TRADITIONAL CHINESE MEDICINE PRACTITIONERS BOARD

GROUNDS OF DECISION ON THE COMPLAINT AGAINST CHUA KAH GAY (REGISTRATION NUMBER T1903613G)

A. INTRODUCTION

1. Mr A ("***Complainant***") submitted his complaint against the Registered Person, Mr Chua Kah Gay ("***Mr Chua***"), to the Traditional Chinese Medicine Practitioners Board ("***Board***") by way of a letter dated 9 October 2021 and a signed statutory declaration dated 22 June 2022 ("***Complaint***").

2. The Complaint related to acupuncture treatment that the Complainant received from Mr Chua at Clinic H (the "***Clinic***") on 19 September 2021. The Board referred the matter to the Inquiry Committee 2023/4 ("***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 ("***Board hearing***") with Mr Chua on 10 October 2024.

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, accept the following findings of the IC:

   (1) 1st Finding: Mr Chua had not provided good clinical care to the Complainant in accordance with paragraph 4.1.1(e) in relation to his acupuncture treatment on the Complainant.

   (2) 2nd Finding: Mr Chua did not remove all the needles after the treatment, including the two (2) needles on the Complainant's toe and head areas respectively, due to his negligence.

(3) 3rd Finding: Mr Chua did not take sufficient steps to ensure that all the needles had been removed.

(4) 4th Finding: Mr Chua did not record the needle count during acupuncture and upon removal of the needles.

(5) 5th Finding: After Mr Chua was first informed about the needle on the Complainant's toe area, Mr Chua did not take sufficient steps to ensure that there were no other remaining needles left in the Complainant (including the needle on the Complainant's head).

(6) 6th Finding: There was no or insufficient appropriate post-treatment care by Mr Chua.

(7) 7th Finding: As a result of Mr Chua's failure to remove the two needles after the treatment, the Complainant suffered physical injury in the form of pain, discomfort and bleeding in his toe and head areas.

(8) 8th and 9th Findings: Mr Chua's aforesaid conduct amounted 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 paragraph 4.1.1(e) of the Ethical Code and Ethical Guidelines for TCM Practitioners (January 2006) ("***ECEG***")] and also read with Regulation 2(2)(*b*) of the Regulations [for breaching Guideline 8.4 of the General Advisory on Acupuncture and Other Related Treatment (June 2021) ("***GAA***")]. Mr Chua's conduct amounted to negligence 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 Mr Chua:

(1) Suspend the registration of Mr Chua as a TCM practitioner for a period of 3 months.

(2) Mr Chua be censured.

(3) Mr Chua 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. The Board has decided to accept the IC's recommendation, and accordingly impose the following measures on Mr Chua pursuant to sections 19(2) and 20 of the Act:

(1) That Mr Chua's registration as a TCM practitioner be suspended for 3 months;

(2) That Mr Chua be censured;

(3) That Mr Chua 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 Mr Chua 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 4 December 2023 ("***ASOF***"). The salient agreed facts are set out below.

8. The Complainant had seen Mr Chua at the Clinic at about 3pm to 4pm on 19 September 2021, where Mr Chua administered acupuncture on the Complainant's body and head areas. After the acupuncture was completed and Mr Chua had removed the needles, the Complainant went to the toilet. The Complainant felt a sharp pain when he wore his slippers and discovered that there was an unremoved needle on his toe area. The Complainant left the Clinic at about 7pm to 8pm.

9. At about 10pm, the Complainant felt dizzy with pain and discomfort at his head area. Upon touching his head, he discovered another needle on his head.

10. The Complainant then rushed down to the Clinic. As Mr Chua had already left the Clinic, Ms S (the Clinic's Massage Therapist) removed the needle on the Complainant's head at approximately 10.15pm. The needle was left on the Complainant's head after the acupuncture treatment, throughout the tuina treatment, and it was only discovered by the Complainant approximately six hours later. Upon removing the needle, the area where the unremoved needle had been was bleeding.

11. As a result, the Complainant suffered from dizziness, headache, migraine and vomiting, and as of 9 October 2021, was still suffering from headache and migraine.

12. Mr Chua stated in his Response that he only gave the Complainant a call on 22 September 2021 during which the Complainant informed Mr Chua that he was suffering from headache and dizziness and could not go to work.

C.2 Board's agreement with the 1st to 7th findings of the IC

13. 1st Finding: The Board agrees with the IC that Mr Chua had failed to provide good clinical care to the Complainant in accordance with paragraph 4.1.1(e) in respect of his acupuncture treatment on the Complainant.

14. In this regard, Mr Chua had failed to provide "competent" and/or "appropriate" care to the Complainant when he did not remove all acupuncture needles from the Complainant, and did not ensure that there were no remaining needles after he was first informed about the needle on the Complainant's toe area.

15. 2nd Finding: The Board agrees with the IC that Mr Chua had failed to remove all the needles after the treatment due to his negligence. This would include the 2 needles on the Complainant's toe and head areas respectively.

16. 3rd Finding: The Board agrees with the IC that Mr Chua had failed to take sufficient steps to ensure that all the needles had been removed. Although Mr

Chua claimed that he done a visual scanning, he had still missed out on the 2 needles on the Complainant's toe and head areas. Mr Chua had also admitted that a visual scanning would be insufficient as it had resulted in him missing out on needles which were lodged in areas that he was *not* able to see.

17. 4th Finding: The Board agrees with the IC that Mr Chua had failed to record the needle count both during the acupuncture and when the needles were removed.

18. 5th Finding: The Board agrees with the IC that after Mr Chua was first informed about the needle on the Complainant's toe area, he had failed to take sufficient steps to ensure that there were no other remaining needles left in the Complainant (i.e. the needle on the head).

19. 6th Finding: The Board agrees with the IC that there was no or insufficient appropriate post-treatment care by Mr Chua. In particular, after Mr Chua found out about the second unremoved needle on 20 September 2021, Mr Chua should have called the Complainant timeously in accordance with paragraph 4.1.1(e) of the ECEG, which states that a TCM practitioner is to provide "*competent…and appropriate care to his patient*" and ensure that "*the most appropriate management is appropriately provided*".

20. 7th Finding: The Board agrees with the IC that the Complainant had suffered physical injury in the form of pain, discomfort and bleeding in his toe area and head area, as a result of Mr Chua's failure to remove the two needles after the acupuncture treatment.

C.3 Board's agreement with the 8th and 9th findings of the IC

21. Mr Chua has admitted that his conduct amounted to a breach of sections 19(1)(f) and 19(1)(i) of the Act and Regulation 2(2) of the Regulations.

22. In this regard, Mr Chua's offending conduct was his failure to remove all the needles after the acupuncture session, which had caused pain, discomfort and bleeding in the Complainant's toe area and head area. Such conduct would warrant the imposition of disciplinary sanctions, for being in breach of various provisions of the Act and paragraphs of the ECEG and GAA.

23. The Board concurs with the IC that Mr Chua'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 paragraph 4.1.1(e) of the ECEG) and also read with Regulation 2(2)(*b*) of the Regulations (for breaching Guideline 8.4 of the GAA):

(1) In breach of paragraph 4.1.1(e) of the ECEG, Mr Chua failed to provide competent and/or appropriate care to the Complainant when he did not remove all acupuncture needles from the Complainant. He did not ensure that there were no remaining needles after he was first informed about the unremoved needle on the Complainant's toe area. Mr Chua also did not call the Complainant timeously to check on his condition after he was informed that another needle had been left in the Complainant's head.

(2) Mr Chua's breach of paragraph 4.1.1(e) of the ECEG amounted to a breach of Regulation 2(2)(*a*) of the Regulations, for failing to comply with all standards of professional conduct and ethics determined by the Board.

(3) Further, in contravention of Guideline 8.4 of the GAA, Mr Chua failed to ensure that all needles had been removed from the Complainant.

(4) Mr Chua's contravention of Guideline 8.4 of the GAA would amount to a breach of Regulation 2(2)(*b*) of the Regulations, for failing to comply with all pronouncements on professional matters issued by the Board.

(5) As Mr Chua has breached Regulations 2(2)(*a*) and 2(2)(*b*) of the Regulations in failing to comply with all standards of professional conduct and ethics determined by the Board and all pronouncements on professional matters issued by the Board respectively, he would be in breach of section 19(1)(*f*) of the Act.

24. In addition, the Board concurs with the IC that Mr Chua's aforesaid conduct would constitute negligence under **section 19(1)(*i*)** of the Act:

(1) His aforesaid conduct amounted to professional negligence, as the same was committed in his professional capacity arising from his acupuncture treatment on the Complainant.

(2) His failure to take steps to ensure that all the needles had been removed had occurred not only once, but on at least 2 occasions.

(3) He had failed to call the Complainant timeously to check on his condition, after being informed about the additional needle which had been left on the Complainant's head.

(4) His conduct would fall so short of expectations as to warrant the imposition of disciplinary sanctions.

D. SENTENCE

25. 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.

26. With regard to **harm**, the Board is of the view that the harm caused by Mr Chua's conduct was at the lower end of "moderate". In this regard, Mr Chua's failure to remove the two needles had caused actual harm to the Complainant in the form of pain, discomfort, and bleeding in his toe and head areas. Such injury to the Complainant was foreseeable. Further, harm has been caused to the standing of and public confidence in the TCM profession.

27. In relation to **culpability**, the Board finds the level of culpability to be "low". Mr Chua's state of mind was negligent. He should have been more careful to check whether there were other unremoved needles on the Complainant, especially since he was already alerted to the first unremoved needle at the Complainant's toe area.

28. Arising from the "moderate" harm and "low" culpability in relation to Mr Chua, the applicable indicative sentencing range based on the *Wong Meng Hang* framework would be a suspension of up to 1 year.

29. Having regard to the levels of harm and culpability in the present case, the Board is of the view that the appropriate starting point in the present case would be a 3 months' suspension.

30. The Board has considered the mitigating circumstances raised by Mr Chua, but is of the view that they would not carry much weight in deciding on the appropriate sentence to be imposed.

31. Taking into consideration all the facts and circumstances of the present case, the Board has decided that Mr Chua's registration be suspended for 3 months and that he be censured, and has also ordered him 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 to pay the costs and expenses of or incidental to the inquiry.

Date of publication: 13 January 2025

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