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6. BIOMEDICAL LAW AND ETHICS

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Introduction

6.1 The year under review truly represents a landmark year for the field of biomedical law and ethics in Singapore. Two watershed judgments on the interests and rights of patients in assisted reproduction and medical practice generally were delivered by five-member panels of the Court of Appeal. These decisions were highly anticipated and certainly did not disappoint in the wealth of legal and policy analysis on fundamental issues. There were also four important decisions delivered by the Court of Three Judges in relation to professional discipline.[1] These decisions discussed aspects relevant to liability (especially in relation to professional misconduct in the form of a doctor's failure to obtain informed consent), aggravating and mitigating factors in sentencing, as well as sentencing considerations in cases where a doctor had failed to obtain informed consent.

Loss of genetic affinity in assisted reproduction

6.2 The action in *ACB v Thomson Medical Pte Ltd*[2] ("*Thomson Medical*") involved wrongful fertilisation. The defendants had negligently fertilised the plaintiff's oocyte with the sperm of a third-party donor, and the resulting embryo led to the plaintiff's pregnancy. The mistake was suspected upon the birth of the child, Baby P, as the donor was of a different ethnic group from the putative parents. This was confirmed after a genetic blood test. The plaintiff sued the defendants for, in particular, the costs of maintaining Baby P till adulthood. In a wide ranging judgment that reviewed various

* 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 The decision in *Chia Foong Lin v Singapore Medical Council* [2017] 5 SLR 334 is not reviewed as no noteworthy legal issues were raised.

2 [2017] 1 SLR 918.

fundamental principles in tort law, the *en banc* Court of Appeal dismissed the claim for upkeep costs, but instead recognised a new head of damage in medical negligence termed "loss of genetic affinity". In reaching this result, the court also dismissed an alternative claim for "loss of autonomy".

6.3 The first important issue resolved in *Thomson Medical* involved a question of causation in the context of claims brought for wrongful birth, conception, or in this case, fertilisation. The trial judge reasoned that since the plaintiff was prepared to raise a healthy child by having recourse to in vitro fertilisation ("IVF"), she had suffered no financial loss upon the birth of Baby P, who was also healthy, albeit genetically different from the child they intended to conceive. The Court of Appeal rejected this argument, emphasising the unique identity of Baby P as a child that the plaintiff did not contemplate raising when she underwent the IVF procedures. The plaintiff was now put to the expense of raising this child.[3] An alternative way of understanding the causation point is that any consideration of the subsequent conduct of the plaintiff and her husband in determining if there was consequential economic loss would impermissibly fetter the reproductive autonomy of the putative parents.[4] They should not have to beget another child in order to demonstrate the actual consequential economic loss, just as it would be unreasonable to expect them to give up Baby P for adoption in order to mitigate that same loss.[5]

6.4 However, notwithstanding that causation was established, the court rejected the claim for upkeep costs after undertaking an admirably comprehensive review of the common law authorities on the issue. This was based on the public policy of preserving the integrity of parental duties, rather than a denial of their practical financial realities. The obligation to maintain one's child as an incident of parenthood is of moral worth, and hence cannot constitute legally cognisable loss compensable by damages.[6] It would also be unprincipled to distinguish financial sacrifice from the other intangible sacrifices made by parents, the latter being incapable of valuation. The court summarised this idea in the following terms:[7]

> Baby P is *a holistic person* who must be accepted as she is. If she is accepted, as we are gratified to observe she has been, then the Appellant must be taken to have simultaneously assumed the responsibility of maintaining her (financially and in all other respects).

3 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [41].
4 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [42].
5 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [84].
6 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [90].
7 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [93].

> Parenthood comprises an indivisible bundle of rights and obligations which cannot be peeled away and hived off *à la carte*. [emphasis in bold italics in original]

6.5 Secondly, as a corollary, the act of bringing a civil claim for such damages would undermine the integrity of the parent–child relationship. By arguing that the parent–child relationship amounts to a net loss, claimants would be incentivised to disparage the value of their child to maximise recovery, by minimising the notional sum that would offset the correlative benefits of raising the child. Allowing recovery of upkeep costs would also distort parental expectations for the child or lifestyle choices in order to obtain a larger award. The court therefore chose a bright line rule to disallow recovery for upkeep costs to prevent the personal interests of claimants from coming into conflict with their parental duties. Two possible exceptions to recovery were countenanced: a contractual warranty guaranteeing a particular reproductive outcome or a liquidated damages clause providing for an event of wrongful fertilisation.

6.6 Despite the clarity of the policy objections to awarding upkeep costs, the court further explored whether other novel heads of loss should be recognised in order to remedy the negligent conduct of the defendants. Otherwise, the plaintiff would be confined to damages for pain and suffering associated with the pregnancy, and the wasted costs of the IVF treatment, which the court thought poorly reflected the substance of the loss suffered. First, the court considered the notion of a loss of autonomy as a distinct head of loss, constituted here by defeating the expectations of the plaintiff for a child conceived with the gametes of her spouse. They rejected this as a general head of loss for the purposes of negligence. The notion of autonomy itself is contested, and it would result in unacceptable uncertainty over the proper bounds of legal protection. Further, the concept of damage in negligence emphasises remedies for objective detriment or tangible harms, rather than serve as a vindicatory tool for rights infringement. Finally, there is the danger of allowing circumvention of existing legal restrictions on recovery in negligence by reconceptualising the damage as one implicating some aspect of autonomy. This rejection of loss of autonomy as a general head of damage will have repercussions beyond reproductive medicine, and have an important influence on the implications of the decision in *Hii Chii Kok v Ooi Peng Jin London Lucien*[8] ("*Hii Chii Kok*"), discussed below.[9]

8 [2017] 2 SLR 492.

9 See para 6.30 below.

6.7 The most significant impact of the decision in *Thomson Medical* is likely to be its recognition of a new head of damage: loss of genetic affinity, an interest articulated by Norton in his article, "Assisted Reproduction and the Frustration of Genetic Affinity: Interest, Injury, and Damages",[10] and approved of by the Court of Appeal. It is a shorthand for "all those ties which are partly the result of genetic relatedness and partly a result of the social significance which it carries".[11] While this interest connotes the socio-cultural significance of genetic relatedness to familial ties, the gist of the harm appears to be its impact on the reproductive autonomy of the putative parents: what the court described as "serious consequences that the disruption of the Appellant's reproductive plans had on her life", which were "to maintain an intergenerational genetic link and to preserve 'affinity'".[12] This legal recognition arguably also gives greater moral and social legitimacy to the interests of couples in seeking technological solutions to their infertility. Evaluations of the ethics of permitting access to the latest, experimental assisted reproductive technologies should take this new legal interest into account in determining where the risk–benefit calculus should lie[13] – for example, in the Bioethics Advisory Committee's current ethical evaluation of mitochondrial genome replacement therapy to allow women suffering from various mitochondrial diseases the chance to bear genetically related children free from those diseases.[14]

6.8 Perhaps the most difficult aspect of the idea of genetic affinity is the court's decision to include the social and emotional impact of the loss of desired genetic relatedness on the plaintiff within this head of damage, in so far as it arose in response to social attitudes and reactions to Baby P's manifest physical differences arising from inherited genetic traits. This impact was brought home to the plaintiff through the socially awkward or distressing queries from family and members of the public on Baby P's different complexion.[15] With respect, while this might represent the reality of social harms faced in certain situations of genetic mix-ups in IVF, one wonders why this aspect of a loss of genetic affinity was exempt from the normative expectations of the parent–child

10 Fred Norton, "Assisted Reproduction and the Frustration of Genetic Affinity: Interest, Injury, and Damages" (1999) 79 NYU L Rev 793.

11 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [129].

12 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [130] and [135], respectively.

13 G Owen Schaefer & Markus K Labude, "Genetic Affinity and the Right to 'Three-Parent IVF'" (2017) 34(2) *Journal of Assisted Reproduction and Genetics* 1577.

14 Bioethics Advisory Committee, *Ethical, Legal and Social Issues Arising from Mitochondrial Genome Replacement Technology: A Consultation Paper* (19 April 2018) <http://www.bioethics-singapore.org/index/publications/consultation-papers.html> (accessed 20 June 2018).

15 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [131].

relationship that had earlier immunised the defendants from much of the financial consequences of their reproductive negligence.[16]

6.9 Suppose a mixed couple of different ethnic ancestry suffered the same experience of reproductive negligence that fertilised the intending mother's oocytes with that of a stranger, albeit of the same ethnicity as her husband. Should any resulting social awkwardness or stigma constitute a cognisable harm in raising the resulting child, if they would have experienced similar reactions in any case? Or what if reproductive negligence introduced a genetic mutation from a third party resulting in a disability that would otherwise have been avoided? Should any resulting social stigma arising from public reactions to the disability, or social questioning on the source of the genetic mutation, be considered part of the resulting composite harm? These questions could arise in future with an expansive notion of a loss of genetic affinity. An alternative framing would consider such emotional distress as equally part of the inherent burdens of the parent–child relationship, experienced by *both* parent and child, rather than distinct harms experienced solely by parents as individuals. This is reinforced because the parents in this case have voluntarily, and commendably, accepted the child as their own despite their defeated expectations. The original parental reproductive interest in establishing genetic affinity arguably crosses into the realm of relational norms that are constituted or reinforced once the parents have chosen to accept the unanticipated child as their own. As the court mentioned in the context of upkeep costs:[17]

> A moment's reflection will reveal that parents provide for their children in a myriad of ways besides ensuring their material well-being … If this is so, one might justifiably ask if there is any principled reason why the financial costs incurred in raising a child should be distinguished from the *emotional investment in providing for a child's self-esteem, happiness, and sense of worth*, and so identified as being capable of being the subject of a claim … [emphasis added]

6.10 In this relational context, the normative ideal of parental love and sacrifice to nurture the child should seek to overcome and dispel such social stigma, rather than seek solace in monetary compensation. It is difficult to see why financial obligations cannot be peeled away from the core of parental responsibilities, but parental emotional resilience in the nurture of the child and for the betterment of the relationship can.[18]

16 See Roger Magnusson, "IVF Stuff-Ups and Tort Liability for Loss of Genetic Affinity" (1 November 2017), *Sydney Health Law*, available at https://sydneyhealthlaw.com/2017/11/01/youve-got-the-wrong-skin-colour-ivf-stuff-ups-and-tort-liability-for-loss-of-genetic-affinity/ (accessed 20 June 2018).

17 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [92].

18 *Cf ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [93].

With respect, such emotional harms or burdens arising from the ensuing parent–child relationship should therefore not be considered part of compensable damage for the similar reasons the court adopts in rejecting the claim for upkeep costs.

6.11 The final issue in resolving this complex legal problem is the quantification of damages for the loss of genetic affinity, which is intangible and non-pecuniary. The court considered three possible alternatives. It rejected the "fixed" conventional award granted in *Rees v Darlington Memorial Hospital NHS Trust*,[19] on the basis that this would ignore the variability of the impact of reproductive negligence on the individuality of the reproductive autonomy of the claimant. The second alternative methodology of assessing "necessary expenses to avoid or cope with restrictions on autonomy" was over-inclusive as it encompassed claims based on resulting parental obligations that were not normatively considered an injury.[20] It was also under-inclusive in that it is tied to a negative conception of autonomy, when the interests embedded in genetic affinity included positive aspects of autonomy to bring about a desired state of familial ties.

6.12 The court therefore relied on the award of a conventional sum that is akin to compensatory awards for non-pecuniary loss. This approach requires a consideration of the precise motivations of the claimant and unique harms suffered because of a disruption to her reproductive plans. For want of an existing comparable benchmark, recourse was made to a percentage of the upkeep costs. This was fixed at 30%, reflecting in particular the emotional distress inflicted on the plaintiff and her family.[21]

6.13 A few points may be made on this method of assessment. It is, with respect, questionable why a benchmark rooted in pecuniary damage was chosen in relation to what was undoubtedly a non-pecuniary head of damage. Perhaps a better benchmark would have been the conventional sums typically awarded for the loss of amenity as a result of female infertility, which attracts a tariff in the range of $30,000–50,000.[22] While this loss typically results from physical injury, the nature of the harm is more functionally analogous to reproductive negligence in IVF, encompassing the loss of reproductive autonomy in the ability to bear one's own genetically related children. There are undoubtedly differences; infertility leaves the plaintiff childless apart

19 [2003] 3 WLR 1091.
20 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [144].
21 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [150].
22 Subordinate Courts of Singapore, *Guidelines for the Assessment of General Damages in Personal Injury Cases* (Academy Publishing, 2010) at pp 46–47.

from medical assistance, while loss of genetic affinity leaves the plaintiff with the difficult choice of raising a child that is not genetically related in the way that was intended. Nevertheless, it seems to provide a more stable and analogous benchmark than pecuniary loss which is a function of variable socio-economic factors and subjective desires.

6.14 A second concern with the choice of upkeep costs as a benchmark is this: while there may be a theoretical difference in the compensatory objective of the assessment, reliance on upkeep costs attracts some of the same policy objections that militated against its independent standing as a head of pecuniary damage. Even though the question of setting off the benefits of being a parent would not arise, claimants would similarly be incentivised to emphasise the resulting financial detriments of raising the child in order to maximise the monetary award for loss of genetic affinity.[23]

6.15 Thirdly, the practical result of this benchmark could also be widely varying awards depending on the claimant's financial wherewithal or socio-economic status. Notwithstanding the individuality of a claimant's reproductive autonomy, awards that vary widely as a result of such benchmarking could lose sight of the common reproductive interests of all infertile couples seeking IVF, and common resulting emotional and psychological harms to this group of individuals from the loss of genetic affinity *per se*. The foundational interest in genetic affinity is just as much the result of the "socially-constituted value of genetic relatedness"[24] as it is an expression of individual reproductive autonomy. Finally, settlements in such cases would also invariably be more difficult given the uncertainties on how the parents would exercise future discretion in incurring expenditure to raise their child, and where the line between the reasonable and unreasonable is to be drawn.[25]

6.16 In summary, *Thomson Medical* adds an important chapter to the continuing, global common law dialogue on the significance and consequences of reproductive negligence. While it offers many definitive legal answers to these complex, moral issues, it also opens the door to an antechamber in which more particular legal and ethical issues await debate and resolution.

23 *Cf ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [100].
24 *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [125].
25 *Cf ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [151].

Informed consent

6.17 The Court of Appeal's decision in *Hii Chii Kok* has recalibrated the standard of care expected of a medical professional in advising his patient. For decades since the House of Lords' decision in *Sidaway v Board of Governors of the Bethlem Royal Hospital*,[26] Singapore courts have routinely assessed the advice rendered to a patient contemplating medical diagnostic and therapeutic procedures by reference to a responsible body of medical opinion. Thus, as long as a defendant physician adduces relevant expert evidence of what responsible physicians would have advised in the same clinical scenario, that evidence would be accepted as the applicable standard unless it fails the test of logic first articulated in *Bolitho v City and Hackney Health Authority*[27] ("*Bolitho*") and refined in *Khoo James v Gunapathy d/o Muniandy*.[28]

6.18 For reasons based principally on the "seismic shift in medical ethics, and societal attitudes towards the practice of medicine",[29] the court decided that the *Bolam*/*Bolitho*[30] profession-centred approach to setting the standard of care could only be defended in relation to a doctor's conduct in diagnosis and treatment. In relation to medical advice, there had to be a balance between the ethical principles of respect for patient autonomy and beneficence, with neither dominating the other. Patients now expect to have greater involvement in their medical decision-making, and it is their *prima facie* right to make these decisions. These decisions are also not purely clinical in nature, but involve the patient's values, objectives and concerns, and cannot be placed solely within the province of medical judgment. Consequently, "it is the court that must be the ultimate arbiter of the adequacy of the information given to the patient, and in reaching its decision, it would be illogical not to adopt … the perspective of the patient who is, after all, the rights-holder in this scenario".[31]

6.19 This new evaluative approach is seen in the court's formulation of a three-stage test to determine if reasonable care was taken in advising the patient, which is a modification of the test in *Montgomery v Lanarkshire Health Board*.[32] The critical stage 1 of the test determines whether the undisclosed information was relevant and material.

26 [1985] AC 871.
27 [1997] 3 WLR 1151.
28 [2002] 2 SLR 414 (CA).
29 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [120].
30 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; *Bolitho v City and Hackney Health Authority* [1998] AC 232.
31 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [125].
32 [2015] 1 AC 1430.

Materiality is assessed from two perspectives: (a) the reasonable patient situated in the particular patient's position; or (b) what the doctor knows is important to that particular patient. The second limb does not require the physician to divine the patient's subjective state of mind, but is derived from what the physician reasonably knew based on the patient's queries or expressed concerns. In addition, relevance and materiality do not relate to just treatment risks and alternatives, but also the diagnosis, prognosis and nature of the treatment offered.

6.20 How is the court to determine what the reasonable patient needs to know in making a medical decision? Common sense is to prevail,[33] but the difficulty here is that reasonable patients are likely to differ on what they deem material, depending on their personal circumstances and values.[34] Relying on the dimensions of the likelihood and magnitude of the risk do not seem to offer a sufficiently clear matrix to assess materiality of treatment risks. The court acknowledged the continued relevance of expert opinion and professional ethical guidelines, but these cannot be determinative. Finally, the court briefly mentioned the relevance of context, and illustrated this by reference to the Singapore Medical Council ("SMC") "Ethical Code and Ethical Guidelines"[35] ("ECEG") recommendations on consent in relation to aesthetic medical procedures. Here, the scope of materiality is broadened by including risks of a lower magnitude or probability on the basis that such procedures are elective.[36] In the previous year's review of the High Court decision in *Hii Chii Kok*, the authors had suggested that clinical context could serve as the main engine in determining what counts as material information for a reasonable patient.[37] While the ideal scenario envisaged by a patient-centred standard of advice is a collaborative process leading to an optimal decision that factors in both clinical and patient perspectives, not all medical encounters warrant the same level of discussion. Considerations such as the absence of meaningful alternatives, whether the medical procedure is complex, invasive, elective or routine, will be important points of reference to

33 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [139].

34 See, *eg*, Jaime Staples King & Benjamin W Moulton, "Rethinking Informed Consent: The Case for Shared Medical Decision-Making" (2006) 32 *American Journal of Law & Medicine* 429 at 451–452.

35 Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2016 Edition" (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 20 June 2018).

36 Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2016 Edition" (13 September 2016) at p 32, para B10(4) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20-%20(13Sep16).pdf> (accessed 20 June 2018).

37 (2016) 17 SAL Ann Rev 138 at paras 6.11–6.13; see also *Montgomery v Lanarkshire Health Board* [2015] 1 AC 1430 at [89].

evaluate materiality of risk apart from the probability and magnitude of the risks.

6.21 However, in the application of the test, the court made a valuable observation that materiality does not connote all-inclusive detail. Rather, the professional responsibility of the physician is to "curate" the relevant information required to make an informed decision.[38] Thus, on the facts, the precise history of the deployment of Gallium test was not material, so long as the patient was appraised of the limitations of the test and the possibility of false positives. This illustrates the dynamics between material relevancy and explanation: the medical professional is not merely an information conduit, but a facilitator in coming to a shared decision on what is best for the patient. Indeed, to respond to the *Hii Chii Kok* test with undiscriminating disclosure would amount to an abdication of the professional responsibility to reasonably advise a patient.

6.22 Stage 2 allows for the possibility that it was not unreasonable for the physician to be ignorant of the material information. This could be because a diagnostic procedure that would have revealed the material information was not *Bolam*/*Bolitho* indicated, or because it was not reasonable to expect the physician to be aware of newly emerging scientific or clinical data on the existence or probability of the risk. At this stage, there is no question that *Bolam*/*Bolitho* evaluation continues to determine the outcome.

6.23 Finally, stage 3 illustrates most clearly the interplay of the underlying ethical principles of respect for autonomy and beneficence. The physician may justify non-disclosure of material information on various grounds such as waiver, emergency or therapeutic privilege. However, the categories are not closed, and any justification for non-disclosure is determined by the court – otherwise, *Bolam*/*Bolitho* would be introduced *via* the back door.

6.24 The ground of patient waiver is arguably not so much an exception as a further expression of respect for autonomy, for there are patients who are more comfortable in entrusting their medical decisions to their physicians or close family members.[39] The important qualification to this is that the patient must at the very least appreciate

38 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [187]; see also *Montgomery v Lanarkshire Health Board* [2015] 1 AC 1430 at [90].

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

the seriousness of the situation that he is entrusting to his physician.[40] It might be useful to link this threshold to the basic requirement of real consent to treatment as a defence to battery; that the patient must understand in broad terms what is being proposed, for waiver of disclosure to be real.[41]

6.25 Emergency situations relate to circumstances where the patient is temporarily incapacitated and a proxy decision-maker is unavailable, or where the urgency of the need for treatment does not allow time for a dialogue eliciting informed consent. The former situations are more accurately classified as an exception to consent *per se*, rather than the obligation to disclose material information and facilitate an informed patient decision. There is no obligation to obtain consent to begin with, because of the necessity for timely treatment. This power to treat without consent is now drawn from s 7 of the Mental Capacity Act[42] ("MCA") for adults.

6.26 The most intriguing exception under stage 3 is the notion of therapeutic privilege – which has consistently been recognised in various common law jurisdictions as an exception to material disclosure, but never carefully defined despite its potential to subvert the rationale for a patient-centred approach to medical advice.[43] The court suggested two situations where the privilege or exception applies – where the very disclosure of material information would cause serious physical or mental harm. Patients with anxiety disorders or who lack decision-making capacity are offered as examples,[44] but the court singled out a particular patient candidate for therapeutic privilege as follows:[45]

> [The] patient, *though not strictly lacking mental capacity*, nonetheless suffered from such an impairment of his decision-making abilities that the doctor would be entitled to withhold the information having regard to (a) the benefit of the treatment to the patient; (b) the relatively low level of risk presented; and (c) the probability that *even with suitable assistance*, the patient would likely refuse such treatment owing to some *misapprehension of the information* stemming from the impairment … [emphasis added]

6.27 This suggested instance of therapeutic privilege creates some difficulties in relation to the principles of the MCA. An adult patient is

40 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [150].
41 *Chatterton v Gerson* [1981] QB 432.
42 Cap 177A, 2010 Rev Ed.
43 See Rachael Mulheron, "Has *Montgomery* Administered the Last Rites to Therapeutic Privilege? A Diagnosis and Prognosis" (2017) 70(1) *Current Legal Problems* 149.
44 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [152].
45 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [153].

assumed to possess capacity until it is established that he lacks it, and should not be considered unable to decide merely because he makes an unwise decision.[46] In order to establish incapacity, a patient must have a neurological or psychological impairment, and this should not be inferred merely on the basis of age, appearance or some aspect of his behaviour.[47] The court's suggestion that therapeutic privilege countenances the ability of a physician to override an obligation to disclose material information by reason of some "misapprehension of the information" implicitly suggests that there is a dichotomy between the understanding needed for the capacity to make a decision, and other misapprehensions that are peripheral to capacity. With respect, this does not seem congruent with the principles of the MCA.

6.28 Section 5(4) of the MCA explains that the "information relevant to a decision" which must be understood in order to possess capacity includes information about the reasonably foreseeable consequences of deciding one way or not deciding at all. The MCA Code of Practice supplements this by including information about the nature of the decision, the reasons for the need to decide and the options available.[48] A harmonious reading of *Hii Chii Kok* with these pertinent provisions under the MCA framework indicates that "information relevant to a decision" should correspond with material information under the *Hii Chii Kok* test. On this reading, if such patients misunderstand information material to making a decision, notwithstanding all reasonable assistance, then they lack decision-making capacity. The best-interests standard under s 6 of the MCA then applies to protect the interests of such a patient, and this includes involving the incapacitated patient in the decision-making, as far as possible. There is no need to resort to a therapeutic privilege. The persistence of such an exception in the situation envisaged has the potential to undermine the protections and processes under the MCA, including the need for a formal capacity assessment to displace the presumption of capacity to make a medical decision which has serious consequences.[49]

6.29 The foregoing does not intend to suggest that there is no role left for therapeutic privilege. It properly covers situations where disclosure *itself* would cause serious harm to a competent patient. The nocebo effect is one example, where the disclosure of potential side

46 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 3(2) and 3(4).
47 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 4(1) and 4(3).
48 Office of the Public Guardian, "Code of Practice: Mental Capacity Act (Chapter 177A)" (October 2016) at para 4.6.1.
49 Office of the Public Guardian, "Code of Practice: Mental Capacity Act (Chapter 177A)" (October 2016) at paras 4.8.2(d) and 4.8.3.

effects can itself contribute to producing adverse effects.[50] Disclosure could conceivably exacerbate the condition of a patient with an anxiety disorder, who nevertheless can use or weigh that information in coming to a decision. In the latter case, such a risk could also properly be mitigated by carefully tailoring the disclosure to reduce its psychological impact in the exercise of reasonable care to advise.[51]

6.30 The court in *Hii Chii Kok* concluded on the facts that the plaintiff was engaged in a dialogue with his various physicians that reasonably appraised him of the uncertainties of his diagnosis, the risks of the Whipple procedure and of delaying surgery. There was no breach in the duty to reasonably advise the patient, although the prescribed standard was recalibrated to reflect the greater respect needed for patient autonomy. However, it remains to be seen if this legal reorientation will influence a real shift in clinical practices to better engage patients in a shared decision-making dialogue when it is most needed. Even if a patient gets past the *Hii Chii Kok* threshold for negligent advice, causation of loss remains another formidable hurdle.[52] The local courts have thus far rejected the autonomy vindicating modification of the conventional but for test in *Chester v Afshar*,[53] in favour of orthodoxy.[54] This, coupled with the Court of Appeal's rejection of a general loss of autonomy head of damage in negligence in *Thomson Medical*, greatly narrows the avenues of effective private law redress for negligent medical advice. It remains to be seen if the "seismic shift" in medical ethics and societal expectations of medicine will see its tremors extend further in the core elements of medical negligence to offer a more effective remedy for substandard professional medical advice.

Proof of medical negligence and innovative techniques

6.31 There was one other medical negligence case decided in 2017. In *Rathanamalah d/o Shunmugam v Chia Kok Hoong*,[55] the plaintiff sued her vascular surgeon for nerve damage to her legs after she underwent a surgical procedure to treat superficial reflux disease. Medical negligence was alleged in the advice and obtaining consent to undergo the surgery, the conduct of the operation and in post-operative care. The claims were

50 See Luana Colloca & Franklin Miller, "The Nocebo Effect and Its Relevance for Clinical Practice" (2011) 73(7) Psychosomatic Medicine 598–603.

51 See Emma Cave, "The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception" (2017) 46(2) *Common Law World Review* 140 at 153.

52 The court alluded to this in *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [222] but saw no need to address the issue.

53 [2005] 1 AC 134.

54 See *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18 at [170]–[173].

55 [2018] 4 SLR 159.

dismissed by the High Court essentially on factual bases – the plaintiff had not discharged her burden of proof that there were any such breaches. In rendering its judgment, the court reiterated that the principle of *res ipsa loquitur* had no application in medical negligence cases where the evidence established that the resulting damage was an inherent risk of the surgical procedures.[56]

6.32 Secondly, the use of a novel surgical technique, or novel combination of surgical procedures was, without more, not negligent. The defendant physician had combined endovenous laser therapy with foam sclerotherapy in an unorthodox fashion in treating the plaintiff. However, the expert evidence demonstrated that the novel technique posed minimal risk and had the potential to reduce the risk of injury.[57] The court reasoned that there was no evidence that no responsible body of medical opinion, logically held, would support such innovation – an innovation-friendly inversion of the *Bolam*/*Bolitho* standard that was first articulated in *Hunter v Hanley*.[58]

Professional discipline

6.33 The four key decisions of the Court of Three Judges on professional discipline discussed aspects relevant to liability (especially in relation to professional misconduct in the form of a doctor's failure to obtain informed consent), aggravating and mitigating factors in sentencing, as well as sentencing considerations in cases where a doctor had failed to obtain informed consent.

Liability

6.34 Dr Yong Thiam Look Peter ("Dr Yong") was a general practitioner in a group practice. In *Yong Thiam Look Peter v Singapore Medical Council*[59] ("*Peter Yong*"), he appealed against a six-month suspension imposed on him by a disciplinary tribunal[60] on the ground that it was manifestly excessive. Before the disciplinary tribunal, he had

56 *Rathanamalah d/o Shunmugam v Chia Kok Hoong* [2018] 4 SLR 159 at [113].
57 *Rathanamalah d/o Shunmugam v Chia Kok Hoong* [2018] 4 SLR 159 at [127].
58 [1955] SC 200 at 206; for a more detailed analysis of the standard of care for innovative treatments, see Tracey Evans Chan, "Legal and Regulatory Responses to Innovative Treatment" (2013) 21 *Medical Law Review* 92 at 111–115.
59 [2017] 4 SLR 66.
60 Apart from the six-month suspension, the disciplinary tribunal had also imposed a $10,000 fine, a censure, as well as the usual orders in relation to the imposition of an undertaking and payment of the fees and expenses of the Singapore Medical Council. Dr Yong appealed only against the suspension order.

pleaded guilty to three charges – all arising from a surgery he had performed on a patient's finger at a clinic:

> (a) two charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ('the MRA') [for failing to]:
>
> > (i) … obtain informed consent from the Patient[, whom he had advised to undergo the surgery[61]] ('the informed consent charge'); and
> >
> > (ii) … keep clear and accurate medical records[62] in respect of [his] performance of the Surgery on the Patient … ('the inadequate records charge'); and
>
> (b) one charge under s 53(1)(*e*) of the MRA [for] failing to provide professional services of a quality that may reasonably be expected – [having performed] the Surgery at his consultation table … when it should … have been [done] in a procedure room or an operating theatre [('the professional services charge')].

6.35 Dismissing Dr Yong's appeal against the suspension order, the court made important observations on the rationale and/or scope of the rules contravened in each of the three charges.

Rationale for informed consent

6.36 The informed consent charge was noted to reflect the concept of patient autonomy.[63] According to the court, the requirement for informed consent "seeks to ensure that patients give their considered consent to any medical test or treatment and that in doing so, they have been given enough information to enable them to meaningfully participate in decisions about the care that they may receive from medical practitioners".[64] The court observed that Dr Yong had completely failed to comply with Guideline 4.2.2 of the ECEG[65] issued

61 This was in breach of Guideline 4.2.2 of the Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2002 Edition", available at http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20(2002%20edition).pdf (accessed 20 June 2018).

62 This was in breach of Guideline 4.1.2 of the Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2002 Edition", available at http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20(2002%20edition).pdf (accessed 20 June 2018).

63 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [9].

64 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [9].

65 See Guideline 4.2.2 of the Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2002 Edition", available at http://www.healthprofessionals.gov.sg/

(*cont'd on the next page*)

by SMC, on informed consent, which required him to cover, amongst other things, "the nature of the procedure or treatment that [was] contemplated, the associated benefits and risks, possible complications and alternative courses".[66] Indeed, Dr Yong had made no attempt to cover *any* of these aspects.

Rationale for keeping proper medical records

6.37 In relation to the inadequate records charge, the court noted, "[properly] kept medical records form the basis of good management of the patient and of sound communications pertaining to the care of the patient".[67] According to the court, "[by] documenting such matters as patients' symptoms, history of illnesses, findings of clinical examinations, relevant investigative data, diagnosis and treatment plans, doctors not only set out the basis upon which they have acted but also ensure that the care of patients can be safely taken over by another doctor should the need arise".[68] The need for detailed medical notes was "imperative"[69] here because Dr Yong practised in a group practice with several other doctors any of whom might be called upon to take over any given case. "There is also a significant public health consideration in that detailed records enable effective reviews of cases where problems have ensued and this helps ensure that remedial or preventive measures can be developed."[70] The court observed, "Dr Yong's scant notes were illegible and there was inadequate documentation in respect of virtually every visit by the Patient".[71]

Assessing if doctor has failed to provide services of quality reasonable to expect of him

6.38 The court further observed that a charge under s 53(1)(*e*) of the Medical Registration Act ("MRA") (like the professional services charge) calls for an "objective assessment … of what reasonable medical practitioners would expect of their peers in delivering medical care".[72] To this end, the "minimum standards of acceptable care derived from the expectations of reasonable medical practitioners"[73] must be considered. The court noted that Dr Yong had disregarded the principles affecting

content/dam/hprof/smc/docs/guidelines/SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20(2002%20edition).pdf (accessed 20 June 2018).

66 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [9].
67 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].
68 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].
69 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].
70 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].
71 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].
72 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [11].
73 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [11].

asepsis, sterile technique, and adequate lighting – "fundamental medical techniques that any doctor … should be familiar with".[74] His conduct of the surgery on the consultation table was plainly unacceptable and increased the risk of infection and surgical injury.

6.39 The decision in *Peter Yong* was followed soon after by *Ang Peng Tiam v Singapore Medical Council*[75] ("*Ang Peng Tiam*"). There, Dr Ang Peng Tiam ("Dr Ang"), a prominent medical oncologist, had appealed against his convictions by a disciplinary tribunal on two charges of professional misconduct under s 53(1)(*d*) of the MRA. These charges were for:

> (a) making a false representation to his patient, who had been diagnosed with a variety of cancer, on the chances of her disease responding to his prescribed treatment of chemotherapy and targeted therapy ("the misrepresentation charge"); and
>
> (b) failing to offer his patient the alternative option of surgery ("the alternative option charge").

6.40 In relation to both charges, SMC had proceeded under the first limb of professional misconduct set down in *Low Cze Hong v Singapore Medical Council* ("*Low Cze Hong*").[76] The findings a disciplinary tribunal must make with respect to this limb before it can hold that SMC has proven a charge against an allegedly errant doctor are set out in the following table:[77]

	Professional misconduct	**Findings a disciplinary tribunal 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

74 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [11].
75 [2017] 5 SLR 356.
76 [2008] 3 SLR(R) 612.
77 See *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436.

		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

6.41 Dismissing Dr Ang's appeal against his convictions, the court made important observations on the scope of liability *vis-à-vis* each charge.

Assessing if doctor has made false representation to his patient

6.42 In determining if a doctor charged with misrepresentation should be convicted on the charge (like the misrepresentation charge), the court noted:[78]

> (a) Medical knowledge, by its nature, evolves constantly with new discoveries and learning – so that what might be regarded as a true statement today based on the current state of medical knowledge may subsequently come to be viewed as false with the emergence of new findings, and *vice versa*.
>
> (b) The inquiry should be directed at whether, as an objective matter, the representation was made with a reasonable basis, based on the state of (i) knowledge of the doctor in question, and (ii) scientific knowledge in general at the time the representation was made. If the state of medical knowledge as at the time the representation was made was such that there was no reasonable basis for the representation, then the representation will be found to be false.
>
> (c) The use of increased knowledge or experience embraced in hindsight after the event should form no part of the inquiry of what was reasonable in all the circumstances.[79]

6.43 Here, Dr Ang had represented to his patient that there was at least a 70% chance that her disease would respond to treatment and achieve control with his prescribed treatment of chemotherapy and targeted therapy because she had four phenotypes ("the

78 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [44].
79 See *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [157]–[159].

representation"). Applying the principles outlined above,[80] the court found that Dr Ang had no reasonable basis for making the representation.[81] Amongst other things, the court noted there was no scientific evidence or literature that supported a disease response rate of 70% in patients like the patient in question on receiving the same treatment Dr Ang had prescribed for the patient in question. To this end, the court emphasised that it was not concerned with averages or statistical probabilities (stated in the scientific literature), and cited the following extract from *Gregg v Scott*[82] (which it had earlier endorsed in *Quek Kwee Kee Victoria v American International Assurance Co Ltd*):[83]

> Statistical evidence, however, is not strictly a guide to what would have happened in one particular case. Statistics record retrospectively what happened to other patients in more or less comparable situations. *They reveal trends of outcome.* They are general in nature. The different way other patients responded in a similar position says nothing about how the claimant would have responded. *Statistics do not show whether the claimant patient would have conformed to the trend or been an exception from it.* They are an imperfect means of assessing outcomes even of groups of patients undergoing treatment, let alone a means of providing an accurate assessment of the position of one individual patient.

6.44 Having found that Dr Ang had no reasonable basis for making the representation, the court then moved on to consider if Dr Ang had intentionally and deliberately departed from standards observed or approved by members of the profession of good repute and competency.[84] The court noted that the disciplinary tribunal had given little reason for its finding that Dr Ang had intentionally or deliberately departed from the applicable standards. It observed that the disciplinary tribunal appeared to have relied on *Lim Mey Lee Susan v Singapore Medical Council*[85] ("*Susan Lim*") as support for a *general* proposition that "any false representation would necessarily constitute an intentional departure from the applicable standards".[86] This was, however, wrong because the court in *Susan Lim* had inferred from all the facts *in that case* that the doctor had deliberately made false representations to the patient. That said, the court nonetheless found that Dr Ang had intentionally and deliberately departed from the applicable standards because it was not Dr Ang's case that he was negligent or careless in relying on the material which formed the basis for his representation (or

80 See para 6.41 above.
81 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [46]–[67].
82 [2005] 2 AC 176 at [28].
83 [2017] 1 SLR 461 at [71].
84 See para 6.39 above.
85 [2013] 3 SLR 900.
86 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [69].

misrepresentation). This was not a case where Dr Ang had made a mistake, a misjudgment, or a misinterpretation of the underlying material. Rather, this was a case where Dr Ang had persisted in his view that he was justified in making the representation (even though, in truth, he had not adduced any evidence to show that he was so justified). There was also no dispute that Dr Ang had made the representation intentionally. To this end, the court concluded that "to intentionally make [a representation] without being able to advance a reasonable basis … constitutes misconduct within the first limb of *Low Cze Hong*".[87]

Whether doctor should present all alternative treatment options to his patient

6.45 With respect to the alternative option charge, Dr Ang accepted the finding of the disciplinary tribunal that he never mentioned or discussed surgery as an option with his patient at the time she consulted him.[88] He also accepted that based on the relevant guidelines,[89] surgery would have been the preferred option for the patient at the time she consulted him.[90] His contention, however, was that "as a doctor, he was obliged to exercise his clinical judgment in deciding on the viable options for treatment that are to be presented to a patient, instead of blindly and rigidly following guidelines".[91] The court characterised the issue as such: "whether surgery, which according to [the guidelines] was the preferred option for patients suffering from the same stage of cancer as [the patient], was a viable option that ought to have been presented [by Dr Ang] to [his patient] on 1 April 2010".[92] Answering the issue in the affirmative, the court observed:[93]

> (a) In general, a doctor may and should depart from guidelines when there are good reasons for him to do so. A doctor ought not to suspend his clinical judgment simply because there are guidelines which, after all, are not intended for slavish adherence, but are there to assist and guide a doctor in the exercise of his clinical judgment. A doctor should

87 See para 6.39 above.
88 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [74].
89 National Comprehensive Cancer Network, "Practice Guidelines in Oncology (v.1.2010) for Non-small Cell Lung Cancer".
90 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [75]. The expert witnesses on both sides were in agreement that the patient's tumour was resectable. It was also not disputed that the patient, who was only 55 years old, had the physical fitness to undergo surgery.
91 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [75].
92 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [77].
93 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [78]–[80].

evaluate the pros and cons of various treatment options for his patient having regard to the specific circumstances of each case.

(b) While a doctor was entitled to exercise his clinical judgment in evaluating which treatment options were best for his patient, the applicable standards, set out in Guidelines 4.2.2 (on informed consent) and 4.2.4.1 (on right to information) of the ECEG of 2002, required him to share with his patient the various *viable* treatment options as well as the pros and cons that he thought were associated with each.[94] The doctor should advise his patient as to which, of the various *viable* options, he, in his judgment, thought was the best option for the patient. That said, it was not for the doctor to decide for his patient which option the patient must take, by omitting even to mention, for the patient's consideration, other options including those the doctor might have thought were inferior to his planned course of treatment. A doctor might believe that a particular treatment option is in his patient's best interests, but ultimately, it is the patient who must make the decision on the patient's treatment.

(c) A doctor need not mention a treatment option if such an option was, objectively, *not* a viable option. The provision of useless information about non-viable treatment options to a patient in such instances is likely to confuse rather than assist and empower the patient.

Whether doctor should always explain all benefits, risks, complications, and alternative treatment options to his patient

6.46 In *Lam Kwok Tai Leslie v Singapore Medical Council*[95] ("*Leslie Lam*"), the court observed that the duty set out in Guideline 4.2.2 of the ECEG does not, however, impose on doctors an absolute and unyielding obligation to explain *all* the benefits, risks, complications, and alternative viable treatment options to a patient regardless of the patient's existing knowledge. Rather, it only imposes on doctors a duty to *ensure* that the patient is apprised of the relevant information about the various viable treatment options. This obligation will be satisfied if the doctor has *reasonable grounds* to believe that the patient was already well acquainted with such information. According to the court, Guideline 4.2.2 of the ECEG does not mean that a doctor has to

94 Singapore Medical Council, "Ethical Code and Ethical Guidelines: 2002 Edition", available at http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20(200%20edition).pdf (accessed 20 June 2018).

95 [2017] 5 SLR 1168.

mechanically recite information about the "benefits, risks and possible complications of [a] procedure and any alternatives available to [the patient]" without regard to what the patient already knew. That said, the court noted that where a doctor seeks to defend himself against a charge of failure to obtain informed consent on the basis that the patient was already familiar with the relevant benefits, risks, complications, and alternative viable treatment options, the burden is on the doctor to show that he had reasonable grounds for believing that the patient was already sufficiently informed of these matters.[96]

Signed consent form not conclusive defence that informed consent was indeed obtained

6.47 In *Jen Shek Wei v Singapore Medical Council*,[97] Dr Jen Shek Wei ("Dr Jen"), an obstetrician and gynaecologist, appealed against his convictions by a disciplinary tribunal on two charges of professional misconduct under s 53(1)(*d*) of the MRA. These charges were for:

> (a) advising his patient to undergo surgery to remove a pelvic mass without conducting further evaluation and investigation of her condition, when such further assessment was warranted ("the advice charge"); and
>
> (b) performing a left oophorectomy (a surgical procedure to remove an ovary) on the patient without having obtained her informed consent ("the informed consent charge").

6.48 The patient had been referred to Dr Jen (whom she had previously consulted for fertility treatment) by an orthopaedic surgeon she had consulted for backache and sciatica. Dr Jen performed a scan on the patient and found a lump in each of her ovaries. He advised her to remove the lumps given the risk of malignancy. He also offered the patient a choice of keyhole surgery (*viz*, laparoscopy) or open surgery (*viz*, open laparotomy). The patient opted for open surgery as she did not want to take the risk of any cancerous cells in the lumps spreading with laparoscopy. On the day of the surgery, the patient signed a number of documents including a generic consent form which allowed the names of the operation and the doctor to be filled in (which she alleged was blank when she signed it, but the disciplinary tribunal did not make a finding on this). Dr Jen was not present when the patient signed the consent form. During the operation, Dr Jen decided to remove the patient's entire left ovary (as opposed to just the lump within) due to certain "suspicious features" he saw. Observing that the fallopian tube on the left side was already badly damaged, he removed the patient's

96 *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] 5 SLR 1168 at [77].
97 [2018] 3 SLR 943.

fallopian tube as well. A subsequent histopathology report indicated that the lumps were benign. The patient only found out that Dr Jen had removed her left ovary about eight months later when she consulted another obstetrician and gynaecologist (as she was pregnant).

6.49 Dr Jen's appeal against his convictions was dismissed by the court. This review focuses on the informed consent charge only (which was framed under the first limb of professional misconduct set down in *Low Cze Hong*),[98] as the appeal in relation to the advice charge was dismissed largely on the findings of fact made by the disciplinary tribunal.

6.50 Referring to Guideline 4.2.2 of the ECEG (which sets out the duty to obtain informed consent) for the applicable standard of conduct, the court noted that the duty to obtain a patient's informed consent to a surgical procedure crystallises when the procedure is first suggested to the patient. It is at this time that the doctor must explain to the patient "the benefits, risks and possible complications of the procedure and any alternatives available".[99] In the instant case, this duty would have crystallised at the consultation where Dr Jen first advised the patient to undergo surgery to remove the lumps. The court then proceeded to examine whether Dr Jen's conduct represented an "intentional and deliberate departure" from the applicable standard of conduct, and analysed this issue in two parts:

> (a) whether Dr Jen obtained the patient's informed consent to the left oophorectomy; and
>
> (b) if Dr Jen did not obtain the patient's informed consent to the left oophorectomy, whether this failure to do so represents an "intentional and deliberate departure" from the applicable standard of conduct.

6.51 Contending that he did obtain the patient's consent to the left oophorectomy, Dr Jen argued, amongst other things, that the signed consent form[100] alone was sufficient evidence of informed consent. The court rejected this argument, noting that Dr Jen had failed to show that the patient knew that the operation she was going for would involve the removal of her ovary. According to the court:[101]

> Only when it is established that [the patient] understood the nature of the operation, would it be logical to place weight on the consent form that she signed. If the Patient did not understand the purpose of the

98 See para 6.40 above.
99 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [94].
100 See para 6.48 above.
101 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [103].

> operation – if she did not know in the first place that the operation was to remove her ovary – then her signing on the form, whether blank or filled in, does not suggest that Dr Jen had explained the required matters about the removal of her ovary to her. Hence, on the unique facts of this case, the consent form alone is irrelevant to the analysis unless and until it is proven that the Patient understood that she was undergoing a left oophorectomy.

6.52 To this end, the court stressed that the obligation to obtain informed consent is rooted in the process (that requires the doctor to explain to the patient "the benefits, risks and possible complications of the procedure and any alternatives available") and not a mere signed piece of paper.[102] The court also noted that it is too late to obtain informed consent in the waiting area of the operating theatre, given the reality that the patient in such a position would not be in the proper frame of mind to receive and evaluate any advice on risks and treatment options.[103]

6.53 As in *Ang Peng Tiam*,[104] the disciplinary tribunal gave little reason for its finding that Dr Jen had intentionally or deliberately departed from the applicable standards. That said, the court noted that if a doctor knows of the applicable standard of conduct (as Dr Jen admitted), but chooses not to comply with it, such non-compliance amounts to an intentional and deliberate departure from the applicable standard. This was especially so where the applicable standard of conduct is found in the ECEG, which embodies the minimum standards required of all practitioners.[105]

Aggravating and mitigating factors in sentencing

6.54 SMC in *Ang Peng Tiam* had also cross-appealed against the aggregate fine of $25,000 imposed by the disciplinary tribunal on Dr Ang. It had contended that the sentence was manifestly inadequate, and should be substituted with a suspension term of at least six months per charge. The appeal was allowed, and the court imposed an aggregate term of suspension of eight months. In allowing the appeal, the court made a number of significant observations on aggravating and mitigating factors in sentencing. These observations are set out below, together with those that arose in *Peter Yong* and *Jen Shek Wei*.

102 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [104].
103 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [138].
104 See para 6.44 above.
105 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [140]–[144].

Relevance of harm caused where harm is not element of offence

6.55 In *Peter Yong*, Dr Yong's counsel had cited the absence of harm to the patient as a mitigating factor.[106] Disagreeing, the court observed that if actual physiological harm to the patient is not an element of the offence:

> (a) The absence of such harm will "generally be a neutral consideration without any mitigating value".
>
> (b) The causing of such harm will be a "seriously aggravating factor".[107]

6.56 It may be added that where actual physiological harm to the patient *is* an element of the offence, it is the *severity* of the harm caused that should be factored in sentencing. In general, the seriousness of the harm caused and the severity of the sanctions imposed should follow a direct relationship.

Doctor's eminence and seniority is an aggravating factor

6.57 In *Ang Peng Tiam*, Dr Ang was an eminent and senior doctor of some 35 years' experience. He had held, and continued to hold, various key positions.[108] Against this backdrop, SMC argued that Dr Ang's misconduct in respect of the two charges[109] was aggravated because he was "in a position where he [was] expected to set an exemplary standard and to serve as a role model for fellow practitioners".[110]

6.58 The court agreed that, in the specific context of disciplinary proceedings for professional misconduct, an offender's eminence and seniority is an aggravating factor – because "[seniority] and eminence are characteristics that attract a heightened sense of trust and

106 In any event, it is not immediately apparent from the decision that the patient suffered no harm at all. In *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66, at [4], it was noted that when the patient sought a second medical opinion at the Singapore General Hospital, it was recorded:

> [He was] diagnosed with numbness over his radial aspect left middle finger and a poorly healing wound post trigger finger surgery. He was started on daily dressings, neurobion and oral antibiotics, and arrangements were made for a nerve conduction study. Between September 2012 and June 2013, the Patient had to undergo medical treatment and consultations at SGH approximately eight times.

107 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [12].

108 See *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [96], where the court detailed the various positions Dr Ang had held and was presently holding.

109 See para 6.39 above.

110 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [92].

confidence, so that when a senior and eminent member of the profession is convicted of professional misconduct, the negative impact on public confidence in the integrity of the profession is correspondingly amplified".[111]

Doctor's good character of little mitigating weight in the face of other sentencing objectives

6.59 In *Ang Peng Tiam*, the disciplinary tribunal had taken into account testimonials attesting to Dr Ang's dedication and professionalism as a doctor. It was also not disputed that Dr Ang had made significant contributions to society. These contributions included service with various institutions for varying periods of time, raising funds for needy patients, and public education. A similar approach had also been taken by the disciplinary tribunal in, *inter alia*, *Chia Foong Lin v Singapore Medical Council*.[112]

6.60 The court in *Ang Peng Tiam* took the opportunity to examine if an offender's good character – which could be indicated by his past contributions to society (such as volunteer work or contributions to charities), favourable testimonials, or an unblemished record – should be regarded as a mitigating factor. It first identified the two justifications that have been articulated as to why such an offender may be given some credit:[113]

> (a) An offender's good character may, in some circumstances, suggest that the offender's actions in committing the offence were out of character and thus likely to be a one-off aberration, with a low likelihood that he would re-offend ("the first justification").
>
> (b) A person of good character is less deserving of punishment when he commits an offence, as compared to some other person who commits a similar offence but who is not regarded as being of good character ("the second justification").

6.61 The court held that the second justification, which is premised on an offender's moral worth, was unprincipled and should be rejected. It observed that:

> (a) The second justification goes against the objective in passing sentence, which is to punish the offender for the wrong he has done and the harm he has occasioned in committing the

111 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [93].
112 [2017] 5 SLR 334 at [21(a)].
113 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [97].

particular offence. As such, the offender's good character,[114] in so far as it is unrelated to the offence, is irrelevant to sentencing.

(b) It is not the place of the court to judge the moral worth of those who are before it.

(c) Treating contributions to society as mitigating may be perceived as unfairly favouring the privileged, who will often be more likely to make such contributions because of their station in life than less privileged offenders.[115]

6.62 That said, the court accepted the first justification.[116] It noted that evidence of an offender's long and unblemished record may be regarded as a mitigating factor of *modest* weight if, and to the extent, such evidence fairly allows the court to infer that the offender's actions in committing the offence were "out of character" and he is therefore unlikely to re-offend[117] (*viz*, specific deterrence is not required).

6.63 However, the court was quick to point out that the first justification will be readily displaced if there are other sentencing considerations that override this – such as general deterrence, which is focused on sending a clear message to others of the harsh consequences that await those who might be thinking of following in the offender's footsteps.[118] On this note, the court observed that in disciplinary proceedings, any mitigating value that an offender's unblemished record might attract must be balanced against the wider interests of protecting public confidence in, and the reputation of, the medical profession. Given that the harm occasioned in undermining public confidence in the integrity of the medical profession is amplified when a senior and eminent doctor is convicted of professional misconduct,[119] any mitigating value that can be accorded on account of the doctor's unblemished record will, at best, be modest.[120] Given that the key sentencing objective, here, was general deterrence, the court accorded little mitigating weight to Dr Ang's unblemished record.[121]

Delays in prosecution can mitigate sentence

6.64 In *Ang Peng Tiam*, the disciplinary tribunal had placed significant weight on the fact that there had been a long delay in the

114 This may be indicated by the means stated at para 6.60 above.
115 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [98]–[101].
116 See para 6.60 above.
117 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [102].
118 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [103].
119 See paras 6.57–6.58 above.
120 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [104].
121 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [105]–[106].

proceedings against Dr Ang. A chronology of the proceedings against Dr Ang appears in the following table:

Dates	Events	Remarks
1 April 2010	Misrepresentation made to the patient, and patient then underwent Dr Ang's prescribed treatment	
October 2010	Patient passed away	
15 December 2010	Patient's daughters lodged complaint with SMC	
27 June 2011	The Complaints Committee ("CC") of SMC wrote to Dr Ang notifying him of complaint and requesting his written explanation	About 6 months after complaint was lodged
19 July 2011	Dr Ang provided his written explanation	
2 May 2012	Dr Ang received letter from the CC notifying him of its decision to refer matter to formal inquiry	About 1 year after Dr Ang had provided his written explanation
Late 2013	First disciplinary tribunal constituted	
3 April 2015	Second disciplinary tribunal constituted (as some members of first disciplinary tribunal had resigned)	
22 April 2015	Notice of inquiry specifying charges of professional misconduct was served on Dr Ang	Nearly 4.5 years had passed between SMC's receipt of complaint and its issuance of notice of inquiry to Dr Ang Dr Ang had to wait for 3 years before he received any further information on charges against him
November 2015; February 2016	Inquiry before disciplinary tribunal	Over the course of 2 tranches
12 July 2016	Disciplinary tribunal delivered its verdict on conviction and sentence	More than 5.5 years had passed between lodgment of complaint and delivery of verdict by disciplinary tribunal

6.65 The disciplinary tribunal considered that such a long delay would have caused Dr Ang considerable suffering over the years.

6.66 Referring to decisions on criminal sentencing, the court noted that:[122]

> (a) There is no general proposition that any or all delays in prosecution will merit a discount in sentencing.
>
> (b) That said, a court may discount the sentence to be imposed if:
>
> > (i) The delay (in the institution or prosecution of proceedings) was inordinate.
> >
> > (ii) The offender was not in any way responsible for the delay.
> >
> > (iii) The delay had resulted in real injustice or prejudice to the offender.
>
> (c) Whether or not there has been inordinate delay is not measured in terms of the absolute length of time that has transpired, but must be assessed in the context of the nature of investigation – *viz*, whether the case involves complex questions of fact which necessarily engender meticulous and laborious inquiry over an extended period (to uncover sufficient evidence, for instance), or whether the case may be disposed of in a relatively uncomplicated manner (for instance, where the offender has fully admitted to his complicity).
>
> (d) The underlying rationale for sentencing discounts to be applied in appropriate cases of delay is fairness to the offender. Where there has been an inordinate delay in prosecution, the sentencing should reflect the fact that the matter has been pending for some time, likely inflicting undue suffering on the offender stemming from the anxiety, suspense, and uncertainty.
>
> (e) There will be no unfairness to the offender if, by virtue of his own conduct or of matters that are within his control, he chooses to prolong the process. The offender must, in such cases, suffer the consequences of his own decisions and actions.
>
> (f) The underlying rationale of fairness to the offender may, on occasion, be offset or outweighed by the public interest which demands the imposition of a heavier penalty. In the context of disciplinary proceedings for professional misconduct, the relevant public interests that must be considered include the

122 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [108]–[118].

need to protect public confidence and the reputation of the profession, as well as the need to protect the public from potentially severe outcomes arising from the actions of errant members of the profession.

(g) Mental anguish, anxiety, and distress suffered by the offender in having the charge "hanging over his head" during the period of delay is prejudice that might warrant a reduction in sentence. In the context of disciplinary proceedings for professional misconduct, such prejudice might be exacerbated if, for instance, news that a doctor has been investigated for professional misconduct has become public such that he has had to run his practice under the cloud of a tarnished name and an impending prosecution which remains in the public eye even as it is delayed. In appropriate cases, other types of prejudice, such as the loss of income or career opportunities, may also be taken into consideration. In all cases, the burden is on the offender to prove that he has suffered particular prejudice by reason of the delay.

6.67 Against this backdrop, the court found that there was an inordinate delay on the part of SMC in instituting and prosecuting the proceedings against Dr Ang. The court also accepted "as a matter of natural inference" that this delay, which could not be attributed to Dr Ang, caused Dr Ang great anxiety and distress.[123]

6.68 Given the aggravating factors, the court noted that it would have suspended Dr Ang for an aggregate period of 16 months in respect of the two charges. It eventually halved this period to eight months, after balancing:

(a) the inordinate delay on the part of SMC in instituting and prosecuting proceedings; and

(b) the relevant interests of protecting public confidence and the reputation of the profession.

6.69 Similar observations were also made by the court in *Jen Shek Wei*, where there was a comparable delay on the part of SMC in instituting and prosecuting the proceedings.[124]

123 *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 at [122]–[123].
124 *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 at [167]–[173].

Sentencing considerations in cases where doctor has failed to obtain informed consent

6.70 In *Leslie Lam*, the court set out the following non-exhaustive list of factors that should be considered in sentencing errant doctors for professional misconduct under s 53(1)(*d*) of the MRA in the form of a failure to obtain informed consent:[125]

> (a) the materiality of the information that was not explained to the patient, namely, whether there is evidence that the patient would have taken a different course of action had such information been conveyed;
>
> (b) the extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and
>
> (c) the possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information …

125 *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] 5 SLR 1168 at [90].