6. BIOMEDICAL LAW AND ETHICS

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Introduction

6.1 The year 2016 saw two significant decisions. In *Hii Chii Kok v Ooi Peng Jin London Lucien*[1] ("*Hii Chii Kok*"), the High Court considered questions of informed consent and non-delegable duty ("NDD") in a medical negligence action. In *Singapore Medical Council v Wong Him Choon*[2] ("*Wong Him Choon*"), the Court of Three Judges allowed an appeal by the Singapore Medical Council ("SMC") against the decision of a disciplinary tribunal ("DT") to acquit a medical practitioner of professional misconduct. The medical practitioner had been charged with inappropriately: giving a patient insufficient hospitalisation leave; and certifying the patient to be fit to perform light duties. The Court of Three Judges also made several observations in the process.

Informed consent

6.2 The decision in *Hii Chii Kok* considered the impact of two significant UK Supreme Court's ("UKSC") decisions on the issues of informed consent and NDD in the healthcare context. This case involved claims in medical negligence for lack of informed consent in a decision to opt for Whipple surgery, and in the post-operative care received. The plaintiff had also brought claims against the National Cancer Centre Singapore ("NCCS") for breach of a non-delegable duty in relation to the surgery and post-operative care and, alternatively, on the basis of vicarious liability.

* The views expressed in this article are those of the authors alone. They do not represent the views of the State Courts of Singapore.

1 [2016] 2 SLR 544.

2 [2016] 4 SLR 1086.

6.3 In *Montgomery v Lanarkshire Health Board*[3] ("*Montgomery*"), UKSC departed from the decision in *Sidaway v Board of Governors of the Bethlem Royal Hospital*[4] ("*Sidaway*") that a comprehensive duty of care was owed in relation to diagnosis, advice, and treatment on the basis of the *Bolam* test.[5] For reasons of changed social and legal conditions, the court held that a patient's right to make his own decisions regarding whether to accept medical advice required that the standard of care in rendering medical advice ought to be assessed on the basis of what the reasonable patient was likely to attach significance to, or did in fact place importance on. Adherence to a responsible body of medical opinion on the matters to be disclosed was no longer acceptable in discharging a doctor's duty of care.

6.4 The court in *Hii Chi Kok*[6] made clear that the *Sidaway* standard for medical advice remains the law in the light of the Court of Appeal's decision in *Khoo James v Gunapathy d/o Muniandy*[7] ("*Gunapathy*"), although the Court of Appeal had expressly left the question of the merits of a doctrine of informed consent open.[8] This assessment has been the consistent line taken at the High Court level.[9] Interestingly, the court in *Hii Chii Kok* went on to analyse *Montgomery* and considered that, even if the reasonable patient standard were to apply, the defendant had comprehensively disclosed and explained the various alternatives and risks associated with Whipple surgery via his comprehensive written communications with the plaintiff.[10] This had more than reasonably enabled the plaintiff to make an informed decision to choose an "aggressive" treatment strategy in relation to his symptoms. This course was perhaps taken in anticipation that on appeal, the issue of departing from *Gunapathy* (and its preference for a comprehensive *Bolam*-based duty) was ripe for reconsideration.

6.5 Should *Gunapathy* be reconsidered in Singapore, in so far as it relates to the issue of what amounts to reasonable medical advice? Earlier High Court decisions had dismissed contrary English decisions like *Pearce v United Bristol Healthcare NHS Trust*[11] because they reflected human rights considerations instantiated by the European

3 [2015] AC 1430.
4 [1985] AC 871.
5 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
6 See para 6.1 above; see also *Hii Chii Kok v Ooi Peng Jin London Lucien* [2016] 2 SLR 544 at [5].
7 [2002] 2 SLR 414.
8 See *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 2 SLR 414 at [142].
9 See, *eg*, *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18.
10 See *Chua Thong Jiang Andrew v Yue Wai Man* [2015] SGHC 119 at [36], which mentions *Montgomery*, without considering its merits.
11 [1999] PIQR P53.

Convention on Human Rights ("ECHR") and the UK Human Rights Act 1998.[12] It is, therefore, significant that the unanimous decision in *Montgomery* was based on several different considerations, the ECHR being only one of them. UKSC pointed out the doctrinal incoherence in *Sidaway* of determining the standard of advice in accordance with responsible medical opinion, whilst in the same breath requiring the doctor to address truthfully any questions that the patient did in fact ask.[13] Similarly, the exception alluded to by Lord Bridge of Harwich in relation to a "particular risk … so obviously necessary to an informed choice" is just as susceptible to the incoherence critique, reflecting a different basis of assessment rooted in patient autonomy.[14] Ironically, the criticisms of incoherence and uncertainty that were levelled against the *Canterbury v Spence*[15] reasonable patient approach in *Sidaway* have now been similarly brought to bear on the latter decision.

6.6 This reversal of *Bolam*'s fortunes in relation to medical advice can only be fully understood by recognising the significantly changed social and legal circumstances in the UK that their Supreme Court highlighted, human rights being only one of them. For one, the court recognised that patients today, having far better access to and capability of handling medical information, are regarded as rights holders and consumers exercising choice, rather than passive recipients of care.[16] Secondly, the UK General Medical Council had itself embraced a basic model of partnership between doctors and patients in its guidance document.[17] This guidance recognised a shared model of decision-making where both doctor and patient inputs are necessary to work towards a consensus position that best promotes patient interests – especially in the face of multiple treatment options.[18] Finally, UKSC also considered the ECHR jurisprudence that recognises a duty to involve patients in a medical decision, which reinforced its conclusion.[19]

6.7 Putting the ECHR jurisprudence aside, there have been similar social and professional developments in the Singapore healthcare system that warrant a serious reconsideration of *Gunapathy* in relation to medical advice. First, healthcare financing in Singapore is ultimately

12 *D'Conceicao Jeanie Doris v Tong Ming Chuan* [2011] SGHC 193 at [123]; see also *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18 at [64].
13 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [59].
14 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [60]–[62].
15 464 F 2d 722 (DC Cir, 1972).
16 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [75]–[76].
17 UK General Medical Council, "Consent: Patients and Doctors Making Decisions Together" (2 June 2008) <http://www.gmc-uk.org/GMC_Consent_0513_Revised.pdf_52115235.pdf> (accessed 3 May 2017).
18 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [77]–[79].
19 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [80].

rooted in a market-based system, notwithstanding extensive government regulation and subvention. One of the clear policy initiatives of the Ministry of Health is to empower patients as consumers here to make better informed choices by publishing better information on healthcare costs.[20] It would seem odd for this policy to restrict patient involvement to pricing alone, without weighing this against the inherent therapeutic benefits and risks of proposed treatments. The underlying goal, it is submitted, is more prudent patient choices in healthcare.

6.8 Secondly, the National Medical Ethics Committee ("NMEC") and SMC have both endorsed a partnership model in healthcare decision-making that will be strengthened and legitimised by moving to a legal patient-centred standard of medical advice. In its "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" report of 2012,[21] NMEC noted the same social considerations as UKSC that are changing the nature of clinical encounters between doctors and patients, and that the "next step towards better health outcomes has been the involvement of patients in their own medical care, with decisions made in partnership with physicians, rather than by physicians alone".[22] In such a partnership model, NMEC recognised that the patient autonomy is the primary ethical principle at play, although this does not render medicine a mere commodity that patients can adequately handle on their own as many are vulnerable because of their illness.[23]

6.9 In the same, consistent vein, SMC's latest Ethical Code and Ethical Guidelines: 2016 Edition ("ECEG"), which came into force on 1 January 2017, emphasise much more clearly that an important aspect of the ethic of respecting patient autonomy is ensuring that patients are made aware of:[24]

20 Ministry of Health website, "Costs and Financing" (1 November 2016) <https://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html> (accessed 3 May 2017).

21 National Medical Ethics Committee, "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" (11 September 2012).

22 National Medical Ethics Committee, "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" (11 September 2012) at para 2.

23 National Medical Ethics Committee, "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" (11 September 2012) at para 4.

24 Singapore Medical Council, "Ethical Code and Ethical Guidelines" (13 September 2016) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20-%20(13Sep16).pdf> (accessed 3 May 2017) at p 37.

> … the purpose of tests, treatments or procedures to be performed on them, as well as the benefits, significant limitations, material risks (*including those that would be important to patients in their particular circumstances*) and possible complications as well as alternatives available to them … [emphasis added]

6.10 It is difficult to see how the ECEG requirements could be fulfilled without considering the perspective of the patient and her goals and circumstances. SMC's accompanying "Handbook on Medical Ethics"[25] also endorses the partnership or shared decision-making model, and provides numerous factors to be considered in determining the level-of-risk disclosure.[26] This gradual but steady recognition of the importance of respecting patient autonomy in healthcare decision-making has similarly been recognised statutorily: the first step being the setting up of the Advance Medical Directive Act[27] framework that empowered patients so minded to refuse in advance extraordinary life sustaining treatment in cases of terminal illness. Subsequently, the enactment of the Mental Capacity Act[28] introduced the principles of the presumption of capacity, requirement to take all practicable steps to help persons make their own decisions, and respect for autonomous decisions even if they are "unwise".[29]

6.11 Nevertheless, there is legitimate concern that a move to a patient-centred standard will also entail new uncertainty over what counts as material risk that must be disclosed and explained. This can lead to disclosure practices that amount to defensive medicine, entailing additional consultation time that adds to overall healthcare costs without necessarily improving the quality of healthcare decision-making. There are a couple of ways that the law on informed consent may mitigate these downsides. First, as *Montgomery* makes clear, informed consent is not to be foisted on every patient. It is equally consistent with autonomy for a patient to decline to be engaged with the specifics of risk, alternatives, and choice in medical decision-making, and prefer to defer to their doctor's or family's assessment and recommendations. *Montgomery* expressly allows for this alternative,[30] as

25 Singapore Medical Council, "Handbook on Medical Ethics" (13 September 2016) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Handbook%20on%20Medical%20Ethics%20-%20(13Sep16).pdf> (accessed 3 May 2017).

26 Singapore Medical Council, "Handbook on Medical Ethics" (13 September 2016) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Handbook%20on%20Medical%20Ethics%20-%20(13Sep16).pdf> (accessed 3 May 2017) at p 85–86.

27 Cap 4A, 1997 Rev Ed.

28 Cap 177A, 2010 Rev Ed.

29 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 3(2), 3(3) and 3(4).

30 *Montgomery v Lanarkshire Health Board* [2015] AC 1430 at [85].

does NMEC in its collaborative decision-making guidelines.[31] Secondly, in the informed-consent jurisprudence, the test of material risk arguably takes its content from the clinical context: in *Rosenburg v Percival*,[32] Gummow J outlined three distinct stages in the assessment of various notions of materiality of risk. At the second stage, whether risks are material for the purposes of disclosure in medical advice depend on:[33]

> … 'the magnitude of the risk and the degree of the probability of its occurrence', balanced against 'the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have'[; and]
>
> … the extent or severity of the potential injury and the likelihood of it coming to pass, [which] are to be considered together. A slight risk of a serious harm might satisfy the test, while a greater risk of a small harm might not. It is also important to note that, in considering the severity of the potential injury, that severity is judged with reference to the plaintiff's position …
>
> These considerations need to be weighed against the circumstances of the patient. The patient's need for the operation is important, as is the existence of reasonably available and satisfactory alternative treatments. A patient may be more likely to attach significance to a risk if the procedure is elective rather than life saving …

6.12 What Gummow J's approach illustrates is that materiality is not merely a function of severity of risk and its probability, but also the circumstances of the particular patient, the absence of medical alternatives, and the urgency of the needs of the patient. SMC's ECEG offers the beginnings of a working typology of decision-making scenarios which offer meaningful markers for the determination of what amounts to materiality. First, it suggests that informal consent is appropriate for minor tests, treatments, and procedures with low risk. Presumably, in such routine and minor clinical encounters, there are no material risks worth disclosing and discussing with patients. In contrast, where "tests, treatments or procedures are considered complex, invasive or have significant potential for adverse effects", then formal documented consent needs to be taken.[34]

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31 National Medical Ethics Committee, "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" (11 September 2012) at para 14.

32 (2001) 205 CLR 434.

33 *Rosenburg v Percival* (2001) 205 CLR 434 at [76]–[78].

34 Singapore Medical Council, "Ethical Code and Ethical Guidelines" (13 September 2016) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20-%20(13Sep16).pdf> (accessed 3 May 2017) at p 37.

6.13 To this basic typology may be added two other common situations: in relation to acute disorders where time is of the essence and there is a need to keep the patient as anxiety-free as possible, informed-consent processes will need to be adjusted and material risk accordingly assessed.[35] In contrast, where procedures are elective – more specifically, where the weight of clinical evidence and experience cannot point to one clearly superior alternative – then the need for a shared decision-making process is at its greatest and a dialogical consideration of the informational needs of the patient is warranted.[36] The range of material risks and other considerations will be wider, to better facilitate a prudent decision by the patient that best serves his overall interests. In sum, greater specification of the contextual features of typical clinical encounters will offer more predictability for doctors and healthcare institutions about the requirements of meeting a new legal standard of medical advice, without losing sight of the common medical adage that every patient is different. It remains to be seen how the various doctrinal and policy considerations will play out in the appeal before the Court of Appeal in respect of the standard of care applicable to rendering medical advice.

Non-delegable duty

6.14 The other interesting aspect of *Hii Chii Kok* is its consideration of the NDD doctrine and the acceptance of the principles enunciated by Lord Sumption in *Woodland v Swimming Teachers Association*.[37] This is the first instance, to the authors' knowledge, where the doctrine has been considered locally in the healthcare context. The Court of Appeal in *Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction*[38] expressly left open the applicability of NDDs to the hospital–patient relationship.[39] Prior to this, only vicarious liability had been argued as a basis to render healthcare institutions responsible for the negligence of third parties – their employees.[40] The potential application of NDDs in healthcare is, therefore, significant as it extends the scope of liability beyond employees to other otherwise independent

35 Jay Katz, "Physician–Patient Encounters 'On a Darkling Plain'" (1987) 9 West New Engl Law Rev 207 at 222.

36 National Medical Ethics Committee, "Ethical Guidelines for Healthcare Professionals on Clinical Decision-Making in Collaboration with Patients" (11 September 2012) at para 12.

37 [2014] AC 537.

38 [2016] 4 SLR 521.

39 *Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction* [2016] 4 SLR 521 at [47]–[48].

40 See, *eg*, *Denis Matthew Harte v Dr Tan Hun Hoe* [2000] SGHC 248 at [438]–[441].

contractors who are discharging a primary duty assumed by the defendant in relation to vulnerable patients.

6.15 On the facts, however, the High Court found that there was no such duty undertaken by NCCS in relation to the Whipple surgery and post-operative care that was performed across the road at the premises of the Singapore General Hospital. Several factors pointed to this conclusion. First, NCCS was only licensed as a medical clinic and not a surgical facility, whether inpatient or outpatient. Second, NCCS was neither capable nor did it hold itself out as capable of providing surgery and inpatient care. Third, it was clear to the plaintiff that the choice of surgeon and surgical facility was within his choice and control, as he was given the option of seeking a second surgical opinion but declined. Therefore, NCCS did not delegate any function to the defendant surgeon, which was an integral part of its undertakings to the plaintiff.[41]

6.16 Recognition of NDDs in healthcare would be an important step forward in rationalising liability in healthcare. Healthcare delivery has increased in complexity and long moved away from a single physician–patient model to team-based settings in various secondary and tertiary healthcare organisations.[42] When iatrogenic injury occurs within modern healthcare systems, the root causes are multifarious, cumulative, and systemic in origin, although traditional tort analysis tends to search for and focus on an individual actor's negligence.[43] Expanding the scope of organisational liability to cover the acts of independent contractors under the NDD doctrine can serve to better align the incentives of institutional healthcare providers with the current systemic means by which iatrogenic injuries are best addressed and prevented.[44] The more aligned the interests of healthcare organisations are with their agents of care delivery, the better they are positioned to work out systems and procedures that address these root causes rather than seek to deflect or apportion blame to individual members of the healthcare team or the institutional arrangements they operate under.

6.17 Assuming NDDs eventually gain a foothold in the healthcare setting, the next question that arises is: what is the scope of a hospital's positive undertaking? *Hii Chii Kok* considered factors such as the

41 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2016] 2 SLR 544 at [71].

42 See Tracey Evans Chan, "Organizational Liability in a Health Care System" (2010) 18(3) Torts Law Journal 228 at 231–232.

43 See Michelle M Mello & David M Studdert, "Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries" (2008) 96 Geo LJ 599.

44 Tracey Evans Chan, "Organizational Liability in a Health Care System" (2010) 18(3) *Torts Law Journal* 228 at 233–234, but note the conceptual difficulties with NDDs at 239–242.

healthcare institution's licensing status, services the hospital held itself out to provide, and what control the patient retained over the healthcare services received. In *Ellis v Wallsend District Hospital*,[45] Samuels JA held that the key question in such cases is what services the hospital has undertaken to provide and, correspondingly, whom the patient relied upon to do so.[46] In this inquiry, it is submitted that the licensing status of a healthcare institution should not be accorded determinative weight. In *Hii Chii Kok*, the fact that NCCS was not licensed to offer inpatient surgical services was borne out by the conduct of NCCS in making it clear to the plaintiff that he was free to choose his surgeon.[47] In other situations, for instance, for the provision of clinical laboratory services, the lack of licensing authority may not be as transparent to the patient. The outsourcing of such services for want of such a licence need not detract from a hospital's undertaking to provide general healthcare services to the patient.[48]

Professional discipline

6.18 Dr Wong Him Choon ("Dr Wong"), the respondent in *Wong Him Choon*,[49] was a registered medical practitioner and a consultant orthopaedic surgeon at Raffles Hospital ("RH"). On 3 September 2011, he attended to a foreign construction worker ("Patient") in the late evening. The Patient had injured his right hand after falling from height at a construction site. Dr Wong assessed that the Patient had sustained a distal radius fracture (for which surgery was needed) and a metacarpal fracture (which could be treated conservatively). In the early morning on 4 September 2011, Dr Wong performed surgery involving the immediate closed reduction and percutaneous "K-wire" fixation of the right distal radius on the Patient's right hand. This surgery comprised "the driving/drilling of the 'K-wire' through the right hand of the Patient and bending the exposed portions of [this] wire outside the Patient's skin".[50]

6.19 After the surgery, Dr Wong certified the Patient to be fit for discharge that same day. The Patient was discharged sometime that afternoon, after spending about 15 hours at RH. Dr Wong also:

45 (1989) 17 NSWLR 553.
46 *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553 at 604–605.
47 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2016] 2 SLR 544 at [71].
48 See *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 for an illustration of the undertaking of "complete medical services", *cf Farraj v King's Healthcare NHS Trust* [2010] 1 WLR 2139.
49 See para 6.1 above.
50 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [8].

(a) issued a medical certificate to cover the Patient's two-day stay at RH from 3 September to 4 September 2011 (*viz*, hospitalisation leave); and

(b) certified the Patient fit for light duties for one month from 5 September 2011 (*viz*, the first post-operative day) to 5 October 2011.

6.20 The Patient was then given an appointment for a post-operative review with Dr Wong on 7 September 2011, the third day after he was supposed to return to work and perform light duties.[51] He was not given any post-operative or post-discharge medical leave. According to Dr Wong, the Patient had not informed him of any pain in his right hand at the time of discharge.

6.21 Dr Wong reviewed the Patient on 7 September 2011, where he recorded the Patient's complaint of "itchiness" in his right hand. Dr Wong then scheduled a further review on 5 October 2011.

6.22 However, the Patient visited RH earlier, on 21 September 2011. He was attended to by a different doctor, who recorded the Patient's complaint of "discomfort over the K-wire sites".

6.23 Apart from RH, the Patient also visited Changi General Hospital ("CGH") on 11 September 2011 and 23 September 2011. He received 20 days of medical leave in all from CGH, from 11 September to 30 September 2011 (both dates inclusive). Notwithstanding this receipt of medical leave from CGH, the Patient did not receive his salary from his employer.

6.24 On 5 October 2011, the Patient returned to see Dr Wong as scheduled.[52] He told Dr Wong that he had not been paid a salary because he was unable to work on the construction site and was not granted a medical certificate by Dr Wong. Dr Wong then issued the Patient with a medical certificate that backdated the coverage of medical leave to the Patient ("backdated medical certificate"), covering his absence from work from 6 September 2011 to 20 November 2011 (that is, for 76 days).

6.25 SMC charged Dr Wong with one count of professional misconduct under s 53(1)(*d*) of the Medical Registration Act[53] ("MRA"). The essence of this charge was that Dr Wong "inappropriately":

51 See para 6.19(b) above.
52 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [13].
53 Cap 174, 2014 Rev Ed.

(a) gave the Patient a duration of hospitalisation leave that was insufficient for a Patient who was recovering from a distal radius fracture to his right hand for which surgery was necessary as well as a metacarpal fracture that was being treated conservatively; and

(b) certifying the Patient to be fit to perform light duties at work on the first post-operative day, for a period of one month from 5 September 2011 to 5 October 2011 (both dates inclusive).

Proceedings before the DT

6.26 In *Low Cze Hong v Singapore Medical Council*[54] ("*Low Cze Hong*"), the court accepted[55] that "professional misconduct" under the MRA "can be made out in at least two situations" (*viz*, there are at least two limbs of professional misconduct). In *Ang Pek San Lawrence v Singapore Medical Council*[56] ("*Lawrence Ang*"), the court elaborated on the findings a DT had to make *vis-à-vis* these two limbs before it could hold that SMC had proven a charge against an allegedly errant doctor. The effect of *Low Cze Hong* and *Lawrence Ang* may be summarised in a table as follows:

	Professional misconduct	**Findings a DT must make to convict**
Limb 1	There is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.	What the applicable standard of conduct is among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct relates to This applicable standard is an objective standard the doctor is bound to as a member of the profession
		Whether the applicable standard of conduct requires the doctor to do something and at what point in time such duty crystallises
		Whether the doctor's conduct constitutes an intentional and deliberate departure from the applicable standard of conduct

54 [2008] 3 SLR(R) 612.
55 *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [37].
56 [2015] 1 SLR 436.

Limb 2	There has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.	Whether there is serious negligence on the part of the doctor
		Whether such negligence objectively constitutes an abuse of the privileges of being registered as a medical practitioner

6.27 Before the DT, SMC argued that Dr Wong's conduct amounted to professional misconduct as there was an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency (*viz*, limb 1).

Dr Wong fell below the applicable standard of conduct

6.28 On the applicable standard of conduct in relation to the post-surgery discharge of the Patient, the DT found, among other things, that:[57]

> (a) It was for [Dr Wong to take proactive steps to make inquiries with the Patient] *to establish* that there were adequate conditions for rest and rehabilitation if medical leave for two days after the surgery followed by light duty was to be given …
>
> (b) *It was not the practice among members of the medical profession of good* [repute and competency] *to certify a worker fit for light duties instead of two weeks' medical leave immediately after* [a] *surgery for a distal radius fracture* …
>
> [emphasis in original]

6.29 The DT, therefore, found that Dr Wong fell below the applicable standard of conduct.

57 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [55].

Conduct not an "intentional and deliberate departure" from the applicable standard

6.30 The DT, however, held that Dr Wong's conduct was not "an intentional and deliberate departure from the applicable standard of conduct". It found, *inter alia*, that:

> (a) There was "no conclusive evidence to show that Dr Wong proceeded to certify the Patient fit for light duty with full personal knowledge or after having been told that there was no light duty available or provided by the employer for the Patient".[58]
>
> (b) The fact that an inappropriate number of days of medical leave was given by Dr Wong was not sufficient to suggest that Dr Wong was guilty of an "intentional and deliberate departure from the applicable standard of conduct".[59]

6.31 The DT, hence, held that SMC had not proven the charge beyond a reasonable doubt and, thus, acquitted Dr Wong of the charge. SMC appealed.

Decision of the court

6.32 The court first discussed the applicable standard of conduct and the point in time at which this duty crystallised (*viz*, the first two findings that must be made for a conviction to follow on the first limb).[60] The court then proceeded to examine whether Dr Wong's conduct constituted an intentional, deliberate departure from this standard of conduct (*viz*, the third and final finding that must be made for a conviction to follow on the first limb).[61]

Applicable standard of conduct and the time at which duty crystallised

6.33 The court endorsed the finding of the DT that "the applicable standard required Dr Wong to establish that there were adequate conditions for rest and rehabilitation before light duties were given".[62] The court observed that the expert opinion was unanimous on this standard.

58 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [25].
59 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [27].
60 See para 6.26 above.
61 See para 6.26 above.
62 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [58].

6.34 The court noted that the expert opinion was also unanimous that "the duty of the doctor to discuss with the patient whether there were adequate conditions for rest and rehabilitation *crystallised and was to be discharged before the doctor decides* on the type and duration of medical leave to be administered on the patient" [emphasis in original].[63]

Conduct was an "intentional and deliberate departure" from the applicable standard

6.35 The DT had found that there was "no conclusive evidence to show that Dr Wong proceeded to certify the Patient fit for light duty with full personal knowledge or after having been told that there was no light duty available or provided by the employer for the Patient".[64] In this vein, the court held that the DT "*slipped into error* when it focused its mind … on whether Dr Wong had certified the Patient fit for light duties *with the knowledge* that such duties were not available" [emphasis in original].[65]

6.36 According to the court, the DT:[66]

> … should, instead, have considered whether Dr Wong had certified the Patient fit for light duties (a) without first establishing the existence of such duties; and (b) with the knowledge that it was incumbent on him … to ascertain the existence of such duties from the Patient.

On this note, the court reviewed the evidence before the DT and:

> (a) endorsed the finding of the DT that Dr Wong "had not established the availability of light duties" in relation to the Patient. The court noted that Dr Wong had instead simply assumed (which he was not entitled to do) that light duties would be available based on his previous dealings with the main contractor that managed the site on which the Patient was injured.[67] The court observed that the applicable standard required Dr Wong to ascertain that *each* patient before him had adequate conditions for rest and rehabilitation – there was no room to operate on assumptions;[68] and

63 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [62].
64 See para 6.30(a) above.
65 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [84].
66 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [84].
67 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [66]–[69] and [73].
68 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [71] and [73].

(b) observed that the evidence "*squarely supported a finding* that Dr Wong knew" "on 4 September 2011 when he certified the patient fit for light duties that it was *incumbent on him to first establish if there were adequate conditions for rest and rehabilitation*" [emphasis in original].[69] There was, therefore, no need to rely on the "very strong inference", flowing from the finding of the DT that Dr Wong was "covering up" his mistake by issuing the backdated medical certificate,[70] that Dr Wong knew that it was incumbent on him to check with the Patient on the existence of light duties.[71]

6.37 The court, therefore, held that the DT had "veered off-course and erred in concluding that there was no intentional, deliberate departure from the applicable standard" by Dr Wong.[72]

Sentencing

6.38 After Dr Wong was convicted on the charge, SMC submitted that Dr Wong "should be suspended for a period of four months, censured and required to furnish a written undertaking that he will not repeat such conduct".[73] The court largely agreed, but suspended Dr Wong for a term of six months instead. In doing so, the court took into account the following aggravating factors:

(a) Dr Wong's failure to provide medical leave to cover the Patient for even the period between 5 September and 7 September 2011 "demonstrated a wilful disregard for the patient's welfare and interests, and in particular, his need for proper rest and rehabilitation".[74]

(b) Dr Wong chose not to give the Patient medical leave "for a *multitude of extraneous, less than proper, as well as non-medical considerations*" [emphasis in original].[75] According to the court, Dr Wong's "main concern was not the patient's welfare and interest – he was, instead, advancing the interests of the employer and wanted the Patient to return to work as soon as possible".[76]

69 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [78]–[80].
70 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [77]; see also para 6.24 above.
71 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [79].
72 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [64].
73 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [97].
74 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [101].
75 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [110].
76 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [106].

(c) Dr Wong was "unremorseful and sought to pin the blame on the Patient for his own failure to adequately manage his post-operative recovery".[77]

(d) Dr Wong's professional misconduct "influenced the proper care of the Patient and caused harm to the Patient". The Patient had complained of pain when he visited RH on 21 September 2011[78] and he was also in pain when he presented himself at CGH on both occasions.[79]

6.39 *Wong Him Choon* represents the second instance between 2015 and 2016 that the Court of Three Judges displayed a willingness to depart from sentencing precedents "that do not reflect the prevailing circumstances and state of medical practice"[80] and recalibrate sentences upwards. The first instance was in *Singapore Medical Council v Kwan Kah Yee*.[81] Subsequent cases should expect greater scrutiny by the court on the sanctions imposed, notwithstanding such sanctions being in line with precedent cases.

Observations by the court

6.40 In the process of allowing the appeal and sentencing Dr Wong, the Court of Three Judges also made a number of important observations. First, the court reiterated that professional misconduct is not limited to the two limbs in *Low Cze Hong*[82] but "extend[s] *to the breach of other ethical obligations*"[83] [emphasis in original] – such as the doctor's breach of the ethical obligation to charge a fair and reasonable fee for the services rendered to his patient, as in *Lim Mey Lee Susan v Singapore Medical Council*.[84] On this note, the court observed that:[85]

> [I]n so far as the charge brought against a doctor relates to intentional conduct and/or gross negligence *vis-à-vis* his diagnosis and treatment of and advice to the patient … the requisite elements that need to be satisfied to bring a charge within the definition of 'professional misconduct' as set out in s 53(1)(*d*) of the MRA have been set out clearly in both *Low Cze Hong* and [*Lawrence Ang*] and … no further review of the law in this particular regard is necessary …

77 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [108].
78 See para 6.22 above.
79 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [109]; see also para 6.23 above.
80 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [117].
81 [2015] 5 SLR 201; see also (2015) 16 SAL Ann Rev 143 at 158–167, paras 6.47–6.73.
82 See para 6.26 above.
83 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [51].
84 [2013] 3 SLR 900; see also *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [51].
85 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [43] and [51].

6.41 Second, the court observed that there would be a "strong presumption that a doctor had knowledge of the matters contained" in the ECEG issued by SMC because this "represented so fundamentally *the most basic aspects of clinical practice*" [emphasis in original].[86] The court noted that this presumption was also necessary because "[i]t would otherwise be all too convenient for an errant doctor to allege that he did not depart from the applicable standard intentionally on the basis that he did not know of the applicable standard at the relevant time".[87]

6.42 Third, the court clarified that *Lawrence Ang* did not require SMC to elect which of the two limbs of "professional misconduct"[88] it intended to proceed under.[89] In the present case, the court noted that:[90]

> [W]here the SMC could have relied on the same set of facts (and evidence) to establish professional misconduct under both the first limb and the second limb of *Low Cze Hong*, it would have been open to it to have pursued both arguments in the alternative without any prejudice to Dr Wong …

6.43 Fourth, the court recognised that:[91]

> [A]lthough the fact that the doctor was not aware of the applicable standard might result in a charge based on the first limb of *Low Cze Hong* not being made out against him, such lack of awareness of the applicable standard … may itself constitute gross negligence and result in an alternative charge based on the second limb of *Low Cze Hong* being established against him …

The court noted that it may be "essential" for SMC to make such an argument in appropriate cases: otherwise, "it might be all too easy for a doctor to allege his subjective ignorance of the applicable standard when the charge brought against him is based on the first limb of *Low Cze Hong*".[92] An argument based on the second limb of *Low Cze Hong* "would invariably bring within its fold circumstances where the doctor's subjective ignorance of the applicable standard is objectively and wholly unacceptable".[93]

86 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [82].
87 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [82].
88 *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612; see also para 6.26 above.
89 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [88].
90 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [89].
91 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [90].
92 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [90].
93 *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [90].