treatment.
9. After acupuncture, the Respondent instructed Mr W to put "*a heated shoulder pad on [the Complainant's] shoulder and to continue with cupping*" thereafter.
10. On 15 June 2022, the day after the treatment, the Complainant discovered that he had two big round burnt skin blisters with pus, one on each side of his shoulder blades.

C.2 Board's agreement with the findings of the IC

11. Finding on TOR 1(a): The Board agrees with the IC that the Respondent had delegated parts of the Complainant's treatment to Mr W in the following manner:
 - (1) Mr W had performed the cupping treatment on the Complainant, at the areas that the Respondent had performed acupuncture, including the Complainant's upper back and shoulders, where the injuries were located;
 - (2) Mr W had placed the heat pad of the Hot Magner on the Complainant's upper back and shoulders; and
 - (3) Mr W had turned on the Hot Magner for heat-related treatment on the Complainant.
12. Finding on TOR 1(b): The Board agrees with the IC that the Respondent's aforesaid delegation was not in compliance with paragraph 4.1.1(d) of the ECEG.

13. Mr W was not a TCM practitioner or a “*TCM student*” within the meaning of paragraph 4.1.1(d) of the ECEG.
14. There is no evidence to show that Mr W was registered with an approved institute of TCM or was at the material time receiving TCM training in the context of a legitimate training programme.
15. Accordingly, the Respondent had failed to provide good clinical care to the Complainant in accordance with paragraph 4.1.1 of the ECEG as his delegation of parts of the TCM treatment to Mr W did not comply with paragraph 4.1.1(d) of the ECEG.
16. Finding on TOR 1(c): As TOR 1(b) is *not* answered in the affirmative (since the delegation to Mr W did *not* comply with paragraph 4.1.1(d) of the ECEG), TOR 1(c) is not applicable.
17. Finding on TOR 2(a): The Board agrees with the IC that the Respondent remained ultimately answerable and responsible for providing the appropriate treatment to and management of the Complainant.
18. In this regard, paragraph 4.1.1(d) of the ECEG clearly states that the TCM practitioner retains responsibility for the overall management of the patient when he delegates such treatment or care, and that the TCM practitioner is ultimately answerable for the treatment or care provided to such patient. As such, regardless of whether the Respondent had properly delegated parts of his duties to another person, he remained ultimately responsible for the treatment or care to his patient.
19. Finding on TOR 2(b): The Board agrees with the IC that the Respondent failed to manage the care of the Complainant appropriately.
20. In this regard, paragraph 4.1.1(e) of the ECEG states the following:

“A TCM practitioner shall provide competent, compassionate and appropriate care to his patient... A TCM practitioner who avails his patient of any supporting medical service is responsible for the adequate provision of

such supporting medical service and must be reasonably confident that the standard and reliability of such service.”

21. Paragraphs 9.1 and 9.3 of the GAA further state that:

“9.1 Care should be taken not to burn or cause injury to patients when applying moxibustion, cupping, far-infra red lamp (approved by Health Sciences Authority HSA), heat pad and/or other treatment involving heat.

9.3 Patients should not be left unattended when such treatment is applied. If possible, a signalling device should be given to patients to alert the TCMPs when the feeling of heat or pain become excessive.”

22. We are of the view that the Respondent did not take appropriate care not to expose the Complainant to the risk of injury when the cupping and heat pad treatments were applied. In this regard, having improperly delegated the cupping treatment to Mr W (who was an unqualified person), the Respondent had left the Complainant unattended and unsupervised during the heat pad and cupping treatments.
23. In addition, the Respondent also did not inform the Complainant of any signalling device that may have been present or give the signalling device to the Complainant to alert the Respondent if the feeling of heat or pain became unbearable.
24. Arising from the above matters, the Respondent did not manage the care of the Complainant appropriately.
25. Finding on TOR 3: The Board agrees with the IC that there is insufficient evidence to prove that the Complainant suffered injury as a result of Mr W’s administering of treatments to the Complainant.
26. According to the clinical notes of the general practitioner who had seen the Complainant on 18 June 2022 (ie. just 4 days after the Complainant’s visit to the clinic on 14 June 2022), the injuries suffered by the Complainant were “**2 circular well-circumscribed coin like lesions noted about 2x2cm in [size]**” on the left and

right sides of the Complainant's upper back which were "*erythematous with derroofed blister visible esp on right-side lesion*".

27. During the hearing before the IC, the Appointed Person's expert witness, Mr T opined that the *pattern* of the burn injury was *not* consistent with the shape of the Hot Magner device and its heat pad.
28. In this regard, Mr T's expert opinion was to the effect that if at all the heat pad was the cause of the burn, then the Complainant would get a "**square burn**" (and not a circular burn).
29. When asked about the possible causes for the Complainant's injury, Mr T had opined that it would be from inflicted trauma, and from "*something circular*".
30. In the present case, the heat pad was not "*something circular*" (but rectangular), and the pattern/shape of the Complainant's burn marks (ie. circular) was not consistent with any injury that Mr T had opined might have been caused by the heat pad (ie. a "*square burn*").
31. As such, the Appointed Person has not established beyond a reasonable doubt that the heat pad treatment administered by Mr W had caused injury to the Complainant.
32. Finding on TOR 4: The Board agrees with the IC that the Respondent did not provide appropriate post-treatment care to the Complainant.
33. Paragraph 9.4 of the GAA provides as follows:

"If burn injury had occurred, appropriate remedy should be applied immediately to reduce further burn injury and chance of infection. Patients should be referred to a medical emergency centre for further treatment and management, after appropriate dressing is applied."

34. On the facts of this case, after the Respondent had attempted to treat the Complainant's burn injuries for 3 consecutive days but the injuries (which appeared to be fairly serious) did not improve, he ought to have referred the Complainant to

a medical emergency centre for further treatment and management (as required under paragraph 9.4 of the GAA). The Respondent's failure to do so was in breach of paragraph 9.4 of the GAA.

35. Finding on TOR 5(a): The Board agrees with the IC that the Respondent had not complied with all standards of professional conduct and ethics determined by the Board under Regulation 2(2)(a) of the Regulations as he had breached paragraphs 4.1.1(d) and 4.1.1(e) of the ECEG.
36. Finding on TOR 5(b): The Board agrees with the IC that the Respondent had not complied with all pronouncements on professional matters issued by the Board under Regulation 2(2)(b) of the Regulations as he had breached paragraphs 9.1, 9.3 and 9.4 of the GAA.
37. Arising from the matters aforesaid, the Board concurs with the IC that the Respondent's aforesaid conduct would constitute a breach of **section 19(1)(f)** of the Act read with Regulation 2(2)(a) of the Regulations (for breaching paragraphs 4.1.1(d) and 4.1.1(e) of the ECEG) and also read with Regulation 2(2)(b) of the Regulations (for breaching paragraphs 9.1, 9.3 and 9.4 of the GAA).
38. In addition, the Board concurs with the IC that the Respondent's aforesaid conduct would also amount to professional misconduct under **section 19(1)(i)** of the Act, in relation to his breaches under TORs 1, 2 and 4. In this regard, the Respondent's conduct would be regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, arising out of his breaches of various provisions of the ECEG.

D. SENTENCE

39. The Board takes guidance from the sentencing framework set out in ***Wong Meng Hang v Singapore Medical Council*** [2019] 3 SLR 526 ("***Wong Meng Hang***"), based on the harm-culpability matrix.

40. The Board will consider TORs 1, 2 and 4 together as they relate closely to each other on the issue of the provision of good clinical care.

D.1 Levels of harm and culpability

41. With regard to **harm**, the Board is of the view that the harm occasioned by the Respondent's conduct was "moderate".
42. In this regard, the Respondent had improperly delegated the cupping treatment and the heat pad treatment to Mr W, who was an unqualified person and was not competent to carry out such treatment. Despite this, the Respondent had left the Complainant unattended and unsupervised during the treatment.
43. Further, even after the Respondent had observed the Complainant's burn injuries (which had appeared to be quite serious) and attempted to treat the same for 3 consecutive days without improvement, he had failed to refer the Complainant to a medical emergency centre for further treatment and management. His failure to do so would have increased the likelihood of complications developing from the burn injuries.
44. In addition, harm has been caused to the public confidence in the TCM profession, as the public would expect and trust that a qualified TCM professional would not, among other things, delegate treatment to an unqualified person. The public would also expect and trust that a qualified TCM professional would provide appropriate clinical care during and after the treatment.
45. In relation to **culpability**, the Board finds the level of culpability to be "low". In this regard, although the Respondent had improperly delegated parts of the TCM treatment, the substantial parts of the TCM treatment had been carried out by him. There is also no evidence that the Respondent had intentionally or deliberately set out to breach his professional duties.

D.2 Applicable indicative sentencing range and appropriate starting point

46. Based on a level of “moderate” harm and “low” culpability, the applicable indicative sentencing range would be a suspension of up to 1 year.
47. Having regard to the levels of harm and culpability, the Board is of the view that the appropriate starting point would be a ***suspension of 4 months***.
48. In Case Study 01/2020, TCMP Z had breached paragraphs 4.1.1(a), 4.1.1(d), 4.1.1(e), 4.1.1(f), 4.2.2 and/or 4.2.4(a) of the ECEG and was found liable under sections 19(1)(f), (i) and/or (j) of the Act. TCMP Z was suspended for a period of 9 months. Among other things, TCMP Z had inappropriately delegated the task of administering the moxibustion treatment to an unqualified clinic assistant and failed to personally supervise the moxibustion therapy. In addition, TCMP Z also failed to refer the complainant to registered medical practitioners to treat the third degree burns caused by the moxibustion treatment. The patient eventually had to undergo surgery for skin grafting at the hospital.
49. Although Case Study 01/2020 is somewhat similar on the facts in that it also involved improper delegation of TCM treatment to an unqualified person, the present case is less egregious than that of Case Study 01/2020. In this regard, Case Study 01/2020 had involved more breaches of the ECEG than the present case. Moreover, in Case Study 01/2020, the doctors at the hospital had confirmed that the moxibustion treatment had caused third degree burns to the patient (which had subsequently required skin grafting at the hospital), whereas there is insufficient evidence in the present case to prove that the heat pad treatment had caused injury to the Complainant.
50. As such, the Board is of the view that a suspension of 4 months would be the appropriate starting point in the present case.

D.3 Adjustments for offender-specific aggravating and mitigating factors

51. The Respondent’s seniority of more than 14 years as a TCM practitioner at the material time would have reposed a higher degree of trust and confidence in the Respondent. His breach of professional standards would have affected the public

confidence in the TCM profession to a greater extent and would be an aggravating factor.

52. Moreover, as the Respondent eventually contested all of the TORs, he does not have the benefit of the mitigating factor of a timely plea of guilt.
53. However, the Board is prepared to take into account the fact that the Respondent is a first-time offender.
54. On balance, no adjustments need to be made to the starting point of a suspension of 4 months.
55. Taking into consideration all the facts and circumstances of the present case, the Board has decided that the Respondent's registration as a TCM practitioner be suspended for 4 months, that he be censured, that he is to give an undertaking (on such terms as the Board thinks fit) to abstain from the conduct that is the subject of the complaint against him, and that he shall pay the costs and expenses of or incidental to the inquiry against him.

Dated this 8th day of May 2026

A handwritten signature in black ink, consisting of stylized, overlapping loops and strokes, likely representing the name 'DR TEO HO PIN'.

DR TEO HO PIN
CHAIRMAN
TRADITIONAL CHINESE MEDICINE PRACTITIONERS BOARD