IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2022] SMCDT 5

Between

Singapore Medical Council

And

Dr Islam Md Towfique

... Respondent

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

Contents

Singapore Medical Council
v
Dr Islam Md Towfique

[2022] SMCDT 5

Disciplinary Tribunal – DT Inquiry No 5 of 2022
Prof Sonny Wang Yee Tang (Chairman), Dr David Ong Eng Hui, Mr Lim Wee Ming (Judicial Service Officer)
2 November 2021, 5, 6 July, 12 October and 28 November 2022

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

30 November 2022

GROUNDS OF DECISION

(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 ("**the Newton hearing issues**").

3. After the Newton hearing, the Tribunal issued its decision on the Newton hearing issues on 12 October 2022 ("**Newton hearing decision**"). The relevant extracts from the Agreed Statement of Facts ("**ASOF**") and the Tribunal's findings on the Newton hearing issues are set out in the Newton hearing decision. The Grounds of Decision herein are to be read together with the Grounds of Decision for the Newton hearing.

4. In its Newton hearing decision, the Tribunal also directed the parties to address the Tribunal on various concerns of the Tribunal, in the sentencing submissions of the parties.

Submissions on sentencing

5. The parties thereafter filed its written submissions on sentencing.

6. Both parties relied on the four-step sentencing framework in *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("*Wong Meng Hang*"), as follows:

   (a) Step 1: Evaluate the seriousness of the offence with reference to harm and culpability.

   (b) Step 2: Identify the applicable indicative sentencing range using the following sentencing matrix set out in *Wong Meng Hang* (at [33]), as a guide:

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

(c) Step 3: Identify the appropriate starting point within the indicative sentencing range.

(d) Step 4: Adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

Prosecution's Submissions on Sentence

7. The Singapore Medical Council ("**SMC**") submitted that in relation to step 1, the harm caused was at the highest end of the moderate range for the following reasons:

(a) It is not disputed that the Respondent's misconduct may have lowered the Patient's chances of survival. Even though the Patient's chances of survival from a pulmonary embolism were low, they may have been further lowered by the Respondent's delay in recognising the changes in the Patient's vital signs and consequent delay in initiating supportive and resuscitative treatments.[1]

(b) There was substantial potential for the Respondent's conduct to cause serious personal injury to the Patient. When a patient is under general anaesthesia, the patient's basic bodily functions such as breathing, are largely dependent on the anaesthetist. The Respondent's repeated absences from the Patient's side during

[1] SMC's Submissions on Sentencing ("SMC's Sentencing Submission") at [26].

the Operation could have resulted in serous personal injury or even death to the Patient.[2]

(c) The Respondent's misconduct caused significant harm to public confidence in the medical profession as the public would be shocked to learn that patients under general anaesthesia may not be closely monitored by their attending anaesthetist.[3]

(d) The Respondent's misconduct caused significant harm to the public healthcare system as his conduct in repeatedly leaving a high-risk patient's side during a high-risk operation, while the Patient was not stable, greatly undermined the rationale for requiring an attending anaesthetist to be constantly present by a patient's side because of his important role in managing the patient under anaesthesia.[4]

8. SMC further submitted that the Respondent's culpability was high for the following reasons:

(a) The standard which the Respondent failed to uphold was a basic and elementary professional standard, which the Respondent departed from by leaving the Patient's side multiple times up to 9 minutes at a time, when he had no good reason for doing so, and could have avoided the phone calls he took during the Operation.[5]

(b) The Respondent repeated the offending conduct of leaving the Patient's side on at least four separate occasions.[6]

(c) The Respondent's misconduct led him to fail to take prompt action in that:

[2] SMC's Sentencing Submission at [27].
[3] SMC's Sentencing Submission at [28].
[4] SMC's Sentencing Submissions at [29].
[5] SMC's Sentencing Submissions at [32].
[6] SMC's Sentencing Submissions at [33].

(i) He forgot to increase the Patient's oxygen to 100%.[7]

(ii) There was no contemporaneous evidence to prove that the Respondent had administered medications to raise the Patient's blood pressure when it became unreadable.[8]

(d) The Respondent demonstrated a reckless or wilful disregard for the Patient's welfare and interest in leaving the Patient's side repeatedly, despite knowing that it was a high-risk Operation on a high-risk patient, whose parameters were deteriorating.

9. As for steps 2 and 3, based on high culpability and the highest end of moderate harm of the Sentencing Matrix, SMC submitted that the appropriate starting point within the indicative sentencing range is a suspension of 36 months. SMC submitted that the sentence imposed should send a deterrent message to the medical profession that it is unacceptable for anaesthetists to leave the monitoring of their patients to anaesthetic unit nurses during operations, since such conduct undermines the public's confidence in the medical profession and poses harm to the public healthcare system.[9]

10. As for step 4, SMC submitted that there should not be any discount given for any purported delay in prosecution, as it was necessary to investigate the multiple instances in which Respondent left the Operating Theatre and match those findings with the fluctuations in the Patient's vital signs.[10] Nor should any weight be given for the Respondent's plea of guilt, as the evidence against the Respondent was overwhelming, in view of the CCTV records.[11]

11. SMC further relied on, inter alia, the following matters to support its argument that there was no genuine remorse from the Respondent:

[7] SMC's Sentencing Submissions at [34(a)].
[8] SMC's Sentencing Submissions at [34(b)].
[9] SMC's Sentencing Submissions at [43].
[10] SMC's Sentencing Submissions at [44(b)].
[11] SMC's Sentencing Submissions at [48(a)].

(a) The Respondent only abandoned his allegation that it is a common practice for anaesthetists to monitor patients who are stable from the induction room at the Newton hearing.[12]

(b) During the Newton hearing, the Surgeon admitted that the Respondent still has the practice of leaving operating theatres during operations to take phone calls, even till this day.[13]

12. Accordingly, SMC submitted that there should be no adjustment made to the starting point of 36 months' suspension.

13. In its conclusion, SMC sought the following sanctions against the Respondent:

(a) 36 months' suspension;
(b) a censure;
(c) an order that the Respondent undertake to refrain from engaging in the conduct complained of, or any similar conduct, in future; and
(d) an order that the Respondent pay the costs of and incidental to the Inquiry.[14]

Respondent's Submissions on Sentence

14. In relation to the level of harm under step 1, the Respondent submitted that only slight harm was caused for the following reasons:

(a) The focus should be on what harm was directly caused by the doctor's misconduct.[15]

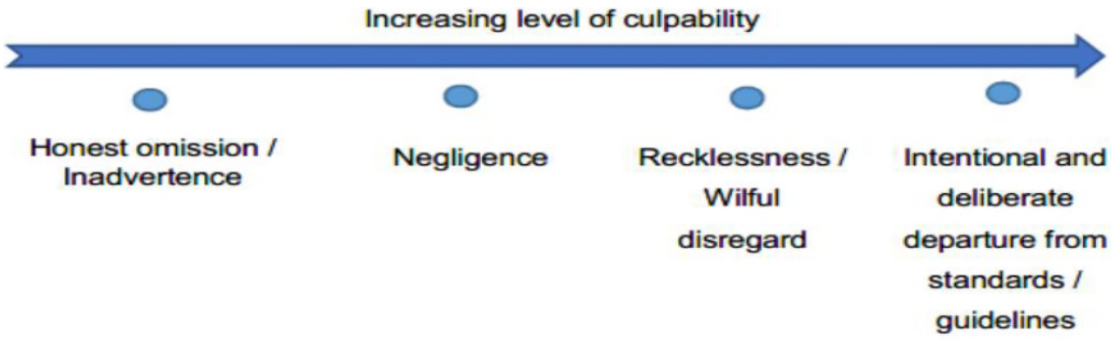
(b) The Respondent's misconduct caused little to no direct harm to the Patient, as the Patient was successfully resuscitated, notwithstanding the Respondent's misconduct.[16]

[12] SMC's Sentencing Submissions at [48(d)].
[13] SMC's Sentencing Submissions at [48(f)].
[14] SMC's Sentencing Submissions at [51].
[15] Respondent's Mitigation Plea at [6].
[16] Respondent's Mitigation Plea at [11].

(c) The eventual harm was caused by the Patient suffering a massive pulmonary embolism and the Patient's chances of surviving such a complication was very low.[17]

(d) The Respondent's misconduct is unlikely to undermine public confidence in the medical profession and the healthcare system as it not of a nature that is concealed or difficult to detect.[18]

15. In relation to the level of culpability, the Respondent submits that there was medium culpability in this case. The Respondent referred to the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals (June 2020 Edition),[19] which sets out the least culpable to the most culpable state of mind as follows:



16. The Respondent submits that the charge that the Respondent has pleaded guilty to was of serious negligence,[20] and that the Respondent was seriously negligent because of:

(a) His wrong judgment that he could leave the Operating Theatre during the Operation to make phone calls as he was not too far and was contactable in seconds.[21]

[17] Respondent's Mitigation Plea at [12].
[18] Respondent's Mitigation Plea at [18].
[19] Respondent's Mitigation Plea at [21].
[20] Respondent's Mitigation Plea at [21].
[21] Respondent's Mitigation Plea at [22a].

(b) His wrong assessment 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.[22]

17. The Respondent further submits that the extent of his departure from the Benchmark Standard was not that egregious as:

(a) There are no official guidelines or notices regarding the making of phone calls while anaesthetists are taking care of their patients.[23]

(b) It is permissible for anaesthetists to leave the operating theatre in certain circumstances, such as an intra-operative hazard, being required to help with resuscitation in another operating theatre, or to use the washroom. Although the Respondent's conduct does not fall within these exceptions, given that the prohibition against leaving the Operating Theatre is not absolute, the Respondent's act of stepping out of the Operating Theatre was not egregious.[24]

(c) The Respondent was either in the corridor just outside the Operating Theatre or in the induction room next to the Operating Theatre, which allowed him to be contactable within seconds if the Patient deteriorated.[25]

(d) The Respondent informed the AU Nurse before he stepped out of the Operating Theatre.[26]

(e) The Respondent gave instructions to the AU Nurse to ensure that matters would continue to move in his absence.[27]

18. In submitting that his culpability was at the medium level, the Respondent further relies on:

[22] Respondent's Mitigation Plea at [22b].
[23] Respondent's Mitigation Plea at [24a].
[24] Respondent's Mitigation Plea at [24b].
[25] Respondent's Mitigation Plea at [24c].
[26] Respondent's Mitigation Plea at [24d].
[27] Respondent's Mitigation Plea at [24e].

(a) his conduct not being motivated by financial gain,[28]

(b) that he had acted in accorded with a common practice among anaesthetists in the private sector,[29] and

(c) the Respondent had wrongly judged that he could leave the Operating Theatre to make phone calls because he was influenced by his subjective view that the Patient was stable at that time.

19. In relation to step 3, the Respondent submits that following his submission that the Respondent's culpability is medium, the appropriate starting point would be a suspension of 7.5 months, being the midpoint of the indicative sentencing range of 3 to 12 months.

20. As for step 4, the Respondent submits that there should be a downward adjustment from 7.5 months to 3 months, in light of the following mitigating factors:

(a) an inordinate delay in the prosecution of proceedings;[30]

(b) the Respondent tried his best for the Patient;[31]

(c) the Respondent demonstrated clinical competence and care for his patients;[32] and

(d) the Respondent is unlikely to re-offend.[33]

[28] Respondent's Mitigation Plea at [25].
[29] Respondent's Mitigation Plea at [26].
[30] Respondent's Mitigation Plea at [39] – [43].
[31] Respondent's Mitigation Plea at [44] – [45].
[32] Respondent's Mitigation Plea at [46] – [47].
[33] Respondent's Mitigation Plea at [38] – [52].

21. The Respondent further raised that Parkway Pantai Limited had already suspended the Respondent for a period of six months from 1 March 2017 to 31 August 2017, to support his argument for a shorter period of suspension.[34]

The Tribunal's Decision on the Appropriate Sentence

22. In determining the appropriate sentence, the Tribunal applied the aforesaid four step approach set out in *Wong Meng Hang*.

23. We will first deal with step 1, which is to determine the level of harm and the level of culpability of the Respondent.

Step 1: Level of harm

24. The Tribunal agrees with SMC that the level of harm caused in this case was at the highest end of the moderate range.

25. In determining the level of harm caused, the Tribunal must consider not only the actual harm caused, but the potential harm that could have been caused by the Respondent's misconduct. In *Wong Meng Hang*, the Court of Three Judges held (at [30(a)] that "*Harm* refers to the type and gravity of the harm or injury that was caused to the patient and indeed to society by the commission of the offence. … Regard may also be had to the *potential* harm that could have resulted from dangerous acts of misconduct, even if it did not actually materialise on the given facts."

26. The Court of Three Judges in *Wong Meng Hang* (at [83]) further observed, "The focus should first be on what harm was directly caused by the doctor's misconduct."

27. It is therefore necessary to look at:

    (a) what the Respondent failed to do, arising from his repeated departures from the Operating Theatre to make phone calls,

[34] Respondent's Mitigation Plea at [51].

(b) the actual harm that was directly caused by those failures, and

(c) the potential harm that could have been caused by those failures.

28. In a letter dated 14 February 2017 from Parkway Pantai Limited ("**Parkway**") 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."[35]

29. In the Respondent's explanation letter to SMC dated 31 January 2018, the Respondent 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%."[36]

30. The aforesaid evidence on the need to increase oxygen, is consistent with the report of Dr PE ("**Dr PE**"), SMC's expert, stating that increasing oxygen concentration,[37] was one of the actions that ought to have been taken.

31. The Respondent in his mitigation plea, sought to rely on the report from Dr DE ("**Dr DE**"), the expert who gave evidence on his behalf. In particular, the Respondent relies on his expert's opinion that:

(a) paradoxically, keeping the Patient at an artificially high level of oxygen (by increasing oxygen delivery to 100%) may mask decline in respiratory function, due to the buffer created at the top end of the oxyhaemoglobin dissociation curve during hyperoxaemia; and

[35] Agreed Bundle of Documents ("ABD") at 31.
[36] ABD20.
[37] ABD65.

(b) in any event, increasing oxygen delivery to 100% would not have made any difference to the outcome.

32. However, we note that this was not the position taken by the Respondent in his letter of explanation to SMC. In that letter, the Respondent stated that he "forgot to increase the oxygen to 100%". There was no explanation given in that letter that he chose not to do so for the reasons cited by Dr DE in his report.

33. In the light of the Respondent's own evidence that "he forgot to increase the oxygen to 100%", we are of the view that this omission was material to the care and management of the Patient and potentially had a bearing on the outcome to the Patient.

34. The Respondent has emphasised that "The eventual harm was caused by the Patient suffering a massive pulmonary embolism, and … his chances of surviving such a complication would have been very low."[38] The Respondent relies on the following:

(a) The evidence of SMC's expert, Dr PE that "At the time the Patient's condition was deteriorating during the Operation, it would have been very difficult for Dr Islam to detect that the Patient was suffering from a massive pulmonary embolism … The chances of the Patient surviving a massive pulmonary embolism would be very low."[39]

(b) The evidence of Dr DE that "the associated mortality of cardiac arrest following a pulmonary embolism was up to 70% within the first hour of presentation."[40]

35. The Respondent further relies on Dr PE's opinion that "[w]hile the chances of the Patient's survival were low, they **may** have been further lowered by Dr Islam's delay in recognizing the changes in the Patient's vital signs".[41] The Respondent emphasised

[38] Respondent's Mitigation Plea at [12].
[39] Respondent's Mitigation Plea at [9].
[40] Respondent's Mitigation Plea at [13].
[41] Respondent's Mitigation Plea at [15].

the word "may" in support of his argument that "Dr Islam's misconduct had only minimal bearing on the eventual harm to the Patient."[42]

36. We are unable to agree with the Respondent's submission.

37. In response to the Chairman's query that "when you put somebody under anaesthesia, the bodily functions are completely controlled by you?", the Respondent replied that "To a certain extent, not completely. But to a large extent with regards to the ventilation, that one is almost 100% if we paralyse the patient … for the purpose of the surgery. … When it comes to blood pressure, we have a large role to play."[43]

38. The Respondent's further evidence was "we actually look after the whole system of the patient. It's very critical the anaesthesia, particularly the patient is anaesthetised and not breathing on their own and plus the patient is paralysed."[44] The Respondent added "we constantly monitor the patient clinically, not only by seeing the monitor. We look at the patient, patient ventilation, his chest is moving up and down or not. The patient colour is okay or not. And so we correlate with all the things."[45] The need for the anaesthetist to be constantly present was further emphasised by the Respondent's own evidence that "Even 10-hour surgery, I didn't go to the toilet, cannot go because the patient will die in my absence."[46]

39. Dr PE's evidence was that "in anaesthesia, 99.9% of the time, things will be alright, but when things go wrong, they go wrong very quickly. So we need to be there … there's not at any point … that it's safe for an anaesthetist to leave the patient."[47] Dr PE's further explained that "all you need is less than a minute for things to go wrong."[48]

40. In the light of the large extent that the anaesthetist is in control of the patient's body when he is under anaesthesia and the rapid speed in which things may go wrong and

[42] Respondent's Mitigation Plea at [16].
[43] Transcript (5 July 2022) at 63, lines 3-5, 15-16.
[44] Transcript (5 July 2022) at 88, lines 5-8.
[45] Transcript (5 July 2022) at 89, lines 3-7.
[46] Transcript (5 July 2022) at 121, lines 10-12.
[47] Transcript (5 July 2022) at 56, lines 2-4, 13-15.
[48] Transcript (5 July 2022) at 57, lines 12-13.

require the anaesthetist's immediate intervention, the Tribunal agrees with SMC that the potential harm that may have been caused to the Patient as a result of the Respondent's multiple departures from the Operating Theatre would be serious injury or even death. In the premises, SMC's submission that the level of harm should be at the highest end of the moderate range, is reasonable and not excessive.

41. The low prospects of surviving a pulmonary embolism cannot negate the potential harm that may have been caused by the Respondent's multiple departures from the Operating Theatre. We are unable to accept the Respondent's argument that because of the low prospects of surviving a pulmonary embolism, the harm caused by the Respondent's misconduct was minimal.[49] That would lead to an illogical outcome where a doctor treating a patient whose condition makes the prospects of survival low, is able to take less care, because the chances of survival were small in any event. Although a doctor who is treating such a patient should not be subject to a higher standard, conversely, the standard should not be lowered simply because the patient had poor prospects of survival to begin with.

42. We further agree with SMC that the Respondent's misconduct causes significant harm to public confidence in the medical profession and the healthcare system. The Respondent's conduct in repeatedly leaving the Operating Theatre to attend to phone calls which he acknowledged were not urgent, would shock the public and harm public confidence in the medical profession. The Respondent's position that it is common amongst anaesthetists in the private sector to leave the operating theatre to make phone calls,[50] may lead to public concerns on the standard in the private sector and the risk to patients who opt to be treated in the private sector.

43. In the premises, we find that the level of harm in this case, is at the high end of the moderate range.

Step 1: Level of culpability

[49] Respondent's Mitigation Plea at [15], [16].
[50] Transcript (5 July 2022) at page 119, lines 9-14. Respondent's Written Submissions for the Newton hearing at [66].

44. As for the culpability of the Respondent, in *Wong Meng Hang*, it was held that the culpability of the offender, means "the degree of blameworthiness disclosed by the misconduct." The court in *Wong Meng Hang* held that this may be assessed by reference to the following (at [30(b)]):

(a) the extent and manner of the offender's involvement in causing the harm;

(b) the extent to which the offender's conduct departed from standards reasonably expected of a medical practitioner;

(c) the offender's state of mind when committing the offence; and

(d) all of the circumstances surround the commission of the offence.

45. The court in *Wong Meng Hang* further held that "whether the doctor intended to depart from the accepted standards of clinical care" is one of the circumstances surrounding the commission of the offence that must be considered, in assessing the culpability of an errant doctor (at [37]).

46. We find that the Respondent's culpability is high for the following reasons:

(a) The Respondent had left the Operating Theatre on multiple occasions to attend to phone calls. Based on the CCTV records which captured the Respondent in the corridor outside the Operating Theatre, the longest of these occasions was 9 minutes and the cumulative period of these occasions was at least 19 minutes.[51] There were also other occasions when the Respondent was outside the Operating Theatre, but in the induction room, that were not captured by CCTV. The Respondent's offending conduct was neither one-off, nor was it for a short period of time. The frequency of the Respondent's offending conduct during the Operation and the length of the occasions when they occurred, point towards higher culpability of the Respondent.

[51] SMC's Sentencing Submissions at [11.2], [11.3], [11.4].

(b) The Patient was a high anaesthetic risk patient as he was elderly, obese, had ischaemic heart diseases and multiple myeloma.[52] The Operation was a high risk surgery, as the fracture suffered by the Patient was likely to be a pathological fracture secondary to multiple myeloma.[53] Yet, the Respondent left a high risk patient undergoing a high risk surgery to talk on his mobile phone, without any good reason. The Respondent agrees that this factor points towards the seriousness of the offence.[54]

(c) None of the phone calls that were attended to by the Respondent were urgent. Save for one family call that dealt with his sister being in ICU, the other phone calls were with patients dealing with matters such as when they could come to Singapore for treatment.[55] Even in relation to the family phone call on his sister, there was no suggestion from the Respondent that this one phone call was urgent or took up the most time.

(d) The Respondent left the Operating Theatre, even though the Patient's SpO_2 became unreadable.[56] The Respondent explained that he had given instructions to the AU Nurse before doing so, but this does not explain why there was such a great need for him to leave the Operating Theatre to attend to phone calls, when his own evidence was that these calls were not urgent.

(e) The Respondent forgot to increase oxygen delivery when the Patient's SPO_2 fell.[57] The evidence of SMC's expert, Dr PE, was that the increase in oxygen concentration was a step that ought to be taken when the Patient's SPO_2 fell. The Respondent's evidence was that "There is no margin of error in the anaesthesia practice",[58] yet he appeared to be inviting a greater likelihood of error by leaving the Operating Theatre to make phone calls even after the Patient's SPO_2 level became unreadable.

[52] Agreed Statement of Facts ("ASOF") at [9(a)].
[53] ASOF at [9(b)].
[54] Respondent's Mitigation Plea at [33].
[55] Transcript (5 July 2022) at page 85, lines 20-25, page 86, lines 8-13, page 87, lines 6-13, page 107, lines 16-24.
[56] Grounds of Decision for the Newton hearing at [42].
[57] ABD20, 31.
[58] Transcript (5 July 2022) at 92, lines 17-18.

(f) The Respondent checked on the progress of the massive blood transfusion on the Patient, while the Respondent was in the induction room, instead of monitoring the Patient at this critical stage from the Patient's side in the Operating Theatre. The Respondent accepts that this factor points towards the seriousness of his offence.[59]

(g) The Respondent stepped 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.[60] This is especially troubling as there was no good reason for the Respondent to be in such a rush to leave the Operating Theatre, in view of his own evidence that none of the phone calls he attended to were urgent. The Respondent could not even be bothered to wait for a second readable blood pressure record, before leaving the Operating Theatre. The Respondent's conduct was again contrary to his evidence that "There is no margin of error in the anaesthesia practice",[61] as well as his evidence that he would only go to the toilet, if nothing was happening to the patient for more than 3 minutes.[62] The Respondent accepts that this factor points to the seriousness of his offence.[63]

(h) The Respondent's mindset was that stepping out to talk on his mobile phone while managing a patient under general anaesthesia was "like … driving", it was "just reflex" and he could "do multi-tasking".[64] The lackadaisical manner in which the Respondent treated his duties and responsibilities as an anaesthetist was deeply disturbing. It appeared from the Respondent's evidence that his work as an anaesthetist had become so mundane that he compared it to driving where he could act upon reflex, and multi-task by dealing with phone calls at the same time.

[59] Respondent's Mitigation Plea at [33].
[60] Grounds of Decision for Newton hearing at [87], [91].
[61] Transcript (5 July 2022) at 92, lines 17-18.
[62] Transcript (5 July 2022) at 121, lines 8-10.
[63] Respondent's Mitigation Plea at [33].
[64] Transcript (5 July 2022) at 109, lines 14-19.

47. The Respondent has suggested that because he had pleaded guilty to a charge of serious negligence, and that this is in the middle of the level of culpability in the Sentencing Guidelines, this points to his level of culpability being medium.[65]

48. The Tribunal is unable to agree with this argument. We would point out that in *Wong Meng Hang*, the respondent in that case also pleaded guilty to a charge of serious negligence (at [18]), yet his culpability was found to be high (at [95]). It is clear that the Tribunal is not constrained from determining a higher level of culpability, merely because the charge that the Respondent pleaded guilty to is one of serious negligence.

49. The Respondent submitted that he had merely made a wrong judgment that he could leave the Operating Theatre during the Operation to make phone calls as he was not too far and was contactable in seconds,[66] and a wrong assessment 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.[67]

50. The Tribunal is unable to agree that the Respondent had merely made a wrong judgment and wrong assessment. We take cognisance of Dr PE's evidence that "in anaesthesia, 99.9% of the time, things will be alright, but when things go wrong, they go wrong very quickly. So we need to be there … there's not at any point … that it's safe for an anaesthetist to leave the patient"[68] and his further explanation that "all you need is less than a minute for things to go wrong."[69]

51. The Respondent's own evidence was that the anaesthetist is largely in control of the Patient's bodily functions and that there was a constant need to monitor the patient clinically, not only be seeing the monitor, but by looking at the patient, his ventilation, his chest moving up and down and his colour.[70] The Respondent in making repeated departures from the Operating Theatre to make non-urgent phone calls for extended

[65] Respondent's Mitigation Plea at [21].
[66] Respondent's Mitigation Plea at [22a].
[67] Respondent's Mitigation Plea at [22b].
[68] Transcript (5 July 2022) at 56, lines 2-4, 13-15.
[69] Transcript (5 July 2022) at 57, lines 12-13.
[70] Transcript (5 July 2022) at 63, 88, 89.

periods of time, completely ignored that critical need for the anaesthetist to be with the Patient constantly.

52. In the premises, there can be no issue of misjudgment or inadvertence in this case. The Tribunal finds that the Respondent's conduct in leaving the Operating Theatre repeatedly to attend to non-urgent phone calls, was an intentional and deliberate departure from the Benchmark Standard that "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".[71] The court in *Wong Meng Hang* (at [94(a)]), observed that "even though the SMC proceeded under … serious negligence", the case could "comfortably have been brought under … deliberate departures from accepted standards." In other words, the charge framed by SMC in serious negligence, does not constrain the Tribunal from making a finding that there were intentional and deliberate departures from accepted standards. The Tribunal's finding of intentional and deliberate departures from accepted standards, further points towards the high culpability of the Respondent.

53. The Respondent has submitted that he was attending to his phone calls in either the induction room next to the Operating Theatre or the corridor just outside the Operating Theatre, and the AU Nurse could easily have called him back to the Operating Theatre in seconds if he was needed.[72] This misses the point. In view of Dr PE's and the Respondent's own evidence of the need of the anaesthetist to be constantly monitoring the patient, the Respondent should have been at the Operating Theatre, instead of departing on multiple occasions to attend to phone calls.

54. Furthermore, we are of the view that the delay in the Respondent's response as a result of his being outside the Operating Theatre would have been significantly more than just a few seconds, in view of:

[71] ASOF at [11].
[72] Respondent's Mitigation Plea at [24(c)].

(a) The time it would take for the AU Nurse to make an observation that the Patient's condition had deteriorated to such a condition that the Respondent had to be called back to the Operating Theatre.

(b) The time for the AU Nurse to make a decision to call back the Respondent.

(c) The time taken for the AU Nurse to go to the induction room or the corridor to call the Respondent back to the Operating Theatre.

(d) The time for the Respondent to end his phone call.

(e) The time for the Respondent to walk back to the Operating Theatre.

(f) The time for the Respondent to make the necessary observations and make a decision on what needs to be done, bearing in mind that he had been out of the Operating Theatre for some time attending to his phone call.

55. In the premises, we are of the view that the Respondent's submission that the delay would have been just a few seconds was unrealistic.

56. The Respondent has further raised that his offending conduct was not motivated by financial gain.[73] The Tribunal is unable to agree with this. Except for one family call, the other phone calls were with patients both overseas and local, dealing with matters such as when they could come to Singapore for treatment. There was nothing urgent about these phone calls and it is reasonable to conclude that the Respondent in attending to these phone calls, the Respondent was simply servicing other patients who would be paying his fees after coming to Singapore for treatment. In the premises, the Tribunal disagrees that the Respondent's offending conduct was not motivated by financial gain.

57. The Respondent submitted that he had acted in accordance with a common practice amongst anaesthetists in the private sector and that acts which are common practice

[73] Respondent's Mitigation Plea at [25].

ought to be viewed as less blameworthy than acts which are wholly out of the norm.[74] This submission is misconceived.

58. It is not disputed that an anaesthetist who steps out of the operating theatre to attend to phone calls while his patient is under general anaesthesia, is in breach of the standards required of anaesthetists. It cannot be that a breach of professional conduct that is common amongst members of the profession is treated more lightly than a breach that rarely occurs. In fact, where such a breach is common, there is a need to send a deterrent message, such that other professionals who may be minded to treat such a breach lightly because they perceive that it is common, are made aware that such a breach will not be tolerated or condoned and there will be severe disciplinary consequences arising from such a breach.

59. Using the driving analogy that was raised by the Respondent in his evidence,[75] a person who speeds while driving, cannot say that he is less blameworthy because speeding is common. Similarly, in the present case, the Respondent cannot take the position that he is less blameworthy because his offending conduct of leaving the operating theatre is common.

60. Furthermore, it is important to distinguish the reasons for an anaesthetist to leave the operating theatre. It is one thing for an anaesthetist to leave the operating theatre to use the toilet or have a quick meal in the course of a long operation. It is another thing altogether for an anaesthetist to repeatedly leave the operating theatre for extended periods to attend to non-urgent phone calls. There can be no justification whatsoever for the latter.

61. The Agreed Statement of Facts ("**ASOF**") states that "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" and describes this as the "Benchmark Standard".[76] The Respondent has submitted that the extent of his departure

[74] Respondent's Mitigation Plea at [26].
[75] Transcript (5 July 2022) at 109, lines 14-19.
[76] ASOF at [11].

from the Benchmark Standard was not that egregious because there are no official guidelines or notices regard the making of phone calls while anaesthetists are taking care of their patients.[77] This submission is misconceived. The Respondent having agreed on the Benchmark Standard required of him, cannot now claim that his departure from that standard is less egregious because there was no official guideline.

62. The Respondent has sought to rely on the evidence of Dr PE, SMC's expert, that anaesthetists may leave the operating theatre when there is some intra-operative hazard, if he is required to help with resuscitation in another operating theatre and when he has to use the washroom. The Respondent's submission is that since an anaesthetist is permitted to step out of the operating theatre under certain situations, his act of stepping out in this case was not such an egregious departure from the Benchmark Standard.[78] This submission is thoroughly misguided. Although there may be exceptions to the Benchmark Standard, the Respondent's conduct in leaving the Operating Theatre to make non-urgent phone calls clearly did not fall under these possible exceptions. A common theme in the exceptions cited by Dr PE is that these exceptions involve events that are urgent and beyond the control of the anaesthetist. Attending to non-urgent phone calls is nowhere analogous to any of these exceptions.

63. The Respondent has further submitted that his conduct was less egregious because he informed the AU Nurse before he stepped out of the Operating Theatre,[79] and that he gave instructions to the AU Nurse to ensure that matters would continue to move in his absence.[80] The Tribunal is unable to agree with this submission. The aforesaid actions taken by the Respondent to inform and instruct the AU Nurse, are basic steps that are expected of a responsible anaesthetist. The taking of those steps does not reduce the blameworthiness of the Respondent. His blameworthiness would have been worse, if he had failed to take those steps.

64. The Respondent relies on the case of *Singapore Medical Council v Dr Foo Chee Boon Edward* [2018] SMCDT 14 ("***Edward Foo***"), where the doctor who was convicted of

[77] Respondent's Mitigation Plea at [24a].
[78] Mitigation Plea at [24b].
[79] Respondent's Mitigation Plea at [24d].
[80] Respondent's Mitigation Plea at [24e].

failing to provide appropriate treatment by failing to send the patient to the ICU or HDU despite the patient's signs of clinical deterioration, was found by the Disciplinary Tribunal ("**DT**") in that case to be of medium culpability.[81] The Respondent submits that his culpability is comparable to that in *Edward Foo*, and that the Respondent's culpability is therefore at the medium level.[82] The Tribunal disagrees that the present case is comparable to *Edward Foo*. The DT in *Edward Foo*, made a finding that the doctor in that case, "had failed or refused to send the Patient to the ICU or HDU, as he had wrongly judged the Patient to be suffering from dehydration, and continued to treat her for such condition in the ward" [at 83(d)]. Essentially, the doctor's misconduct in that case, was one of wrong diagnosis of dehydration.

65. The present case is very different. The Tribunal does not agree with the Respondent's characterization of his misconduct as merely one of having "wrongly judged that he could leave the Operating Theatre to make phone calls".[83] As we have pointed out earlier, the Respondent's misconduct in leaving the Operating Theatre to make phone calls while the Patient was under general anaesthesia was not a mere wrong judgment. Instead, the Respondent's offending conduct completely ignored the critical need for an anaesthetist to be constantly at the patient's side to monitor the patient because the anaesthetist is largely in control of the patient's bodily functions while the patient is under anaesthesia, and was an intentional and deliberate departure from the Benchmark Standard.[84]

66. We further disagree with the Respondent's attempt to compare his conduct with that of Dr Zhu, the junior doctor assisting Dr Wong in the *Wong Meng Hang* case. In that case, Dr Zhu was found less culpable, with a key consideration being Dr Wong was the doctor in charge of the patient's liposuction procedure, with Dr Zhu only being tasked to assist in the procedure (at [108] to [110]). In the present case, it was the Respondent who was in charge and in control of the Patient's bodily functions while the Patient was under anaesthesia.

[81] Respondent's Mitigation Plea at [32a].
[82] Respondent's Mitigation Plea at [33].
[83] Respondent's Mitigation Plea at [31].
[84] See [49] to [52] herein.

67. In the premises, the Tribunal rejects the Respondent's submission that his culpability was only medium. The Tribunal finds that the Respondent's culpability in this case is high, for the aforesaid reasons.

Step 2: applicable sentencing range

68. Step 2 in *Wong Meng Hang* is to identify the applicable indicative sentencing range using the following sentencing matrix as a guide:

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

69. The Tribunal has determined that the level of harm is within the highest end of the moderate range and the level of culpability is high. The applicable indicative sentencing range for moderate harm and high culpability is a suspension of 2 to 3 years.

Step 3: appropriate starting point within indicative sentencing range

70. Step 3 is to identify the appropriate starting point within the indicative sentencing range.

71. As the Tribunal has found that the level of harm is at the highest end of the moderate range and the culpability is high, the appropriate starting point within the indicative sentencing range of 2 to 3 years' suspension, should be at the top end of that range. We agree with SMC that the appropriate starting point for the sentence is a suspension of 36 months.

Step 4: offender-specific aggravating and mitigating factors

72. Step 4 in *Wong Meng Hang* is to adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

73. The Respondent submitted in mitigation that he tried his best for the Patient, demonstrated clinical care and competence and is unlike to re-offend. We are unable to agree with these points raised by the Respondent.

74. In relation to his argument that he tried his best for the Patient, the Respondent sought to rely on the Respondent having taken four of the seven actions identified by Dr PE that should have been taken.[85]That can hardly be a mitigating factor. The Respondent should have taken all steps necessary, rather than just four out of seven.

75. In relation to his argument that he demonstrated clinical care and competence, the Respondent sought to rely on the following statements:

(a) A statement from Dr D1 ("**Dr D1**"), Senior Consultant Surgeon, Clinic A that the Respondent was competent, willing to learn and conscientious.

(b) A statement from Senior Staff Nurse D2 ("**Snr SN D2**"), that the Respondent was particularly fussy and meticulous concerning patient safety.[86]

76. Neither Dr D1, nor Snr SN D2, stated that Dr Islam no longer left the Operating Theatre to attend to phone calls. Instead, the evidence of the Surgeon who carried out the Operation and gave evidence on behalf of the Respondent, is that the Respondent still leaves the operating theatre to take phone calls.[87] The Tribunal is of the view that this carries more weight in our decision on sentence than the aforesaid statements from Dr D1 and Snr SN D2.

[85] Respondent's Mitigation Plea at [45].
[86] Respondent's Mitigation Plea at [46].
[87] Transcript (6 July 2022) at pages 152-153.

77. At the hearing of the Respondent's mitigation plea on 28 November 2022, Counsel for the Respondent submitted that the Surgeon's evidence that the Respondent still leaves the operating theatre to take phone calls was equivocal. We are unable to agree with this submission. The Surgeon's evidence was that after the Operation, he had continued working with the Respondent and that he was "sure at times [the Respondent] does leave the operating theatre when I am operating", including for "small errands", which the Surgeon explained "that when I said small means sometimes he may go out to make a phone call."[88] The Tribunal is of the view that the Surgeon's aforesaid evidence makes it very clear that the Respondent did not stop his practice of attending to phone calls in the middle of operations.

78. We note that at the end of the mitigation hearing on 28 November 2022, the Respondent gave an oral statement to the Tribunal claiming that he no longer leaves the operating theatre while an operation is ongoing. However, we note that this position was not taken by the Respondent when his Counsel re-examined the Surgeon. Nor did the Respondent's Counsel take this position when making his oral mitigation plea on behalf of the Respondent, and merely submitted that the Surgeon's evidence on this point was equivocal. In the premises, we find this belated attempt by the Respondent to claim that he no longer leaves the operating theatre while an operation is ongoing lacking in credibility, and we disbelieve his statement in this regard.

79. The Respondent has submitted that his clinical competence and care for his patients is further demonstrated by his acting beyond the expected standard practice in ordering cross-matched blood for anticipated blood loss during the Operation.[89] The Tribunal may have been prepared to consider this as a mitigating factor, if not for the fact that the Respondent relied on his "anticipating the Patient's needs in advance", in deciding that he could leave the Operating Theatre to attend to phone calls.[90] In the light of this, this point cannot be considered as a mitigating factor.

[88] Transcript (6 July 2022) at 152-153.
[89] Respondent's Mitigation Plea at [47].
[90] Respondent's Mitigation Plea at [22].

80. As for the Respondent's contention that he is unlikely to re-offend,[91] we have serious misgivings as to whether that is really the case, given the aforesaid evidence of the Surgeon that the Respondent still leaves the operating theatre to take phone calls.[92] In the premises, the undertaking sought by SMC for the Respondent to refrain from such conduct in the future, is justified in this case.

81. However, we agree with the Respondent that the delay of almost three years in the prosecution of this case was inordinate. The Respondent in support of his submission that there ought to be at least a one-third reduction[93] in the overall sentence to reflect the inordinate delay in the proceedings, referred to the following cases:

(a) *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943, where a delay of nearly three years, led to a reduction in sentence by half.[94]

(b) *Singapore Medical Council v Dr Tan Joong Piang* [2019] SMCDT 9, where a delay of 2.5 years led to a one-third reduction in sentence.[95]

82. The Respondent has submitted that as observed in *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 (at [123]), "a "natural inference" is that inordinate delay in the prosecution of proceedings would cause the defendant doctor "great anxiety and distress". The Respondent submits that he suffered such anxiety and distress during the period of delay which warrants a reduction in the sentence.[96]

83. In deciding on the appropriate reduction for the delay, the Tribunal took into consideration that the Respondent's culpability was high in this case and that the Respondent continues with his offending conduct of attending to phone calls during operations, which would significantly displace the inference that the Respondent was anxious and distressed by the prosecution against him. With that in mind, the Tribunal is of the view that a reasonable proportion by which the sentence should be reduced

[91] Respondent's Mitigation Plea at [48] to [51].
[92] Transcript (5 July 2022) at pages 152-153.
[93] Respondent's Mitigation Plea at [43].
[94] Respondent's Mitigation Plea at [42a].
[95] Respondent's Mitigation Plea at [42b].
[96] Respondent's Mitigation Plea at [41].

from the delay should be one-sixth, rather than the one-third sought by the Respondent. A one-sixth reduction from the starting point sentence of 36 months, gives rise to a reduction by six months.

84. As for the Respondent's submission that his six months' suspension by Parkway from 1 March to 31 August 2017 should be taken into consideration,[97] we are of the view the suspension by Parkway is irrelevant to our decision on sentencing, for the following reasons:

(a) At the hearing of the mitigation plea on 28 November 2022, the Respondent admitted that although he had been suspended by Parkway for six months in 2017, he continued to work with other hospitals during that period. The Tribunal finds it troubling that the Respondent initially attempted to rely on this suspension as a mitigating factor in his written mitigation plea, and only disclosed the limited extent of this suspension, at the subsequent oral hearing.

(b) As for the period after October 2021 raised in the oral mitigation plea, although the Respondent was unable to practice with Parkway, as well as other hospitals in the course of 2022, he informed the Tribunal that he had also stopped practising as his wife was unwell. Accordingly, this period that the Respondent was not in practice was also irrelevant.

(c) Finally, in the light of the evidence of the Surgeon that the Respondent had continued to leave the operating theatre to make phone calls, it appears that the Respondent's suspension by Parkway in 2017 did little to change the Respondent's conduct. In the premises, the Tribunal is not prepared to take the Respondent's inability to work with Parkway and other hospitals into account, in deciding on the sentence to be imposed on the Respondent.

85. Accordingly, the Tribunal will only reduce the sentence by six months, taking into consideration the delay in prosecution. Taking the aforesaid six months' reduction due to the delay into account, from the starting point sentence of 36 months' suspension,

[97] Respondent's Mitigation Plea at [51].

the appropriate period of suspension to be imposed on the Respondent is 2 years and 6 months.

Conclusion

86. Accordingly, this Tribunal orders that the following sanctions be imposed on the Respondent:

(a) The Respondent be suspended from practice for a period of **2 years and 6 months**.

(b) The Respondent be censured.

(c) The Respondent gives an undertaking to refrain from engaging in the conduct complained of, or any similar conduct, in future.

(d) The Respondent pays the costs and expenses of and incidental to these proceedings, including the costs of counsel of SMC.

87. SMC suggested that the suspension commence 40 days after the date of the order, to take into consideration the time frame for parties to appeal and for the Respondent to settle any outstanding matters before commencing his suspension. There was no objection from the Respondent. In the premises, it is further ordered that the period of suspension is to commence 40 days after the date of the order herein.

88. We further order that the Grounds of Decision herein, as well as the Grounds of Decision of the Newton hearing, be published with the necessary redaction of identities and personal particulars of persons involved.

89. The hearing is hereby concluded.

Prof Sonny Wang Yee Tang Chairman	Dr David Ong Eng Hui	Mr Lim Wee Ming Judicial Service Officer

Mr Edmund Kronenburg, Ms Esther Lim and Ms Tammie Khor (M/s Braddell Brothers LLP)
for Singapore Medical Council

Mr Melvin See and Mr Mok Zicong (M/s Dentons Rodyk & Davidson LLP)
for Dr Islam Md Towfique