IN THE REPUBLIC OF SINGAPORE
SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

Between
Singapore Medical Council

And
Dr Islam Md Towfique

… *Respondent*

Disciplinary Tribunal:
Prof Sonny Wang – Chairman
Dr David Ong Eng Hui
Mr Lim Wee Ming – Judicial Service Officer

Counsel for the Singapore Medical Council ("SMC"):
Mr Edmund Kronenburg
Ms Esther Lim
Ms Tammie Khor
(M/s Braddell Brothers LLP)

Counsel for the Respondent:
Mr Melvin See
Mr Mok Zicong
(M/s Dentons Rodyk & Davidson LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL ON NEWTON HEARING

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

Introduction

1. The Respondent is a registered medical practitioner, practising as an anaesthetist at Gleneagles Hospital ("**the Hospital**"). He pleaded guilty to a charge of professional misconduct, in failing to provide appropriate care and management to his patient ("**the Patient**"), such that his conduct amounts to such serious negligence that it objectively constitutes an abuse of the privileges which accompany registration as a medical practitioner.

2. Although the Respondent pleaded guilty to the charge, parties were unable to agree on various aggravating and mitigating factors raised. A Newton hearing was held for the Disciplinary Tribunal ("**the Tribunal**") to determine the issues relating to these factors.

Agreed Facts

3. The agreed facts in relation to the charge are contained in the Agreed Statement of Facts ("**ASOF**"). The relevant extracts are set out below.

4. On 1 September 2016, the Patient underwent an open reduction internal fixation bone cement right femur surgery ("**the Operation**"). The Operation took place from approximately 1430 to 1705 hours at the Hospital's Operating Theatre Number 4 ("**the Operating Theatre**"). The Respondent was the Patient's sole attending anaesthetist for the Operation. He was assisted by a nurse from the Hospital's anaesthetic unit, PW1 ("**the AU Nurse**").[1]

5. At all material times, the Respondent knew and/or ought to have known that:

   a) the Patient was considered a high anaesthetic risk patient as he was elderly (at 64 years old), obese (with a BMI of 32), as well as a person who had significant co-morbidity of ischaemic heart diseases (with a coronary stent and taking cardiac and anti-lipid medication), and multiple myeloma;

   b) the Operation which the Patient was scheduled to undergo was a high risk surgery, including inter alia the fact that the fracture suffered by the Patient was likely to be a pathological fracture secondary to multiple myeloma; and

   c) the appropriate care and management for the Patient required the Respondent to be constantly present while the Patient was under anaesthesia for the Operation.[2]

6. Despite the foregoing, the Respondent left the Operating Theatre several times on various occasions during the Operation. During these occasions, the Respondent was talking on his mobile phone.[3]

7. A responsible and competent anaesthetist is required to be constantly physically present by the patient's side to closely monitor a patient at all times during an operation ("**Benchmark Standard**").[4]

[1] Agreed Statement of Facts ("ASOF") at [8].
[2] ASOF at [9].
[3] ASOF at [10].
[4] ASOF at [11].

8. There were two sets of intervening doors between the Operating Theatre and the corridor immediately outside of the induction room and Operating Theatre. One set of doors led to the induction room, which was located between the Operating Theatre and the corridor, and the other set of doors led to the corridor. On one occasion when the Respondent was in the induction room, he looked at the Patient's vital signs monitor through the window of the door between the induction room and the operating theatre, but the relevant Benchmark Standard required him to have been constantly physically present by the Patient's side to closely monitor the Patient at all times during the Operation.[5]

9. The Respondent left the Operating Theatre several times during the Operation without briefing the AU Nurse as to what she should do in his absence. During these times, no trained / qualified anaesthetic personnel or medical officers were present to monitor the Patient in his absence.[6]

10. From the pre-anaesthetic assessment, the Respondent anticipated that the Patient would suffer from blood loss during the Operation. He was also aware that a small embolism and cardiac ischaemia were problems that could possibly arise during the Operation.[7]

11. Between approximately 1510 hours and 1520 hours, the Patient's Anaesthesia Vital Signs Report recorded the following $ETCO_2$ and non-invasive blood pressure ("**NBP**") readings.[8]

Time	1510	1515	1520
$ETCO_2$	32	32	30
NBPs	125	97	86
NBPd	69	45	40

12. The Respondent ordered cross-matched blood at around 1520 hours to address anticipated blood loss.[9]

13. Subsequently, at approximately 1540 hours, the alarm went off and both the Patient's SpO_2 and pulse reading from the SpO_2 finger probe became unreadable. The ECG monitor continued to have pulse and NBP readings. The SpO_2 finger probe was switched to the Patient's other fingers, but there was no reading recorded. No SpO_2 or pulse readings could be obtained with a SpO_2 ear probe either.[10]

[5] ASOF at [12].
[6] ASOF at [13].
[7] ASOF at [14].
[8] ASOF at [15].
[9] ASOF at [16].
[10] ASOF at [17], [18].

14. The Respondent ordered emergency blood thereafter.[11]

15. The Hospital's CCTV recordings also showed that the Respondent was in the corridor when blood products were brought into the Operating Theatre. The Respondent returned to the Operating Theatre after that. The blood products were cross-checked by two nurses and confirmed by the Respondent. The Respondent then instructed commencement of the blood transfusion and the cross-matched blood was transfused into the Patient by the AU Nurse. There was no delay in the transfusion of blood into the Patient.[12]

16. As a result of the Respondent's absences from the Operating Theatre when the Operation was being performed on the Patient, he failed to detect, recognise and/or closely monitor the changes in the Patient's vital signs and failed to initiate early supportive and resuscitative treatments when the Patient suffered from intraoperative acute pulmonary embolism.[13]

17. The Respondent wrongly judged that he could leave the Operating Theatre during the Operation to make phone calls, as he thought that he did not leave the Patient too far away and was contactable in seconds. He wrongly assessed that he was able to handle the total management of the Patient by anticipating the Patient's needs in advance, based on his experience and knowledge.[14]

18. The Patient suffered from cardiac arrest in the Operating Theatre, but was resuscitated by a team which included the Respondent, Dr FW2, Dr FW3, and Dr FW4. The Patient was then sent to the intensive care unit to recover.[15]

19. Unfortunately, the Patient passed away the next day. A post-mortem report reported findings in relation to the pulmonary arteries that there were coils of dark red, thromboemboli lodged at the bifurcation of the main pulmonary artery resulting in near-complete occlusion of the arterial lumen. The cause of death was stated as pulmonary thromboembolism.[16]

20. The chances of the Patient surviving a massive pulmonary embolism would be very low. While the chances of the Patient's survival were low, they may have been further lowered by the

[11] ASOF at [19].
[12] ASOF at [20].
[13] ASOF at [21].
[14] ASOF at [22].
[15] ASOF at [23].
[16] ASOF at [24].

Respondent's delay in recognising the changes in the Patient's vital signs and consequent delay in initiating supportive and resuscitative treatments.[17]

21. The Respondent therefore failed to provide appropriate care, management and treatment to the Patient. His conduct in repeatedly leaving the Operating Theatre during the Operation was in breach of Guideline 4.1.1.5 of the 2002 edition of the SMC's Ethical Code and Ethical Guidelines ("**2002 ECEG**") in force at the material time.[18]

Guideline 4.1.1.5

22. The relevant extract from the aforesaid Guideline 4.1.1.5 is as follows:

> 4.1.1.5 Duty of care
>
> 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.[19]

Newton hearing

23. There were nine mitigating facts that were raised by the Respondent that were disputed by SMC. On SMC's side, it raised five aggravating facts that were disputed by the Respondent. A Newton hearing was held for the Tribunal to hear the evidence and make a determination on these disputed facts.

24. The Respondent has submitted that the burden and standard of proof is as follows:

a) In relation to mitigating facts, the Respondent has the burden of proving its case on the balance of probabilities – *Public Prosecutor v Aniza bte Essa* [2009] 3 SLR I 327 at [57], *R v Storey* [1998] 1 VR 359 and *Chang Kar Meng v Public Prosecutor* [2017] 2 SLR 68 at [42].[20]

b) In relation to aggravating facts, the burden falls upon SMC as prosecution, to prove these facts beyond reasonable doubt. The Respondent relies on the cases of *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [41]-[43], *K Saravanan*

[17] ASOF at [24].
[18] ASOF at [25].
[19] Amended Notice of Inquiry by Disciplinary Tribunal ("NOI") at 55.
[20] Respondent's Written Submissions at [12]-[15].

Kuppusamy v Public Prosecutor [2016] 5 SLR 88 at [27] and *Rupchang Bhojwani Sunil v Public Prosecutor* [2004] 1 SI(R) 596 at [18].[21]

25. The Respondent's position on the burden and standard of proof is not disputed by SMC.

26. The witnesses at the Newton hearing were:

a) Witnesses for SMC:

i) PW1, the AU Nurse.

ii) PW5, the circulating nurse ("**the Circulating Nurse**").

iii) PW6, Senior Manager in the Clinical Safety and Risk Management team ("**Ms PW6**").

iv) Dr PE, SMC's expert witness ("**Dr PE**").

b) Witnesses for the Respondent:

i) The Respondent.

ii) Dr DW1, the surgeon for the Operation ("**the Surgeon**").

iii) Dr DE, the Respondent's expert witness ("**Dr DE**").

Respondent's Position

27. The following factual issues relate to mitigating facts that the Respondent intends to rely on at sentencing and are required to be proven by the Respondent:

a) **Issue 1**: Whether the Respondent had informed any medical personnel present during the Operation that he intended to leave the Operating Theatre, before leaving.

b) **Issue 2**: Whether the Respondent had told the AU Nurse at various times during the Operation that "I am outside, I am making phone call" or "I'm here, I am making a phone call".

c) **Issue 3**: Whether the Respondent gave a series of instructions to the AU Nurse when the Patient's SpO2 became unreadable – to switch the SpO2 finger probe to other fingers, change the cable, try an ear probe, and try the nose tip – before stepping out to the induction room.

[21] Respondent's Written Submissions at [6]-[11].

d) **Issue 4**: The size, shape and visibility through the windows on the intervening doors between the Operating Theatre and the induction room.

e) **Issue 5**: Whether the Respondent instructed the AU Nurse to get the Rapid Infusion System in the Operating Theatre ready, prime the blood set and get the help of senior Anaesthesiology Unit nurses to manage the patient together after the Respondent noticed that the Patient had low blood pressure and the Respondent checked the operation site oozing.

f) **Issue 6**: Whether it is standard practice, for the type of operation that the Patient underwent, for cross-matched blood to be ordered for anticipated blood loss.

g) **Issue 7**: Whether the Respondent had managed the Patient's blood pressure by administering fluids and medication until blood was made available in the Operating Theatre.

h) **Issue 8**: Whether it is common practice for anaesthetists to leave patients who are stable with nurses from the Hospital's anaesthesiology unit during breaks or when stepping out for phone calls.

i) **Issue 9**: Whether it is common practice for anaesthetists to "monitor" patients who are stable from the induction room.

SMC's Position

28. The following factual issues relate to aggravating facts that SMC intends to rely on at sentencing and are required to be proven by SMC:

a) **Issue 10**: Whether the Respondent was in the Operating Theatre or was speaking on his mobile phone in the induction room outside of the Operating Theatre, when the AU Nurse found that there was no saturation (i.e. SpO_2) reading captured for the Patient.

b) **Issue 11**: Whether the Respondent returned to the Patient's side to check on him immediately after the AU Nurse informed the Respondent that there was no saturation reading captured for the Patient, or whether the Respondent had instead instructed the AU Nurse to retrieve an ear SpO_2 probe.

c) **Issue 12**: Whether the Respondent returned to the Operating Theatre from the induction room outside the Operating Theatre only after the AU Nurse informed the Respondent that she could not obtain any readings with the SpO2 ear probe.

d) **Issue 13**: Whether the Respondent was by the Patient's side in the Operating Theatre when the Patient was experiencing substantial blood loss.

e) **Issue 14**: Whether the Respondent was by the Patient's side in the Operating Theatre when the Patient's blood pressure was unreadable.

Disciplinary Tribunal's Findings and Decision on Newton Hearing

Mitigating factors

29. We will first deal with the issues relating to the mitigating facts raised by the Respondent.

30. Both SMC and the Respondent have dealt with issues 1 and 2 together. We will similarly, deal with these two issues together as well.

Issue 1: Whether the Respondent had informed any medical personnel present during the Operation that he intended to leave the Operating Theatre, before leaving the Operating Theatre
Issue 2: Whether the Respondent had told the AU Nurse at various times during the Operation that "*I am outside, I am making phone call*" or "*I'm here, I am making a phone call*"

31. The Respondent's evidence is that he informed the AU Nurse when he left the Operating Theatre.[22] The evidence of the AU Nurse is that that the Respondent stepped out of the Operating Theatre without informing anyone, including herself.[23]

32. The Respondent has submitted that the evidence of the AU Nurse was that she never had to page the Respondent for him to return to the Operating Theatre, which suggests that she was in fact aware of the Respondent's location when he was not in the Operating Theatre and that the Respondent must have informed her of his location.[24]

33. The Respondent has further submitted that as the evidence of the AU Nurse was that she was so engrossed in her paperwork that she did not notice the Respondent leaving the Operating

[22] Respondent's Witness Statement at [11].
[23] AU Nurse's Witness Statement at [11].
[24] Respondent's Written Submissions at [24], [25].

Theatre, it is possible that she also did not register what the Respondent had said before he left the Operating Theatre.[25] The Respondent relies on the evidence of the ANU Nurse that "*When I was filling in the paperwork, I was facing the wall of the operating theatre, with my back to the Patient and to Dr Towfique. I also looked downwards, at the tabletop. When I looked up from the paperwork I was preparing, I noticed that Dr Towfique was not in the operating theatre*."[26]

34. The Respondent's further argument is that the evidence of the AU Nurse is that anaesthetists do inform the AU nurses when they are stepping out for a short while. The Respondent seeks to rely on this, in support of his submission "that [his] behaviour would not be that different from that of his other anaesthetic colleagues."[27]

35. In the light of the aforesaid evidence from the AU Nurse, we are prepared to accept the Respondent's evidence that he had informed the AU Nurse before he stepped out of the Operating Theatre.

36. However, the Tribunal remains concerned on the following matters:

a) The Respondent left a high risk patient undergoing a high risk surgery, under the care of the AU Nurse. The Respondent's position is that he had informed the AU Nurse that he was leaving the Operating Theatre, but submits that she may not have registered what he said because she was engrossed in paperwork. The Tribunal is concerned that the Respondent did not ensure that the AU Nurse acknowledge that she had heard the Respondent and was aware that he was leaving the Operating Theatre.

b) In view of the multiple occasions that the Respondent left the Operating Theatre, it does not appear to be clear, even from the Respondent's own evidence, that he had informed the AU Nurse on every such occasion.

c) In the light of the evidence that it is the usual practice of anaesthetists leaving the operating theatre to inform the AU nurses, to what extent if any, should the Respondent's conduct in following this usual practice, amount to a mitigating factor. In other words, should it amount to a mitigating factor, for the Respondent to merely conduct himself within the standard that is expected of him as an anaesthetist.

[25] Respondent's Written Submissions at [35].
[26] AU Nurse's Witness Statement at [12].
[27] Respondent's Written Submissions at [37].

37. The parties are to address the above concerns in the sentencing submissions and mitigation plea.

Issue 3: Whether the Respondent gave a series of instructions to the AU Nurse when the Patient's SpO_2 became unreadable – to switch the SpO_2 finger probe to other fingers, change the cable, try an ear probe, and try the nose tip – before stepping out to the induction room

38. The evidence of the Respondent is that between 1540 to 1545 hours, the Patient's SpO_2 became unreadable and that he was next to the Patient at that time. He instructed the AU Nurse to change the SpO2 probe to another finger, and if there was still no reading to change the cable of the probe, to change to a new finger probe, to try an ear probe and to try the nose tip. After giving these directions, he stepped into the induction room.[28]

39. The evidence of the AU Nurse is that at about 1541 hours, the SpO_2 reading became unreadable and that the Respondent was not in the Operating Theatre at this time. After trying to troubleshoot the problem without success, she went to the induction room where the Respondent was speaking on his mobile phone to inform him that there was no SpO_2 reading. The Respondent told the AU Nurse to try an SpO_2 ear probe. The AU Nurse went out to fetch the SpO_2 ear probe and returned to see the Respondent still speaking on his mobile phone in the induction room. She then fixed the SpO_2 ear probe in the Patient's ear, but still could not get a reading.[29]

40. The Respondent has submitted that "*Dr DW1 has given evidence that, at one point during the Operation, he heard the alarm go off when the pulse oximeter stopped recording, and he stopped the surgery to look up and make sure that the situation was being attended to. He noticed that Dr Islam was checking on the Patient.*"[30] SMC has submitted that Dr DW1's evidence in this respect is inconclusive, as Dr DW1 conceded that he did not look up immediately after he heard the alarm go off.[31] However, the Respondent has pointed out that Dr DW1's evidence is that the time between the alarm going off and Dr DW1 looking up and seeing the Respondent was just a few seconds.[32]

41. Furthermore, the Respondent's evidence is that "*The fact that I was in the Operating Theatre between 1540 and 1545 hours is evident from the fact that the Patient's respiratory rate was adjusted from 15 rpm to 10 rpm between 1540 hours and 1545 hours. As the sole attending*

[28] Respondent's Witness Statement at [18] – [22].
[29] AU Nurse's Witness Statement at [18] – [21].
[30] Respondent's Reply Submissions at [49].
[31] SMC's Closing Submissions at [43(a)].
[32] Respondent's Reply Submissions at [53].

anaesthetist for the Operation, I was the only person who would have been able to adjust the respiratory rate."[33] This is supported by the evidence from SMC's expert, Dr PE, that based on the change in ventilator, the Respondent could have been by the Patient from 1541 to 1545 hours.[34]

42. In the light of the aforesaid evidence from Dr DW1 and Dr PE that supports the Respondent's position, the Tribunal accepts the Respondent's evidence that he gave a series of instructions to the AU Nurse when the Patient's SpO_2 became unreadable, before stepping out into the induction room.

43. However, this finding is not necessarily in favour of the Respondent. Parties are to address the Tribunal in the sentencing submissions and mitigation plea, as to whether the Respondent in leaving the Operating Theatre, even though the Patient's SpO_2 became unreadable, is an aggravating rather than mitigating factor.

44. Furthermore, we note that the Respondent in his letter dated 31 January 2018 to the Singapore Medical Council, setting out his explanation in response to the Notice of Complaint, stated that "*I was with the patient and did apply my expertise to keep the Haemodynamics but I forgot to increase the oxygen to 100%.*"[35] In an earlier letter dated 14 February 2017 from Parkway Pantai Limited to the Respondent, it was stated "*the patient's SpO_2 readings had started to decline ... It fell below 90%... into the 80s and 70s, and became undetectable on various occasions. Despite this, the oxygen delivery was not adjusted upwards, but was maintained at 42% ... Increasing the oxygen delivery is one of the first few actions that an anaesthetist should initiate when a patient's SPO_2 falls, and yet for almost 50 minutes, with the SpO_2 either un-recordable or in an unacceptable range, this remedial action was not taken.*"[36] Parties are to address in the sentencing submissions and mitigation plea, the impact of the aforesaid facts in determining the sentence to be imposed on the Respondent.

Issue 4: The size, shape and visibility through the windows on the intervening doors between the Operating Theatre and the induction room

45. The key point here is whether the Respondent could from the induction room, see into the Operating Theatre through the windows on the intervening doors.

[33] Respondent's Witness Statement at [20].
[34] Transcript (5 July 2022) at 47-48.
[35] Agreed Bundle of Documents ("ABD") at 20.
[36] ABD31.

46. SMC has submitted that "*When Dr Islam was in the induction room, he was likely to have been visible through the 2016 Windows. The AU Nurse could therefore have spotted him in the induction room through the 2016 Windows when she was looking for him. The AU Nurse has in fact testified that she did, in fact, see Dr Islam in the induction room from the Operating Theatre at least once*".[37]

47. If the AU Nurse could see the Respondent in the induction room from the Operating Theatre through the windows, it is clear that the Respondent could similarly see into the Operating Theatre from the Induction Room through the same windows.

48. Furthermore, the Agreed Statement of Facts provides that "*On one occasion when the Respondent was in the induction room, he looked at the Patient's vital signs monitor through the window of the door between the induction room and the operating theatre*".[38]

49. In the premises, the Tribunal finds that the Respondent was able to see into the Operating Theatre from the Induction Room, through the windows on the intervening doors.

Issue 5: Whether the Respondent instructed the AU Nurse to get the Rapid Infusion System in the Operating Theatre ready, prime the blood set and get the help of senior Anaesthesiology Unit nurses to manage the Patient together after the Respondent noticed that the Patient had low blood pressure and the Respondent checked the operation site oozing

50. The Respondent's evidence is that he had instructed the AU Nurse to get the Rapid Infusion System in the Operating Theatre ready, so that the blood could be quickly transfused, the moment it arrived in the Operating Theatre. He further asked the AU Nurse to seek help from other nurses.[39]

51. The AU Nurse disagreed with this account.[40]

52. SMC has submitted that the Respondent's evidence on this issue was inconsistent in that he "initially testified that on one instance when he was on the phone in the induction room, he pushed open the door between the induction room and the Operating Theatre to "*give the instructions [to the medical personnel] for the rapid transfusion set and what they are going to do*". However, he changed his story on the next day of the Newton Hearing and testified that

[37] SMC's Reply Submissions at [11(a)].
[38] ASOF at [12].
[39] Respondent's Witness Statement at [16]-[17].
[40] Transcript (2 November 2021) at 109, lines 12-18.

he had already given instructions to the medical personnel for the rapid transfusion at about 1520 hours to 1525 hours when he was in the Operating Theatre, and had later pushed open the door between the induction room and the Operating Theatre (when he was in the induction room) to check whether the rapid transfusion had been performed."[41]

53. The Respondent has pointed out that the Respondent's evidence was not inconsistent, as the Respondent's initial evidence, explained that he had already given instructions to the medical personnel.[42]

54. The Respondent has submitted that as it is an agreed fact that there was no delay in the transfusion of blood into the Patient, it is more likely that the medical team was ready to receive the cross-matched blood which the Respondent had ordered earlier, and that he had prepared the team to receive the blood by giving instructions in relation to the transfusion of blood, including setting up of the Rapid Infusion System.[43]

55. As the Agreed Statement of Facts states that "*There was no delay in the transfusion of blood into the Patient*",[44] we accept the Respondent's submission on this issue.

56. Nevertheless, we are concerned that the Respondent from his own evidence was giving instructions from the induction room when there was massive blood transfusion to be carried out. His evidence in this respect, which is referred to in the Respondent's reply submissions,[45] is that:

> … I have given the instruction that prime up with the normal saline, rapid transfusion system and activate the massive blood transfusion for this case. I told, the FW7 came. So I was in the induction room, I said, "Have you done? How far it gone?" So because it's here and there, I have given the instructions, and they could take the instructions. So when the blood came, same thing, I went in with the blood, and have you checked, they checked, I checked and they started the blood immediately.[46]

57. Parties are to address the aforesaid concern in the sentencing submissions and the mitigation plea, and how this may impact on the sentence to be determined.

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[41] SMC's Submissions at [48(b)].
[42] Respondent's Reply Submissions at [18].
[43] Respondent's Written Submissions at [52].
[44] ASOF at [20].
[45] Respondent's Reply Submissions at [19].
[46] Transcript (5 July 2022) at 124, lines 4 to 13.

Issue 6: Whether it is standard practice, for the type of operation that the Patient underwent, for cross-matched blood to be ordered for anticipated blood loss

58. As for this issue, both parties' experts agree that it is not standard practice for the type of operation that the Patient underwent, for cross-matched blood to be ordered for anticipated blood loss.[47]

59. In the premises, the Tribunal accepts the agreed evidence of both parties' experts on this issue.

Issue 7: Whether the Respondent had managed the Patient's blood pressure by administering fluids and medication until blood was made available in the Operating Theatre

60. In relation to this issue, the Respondent submits:

a) The Respondent's evidence is that at 1520 hours, he administered ephedrine and fluids; and at 1530 hours, he once again administered ephedrine and fluids. The Respondent submits that this is consistent with the Respondent's letter of explanation to the SMC dated 31 January 2018.[48]

b) The evidence of SMC's expert, Dr PE, was that although it is "*not definite*" that the changes in the Patient's blood pressure levels from 1520 hours to 1525 hours and 1530 hours to 1535 hours were due to administration of ephedrine, it "*could very well be*" that the Respondent did indeed administer ephedrine for the Patient.[49]

c) Dr DE, the Respondent's expert, agreed that the Respondent's management actions are consistent with the medical records, which the Respondent's submissions describes as contemporaneous.[50] However, the Tribunal notes that in the expert report of Dr DE, he relies on the aforesaid letter of explanation from the Respondent to SMC, when he refers to the administration of ephedrine.[51] This letter of explanation dated 31 January 2018, more than a year after the Operation, is not contemporaneous.

[47] SMC's Closing Submissions at [44], Respondent's Closing Submissions at [55], [56].
[48] Respondent's Written Submissions at [60].
[49] Respondent's Written Submissions at [62].
[50] Respondent's Written Submissions at [61].
[51] ABD108 at [17], footnote 10, ABD 111 at [30], footnote 23.

61. SMC relies on the lack of contemporaneous records showing whether the Respondent had administered any medications to raise the Patient's blood pressure, to rebut the Respondent's position.[52]

62. The Tribunal agrees with SMC that the lack of contemporaneous records showing whether the Respondent had administered any medications to raise the Patient's blood pressure is troubling. No explanation has been given by the Respondent to explain the absence of such contemporaneous records.

63. Dr PE's evidence on the absence of contemporaneous records is set out in his expert report dated 11 June 2020 (at [12d]) as follows:

> The administration times of resuscitation medications were also not recorded clearly (e.g. ephedrine, atropine, adrenaline boluses) in the Anaesthesia Record Chart. For example, I could not tell whether the ephedrine was given at the time when the patient "collapsed" i.e. developed severe bradycardia around 1620 – 1625 (as documented by Dr Islam at 1800 on 1 September 2016 in the Clinician's Collaborative Progress Notes …), or at an earlier stage of the surgery when the Patient developed hypotension, at 1550, as Dr Islam indicated in his report to the SMC dated 31 January 2018 …[53]

64. The aforesaid evidence from Dr PE on the lack of contemporaneous records was not challenged in cross-examination.

65. In the absence of contemporaneous records showing that the Respondent had administered medications to raise the Patient's blood pressure and the lack of any explanation from the Respondent on why there were no such contemporaneous records, the Tribunal is not satisfied that the Respondent has proven on the balance of probabilities that he had administered medications to raise the Patient's blood pressure. The mere possibility that the improvement in the Patient's blood pressure could be due to the administration of ephedrine, is in the view of the Tribunal, insufficient to establish as a fact that ephedrine was administered to manage the Patient's blood pressure.

<u>Issue 8: Whether it is common practice for anaesthetists to leave patients who are stable with nurses from the Hospital's anaesthesiology unit during breaks or when stepping out for phone calls</u>

[52] SMC's Closing Submissions at [50(a)].
[53] ABD56.

66. On this issue, the Respondent relies on the evidence of the Respondent,[54] Dr DW1,[55] Dr DE,[56] the AU nurse[57] and the Circulating Nurse,[58] to support his position that it is common for anaesthetists to leave patients who are stable with nurses from the Hospital's anaesthesiology unit during breaks or when stepping out for phone calls.

67. The SMC relies on the evidence of Dr PE[59] and Ms PW6[60], that this is not the common practice.

68. However, Dr PE did accept that anaesthetists do go for breaks during an operation.[61] Ms PW6's evidence was that anaesthetists "*do leave when they need to go to toilet for toilet break, but nobody leaves the patient unattended without handing over and for phone calls along the corridor … for quite a long duration*".[62]

69. In the premises, the Tribunal accepts the Respondent's submission, that it is common practice for anaesthetists to leave patients who are stable with nurses from the Hospital's anaesthesiology unit during breaks or when stepping out for phone calls.

70. Nevertheless, we note that SMC has further raised that "*Even if it is indeed common practice for anaesthetists to leave patients who are stable with nurses from the Hospital's Anaesthesiology Unit during breaks or when stepping out for phone calls (which the SMC does not accept), the crucial fact remains that Dr Islam left the Operating Theatre when the Patient was not stable on at least 4 separate occasions.*"[63] The Tribunal will fully consider and address this point raised by SMC, after it is dealt with by both parties in the sentencing submissions and mitigation plea.

71. The parties are further directed to address in the sentencing submissions and mitigation plea, the extent if any, a common practice which is in breach of the 2002 ECEG, amounts to a mitigating factor.

72. We further note that the Agreed Statement of Facts provides as follows:

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[54] Respondent's Written Submissions at [66c].
[55] Respondent's Written Submissions at [66d].
[56] Respondent's Written Submissions at [66e].
[57] Respondent's Written Submissions at [66a].
[58] Respondent's Written Submissions at [66b].
[59] SMC's Closing Submissions at [61].
[60] SMC's Closing Submissions at [62].
[61] Transcript (5 July 2022) at pages 7, 8, 11.
[62] Transcript (2 November 2021) at pages 199-200.
[63] SMC's Closing Submissions at [64].

a) the Patient was considered a high anaesthetic risk patient as he was elderly, (at 64 years old), obese (with a BMI of 32) as well as a person who had significant co-morbidity of ischaemic heart diseases (with a coronary stent and taking cardiac and anti-lipid medication), and multiple myeloma,[64] and

b) the Operation which the Patient was scheduled to undergo was a high risk surgery, including *inter alia* the fact that the fracture suffered by the Patient was likely to be a pathological fracture secondary to multiple myeloma.[65]

73. Parties are to address in the sentencing submissions and mitigation plea, the impact on sentence of the Respondent leaving the Operating Theatre on multiple occasion to make phone calls, in view of the Patient being a high anaesthetic risk patient undergoing high risk surgery.

Issue 9: Whether it is common practice for anaesthetists to "monitor" patients who are stable from the induction room

74. The Respondent has in his evidence and submissions accepted that "it is not a common practice for anaesthetists to monitor patients from the induction room."[66]

75. In the premises, the Tribunal finds that it is not the common practice for anaesthetists to monitor patients who are stable from the induction room.

76. Nevertheless, the Tribunal is concerned that up to the Newton hearing, it would appear that the Respondent took the position that it was common for anaesthetists to monitor patients who are stable from the induction room and sought to have this considered as a mitigating factor. The Respondent only conceded that "It is not a common practice and it is not recommended",[67] when he was cross-examined on this point at the Newton hearing. Parties are to address in the sentencing submissions and mitigation plea, how this should impact on the sentence to be determined.

Aggravating factors

77. We will move on to the issues relating to the aggravating factors raised by SMC.

[64] ASOF at [9(a)].
[65] ASOF at [9(b)].
[66] Respondent's Written Submissions at [75].
[67] Transcript (5 July 2022) at 118, lines 4-12.

Issue 10: Whether the Respondent was in the Operating Theatre or was speaking on his mobile phone in the induction room outside of the Operating Theatre, when the AU Nurse found that there was no saturation (i.e. SpO_2) reading captured for the Patient

78. Issue 10 overlaps with issue 3, which we have found in favour of the Respondent. To recap, in relation to issue 3, the Tribunal accepts that the Respondent gave a series of instructions to the AU Nurse when the Patient's SpO_2 became unreadable, before stepping out into the induction room.

79. In the premises, in relation to issue 10, the Tribunal similarly finds that the Respondent was in the Operating Theatre when the AU Nurse found that there was no saturation (i.e. SpO_2) reading captured for the Patient.

Issue 11: Whether the Respondent returned to the Patient's side to check on him immediately after the AU Nurse informed the Respondent that there was no saturation reading captured for the Patient, or whether the Respondent had instead instructed the AU Nurse to retrieve an ear SpO2 probe

80. Issue 11 overlaps with issues 3 and 10. In the light of the Tribunal's aforesaid findings on issues 3 and 10, the Tribunal similarly finds that the Respondent was in the Operating Theatre when there was no saturation reading captured for the Patient.

Issue 12: Whether the Respondent returned to the Operating Theatre from the induction room outside the Operating Theatre only after the AU Nurse informed the Respondent that she could not obtain any readings with the SpO_2 ear probe

81. Similarly, issue 12 follows from issues 3, 10 and 11.

82. In the light of the aforesaid findings in relation to issues 3, 10 and 11, in relation to issue 12, the Tribunal finds that SMC's position that the Respondent returned to the Operating Theatre only after the AU Nurse informed the Respondent that she could not obtain any readings with the SpO_2 ear probe, has not been proven beyond a reasonable doubt.

Issue 13: Whether the Respondent was by the Patient's side in the Operating Theatre when the Patient was experiencing substantial blood loss

83. Issue 13 overlaps with issue 5.

84. In relation to issue 5, although the Tribunal has accepted the Respondent's position on this issue, the Tribunal has expressed its concern that the Respondent from his own evidence was giving instructions from the induction room when there was massive blood transfusion to be carried out.[68]

85. The Respondent further gave evidence that he was in the corridor at the time the bleeding was happening. When questioned by the Tribunal's Dr Ong that "*you were actually in the corridor when the bleeding was happening*", the Respondent's reply was "*Yah, the bleeding is a continuous process, not one time. So I have activated my work and I came back.*"[69]

86. In the light of the Respondent's own evidence that he was giving instructions from the induction room when there was massive blood transfusion to be carried out and that he was in the corridor when the bleeding was happening, the Tribunal finds that there were occasions when the Respondent was not by the Patient's side in the Operating Theatre when the Patient was experiencing substantial blood loss.

Issue 14: Whether the Respondent was by the Patient's side in the Operating Theatre when the Patient's blood pressure was unreadable

87. SMC has submitted that "*it is undisputed that the Patient's blood pressure (NBPs) was unreadable from 1550 hours to 1600 hours*".[70] Based on the Vital Signs Report, the Patient's blood pressure was unreadable at 1550 and 1555, with the blood pressure only becoming readable again at 1600.[71]

88. SMC's position is that the Respondent was in the corridor for four minutes from 1553 to 1557 hours, during the period when the Patient's blood pressure was unreadable.[72] This is based on SMC's submission on the adjustment of the timing in the CCTV records. Based on this adjusted timing, Code Blue would have taken place at 1616 hours.

89. However, the Respondent's position is that based on the Cardiopulmonary Resuscitation Record, the evidence from the AU Nurse, and the evidence from Dr PE that "*The likely point where Code Blue would have been pressed would be 1625, because the heart rate dropped from 52 to 25. So that is quite a significant drop and I mean, a heart rate of 25 is extremely unusual*

[68] Transcript (5 July 2022) at 124, lines 4 to 13.
[69] Transcript (6 July 2022) at 140, lines 9 to 15.
[70] SMC's Closing Submissions at [58].
[71] ABD25.
[72] SMC's Closing Submissions at [13.5].

and life-threatening in fact", "*it is more likely that Code Blue was called at 1625 hours than 1616 hours*".[73]

90. In the light of the aforesaid evidence from the Cardiopulmonary Resuscitation Record, the AU Nurse and Dr PE, the Tribunal agrees that it is more likely that Code Blue was called at 1625, rather than 1616 hours.

91. Based on that Code Blue Timing which is nine minutes later than the time relied upon by SMC, the four minutes that the Respondent was in the corridor would be from 1602 to 1606, instead of 1553 to 1557. In the circumstances, it appears that the Respondent went to the corridor at 1602, just two minutes after the blood pressure became readable again at 1600.

92. In the premises, the Tribunal finds that in relation to issue 14, the Respondent was by the Patient's side in the Operating Theatre when the Patient's blood pressure was unreadable.

93. However, parties are to address the Tribunal in their sentencing submissions and mitigation plea, on whether the Respondent stepping out of the Operating Theatre at 1602, almost immediately after the first readable blood pressure record at 1600, following two instances when the blood pressure was unreadable at 1550 and 1555, is an aggravating factor.

94. This Newton hearing is hereby concluded. The Tribunal has previously given directions on the timelines for parties to file the sentencing submissions and mitigation plea. The sentencing submissions and mitigation plea are to be based on the aforesaid findings, as well as address the matters directed by the Tribunal herein to be dealt with by the parties.

Dated this 12th day of October 2022.

[73] Respondent's Written Submissions at [108].