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6. BIOMEDICAL LAW AND ETHICS

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I. Introduction

6.1 The year under review involved, relatively speaking, a bumper crop of interesting decisions in medical negligence and professional disciplinary cases. Proof of causation of loss or injury featured prominently in medical negligence before the Court of Appeal, while the High Court has for the first time addressed the issue of medical futility in the context of medical negligence. The healthcare institution's primary duty to provide a safe system of care was also an important issue. In professional disciplinary cases, the Court of Three Judges handled a broad range of cases involving various aspects of clinical practice such as obtaining informed consent, upholding medical confidentiality and medical certification of sick leave or light duties. There were also several cases examining points of sentencing and costs in professional disciplinary proceedings.

II. Medical negligence

A. Individual and organisational duties of care

6.2 In *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd*,[1] the Court of Appeal allowed the plaintiff's appeal against the High Court's dismissal of her claim of medical negligence against Changi General Hospital ("CGH") and several of its doctors. To recap, the plaintiff was diagnosed with Stage I lung cancer after a biopsy on 16 February 2012. Pursuant to standard treatment involving the removal of the relevant lobe of the lung and adjuvant chemotherapy, this cancer was reclassified as Stage IIA non-small cell lung cancer. She alleged

1 [2019] 1 SLR 834.

that there were negligent delays in detecting her cancer by the series of doctors – a respiratory specialist and two accident and emergency ("A&E") physicians – whom she had seen at CGH between 2007 and 2011, before the advice to undergo a biopsy in February 2012. In addition, she alleged that CGH failed to provide a reasonably safe system of care in the way it handled follow-up for abnormal radiological findings within its X-ray reporting system. This was a process in which an X-ray was sent for analysis and interpretation by a radiologist, who then prepared a report of the results and sent it to the attending physician for follow-up action. As a result, she claimed that her cancer was allowed to go undetected and untreated. This allowed the cancer to worsen, aggravating and prolonging her suffering, and resulting in her losing a better medical outcome.

6.3 The Court of Appeal essentially affirmed the various trial findings of negligence and reasonable care on the part of the respiratory specialist and A&E physicians respectively. In doing so, the court reaffirmed the application of the *Bolam/Bolitho* standard in matters of clinical diagnosis, even if there were underlying questions of pure fact that did not require recourse to *Bolam/Bolitho*. This is because clinical diagnosis goes beyond pure factual inquiry and into matters of interpretation and opinion that must be measured by the *Bolam/Bolitho* standard.[2] This is also a reaffirmation of the Court of Appeal's decision on the same issue in *James Khoo v Gunapathy*.[3]

6.4 In respect of the diagnosis and recommendations of the two A&E physicians, the Court of Appeal offered general observations on the contextual features of the speciality that ought to inform the standards expected of such physicians. First, the high case volume, and serious and urgent nature of the conditions encountered justified a "targeted approach" that focussed on prioritising the diagnosis and treatment of the patient's presenting symptoms, while giving less priority to incidental findings. While the latter cannot simply be ignored, their incidental nature may merely require that appropriate follow-up be taken by other specialities in the hospital in question, rather that in-depth follow-up by the A&E physician themselves. Interestingly, the court also noted that patient care here is *team based*, which meant that reliance was placed on the system and department as a whole, rather than the individual

2 *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd* [2019] 1 SLR 834 at [63]–[64].

3 [2002] 1 SLR(R) 1024 at [70]–[71].

physician, for follow-up on incidental findings discovered during the A&E consultation.[4]

6.5 On this basis, the court agreed with the trial judge that the two A&E physicians, Drs Yap and Soh, acted reasonably in not immediately diagnosing and treating the incidental finding of an opacity seen on the right mid-zone of the appellant's lungs. Neither was it negligent to order an X-ray instead of a CT scan as this was an incidental finding not directly related to the appellant's presenting symptoms. It was therefore appropriate for Dr Yap to defer diagnosis and treatment for the opacity until after the X-ray taken had been reported on by a radiologist and that the appellant be called back if necessary thereafter. Dr Soh on the other hand could not be faulted for missing the opacity on the right lung as he adopted a targeted approach to resolve the appellant's presenting symptoms emanating from the left side of her chest.

6.6 However, the court agreed with the trial judge that the respiratory physician, Dr Imran, was remiss in not scheduling a follow-up appointment for the appellant even though he was uncertain whether the said opacity in her chest X-ray had completely resolved. He instead discharged her. In this respect, the duty of a respiratory specialist differed from an A&E physician in that he was the "last in line" in the hospital system to diagnose the opacity seen on the appellant's X-ray and there was unlikely to be any other physician to follow-up on the matter.[5] Nevertheless, Dr Imran was not liable as the court found that the nodule in the appellant's lung was more likely to have been benign rather than cancerous based on all the factual circumstances. Accordingly, she suffered no loss by reason of this failure to properly follow up.

6.7 The appellant ultimately succeeded on the claim of primary, systems negligence in relation to CGH's X-ray reporting system, pursuant to which it failed to properly follow-up on the management of the appellant's X-ray opacity. The radiological reports on her X-rays taken in April 2010 and July 2011 noted abnormalities and recommended follow-up action by the A&E department. However, there was a significant evidentiary gap as no evidence was proffered by CGH to explain what follow-up action was taken by CGH A&E staff on the radiological reports. The trial judge was prepared to infer that follow-up was in fact done, but the Court of Appeal thought that an evidentiary burden arose that

4 Based on this practice in organisational healthcare delivery, the High Court in *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 endorsed the practice of a surgeon obtaining informed consent via another member of his surgical team, rather than doing so personally: at [50]–[51].

5 *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd* [2019] 1 SLR 834 at [87]–[88].

CGH failed to discharge. On the balance, they thought that the complete absence of evidence of any follow-up action meant that the stipulated procedure was not adhered to and no proper follow-up action was in fact taken.

6.8 More significantly, the court found that CGH had not put in place a proper system of care in relation to radiological reporting. First, the system was defective in routing radiological reports back to the A&E department instead of a relevant specialist, notwithstanding the patient load and time pressures faced by the former. It was unreasonable for all incidental radiological findings to be routed back to the A&E department when a specialist outpatient clinic would be more suited to the task of proper follow-up. Second, the system was also inadequate because it did not allow for sufficiently comprehensive patient management. There were three separate information systems used for recording clinical notes, test results and X-ray images, but none of them integrated comprehensive information to allow a reviewing A&E physician to make an informed decision regarding a patient's appropriate follow-up on a X-ray report. Finally, there was also no proper system of accountability in place to record the decision made by such a reviewing A&E physician, even though in the present case, two A&E physicians had apparently decided *against* the recommendations of the radiologist to follow-up on the appellant's incidental finding. The cumulative upshot of such deficiencies was the failure of the system to highlight to no less than six doctors that a single respiratory physician had erroneously judged a chest X-ray opacity as resolving or resolved when the nodule was clearly persistent. The court therefore found that CGH had failed to put a reasonably safe system of care in place and was in breach of its primary institutional duty to the appellant.

(1) Causation of loss

6.9 Crucially for the appellant, the Court of Appeal also overturned the trial judge's findings on causation of loss. Notwithstanding any professional or institutional negligence on the part of the defendants, the High Court found that the appellant's nodule was not, on the balance, cancerous between 2007 and July 2011. The Court of Appeal, however, took a different view of the evidence of the nodule growth particularly between the period July 2011 and March 2012, when the appellant was diagnosed with Stage IIA non-small cell lung cancer. Taking into account the fact that the appellant exhibited relevant respiratory symptoms in November 2011, the more significant rate of growth of the nodule between 2010 and 2011, the necessity of ALK positive tumour progression from stage IA through stage IB to stage IIA by March 2012, and the relatively short time period of eight months between July 2011 and March 2012,

the court inferred that it was more likely that the tumour was cancerous by July 2011.

6.10 Consequently, a referral to a respiratory physician would have been made if a proper system of care was in place at CGH at the relevant times, and a CT scan and biopsy would have been done by July 2011. There was, accordingly, a negligent delay in the appellant's cancer diagnosis which resulted in the progression of the cancer from stage IA to IIA, growth of the cancer nodule and nodal metastasis. However, as the trial judge did not address the appellant's consequential loss and damage suffered as a result of the foregoing findings, the case was remitted to resolve these remaining issues, which included a claim for loss of life expectancy.

6.11 The appeal succeeded mainly on a factual finding that the negligent systemic delay in diagnosis and treatment of the appellant's lung cancer caused her loss and damage. It is also significant that the Court of Appeal differed on the finding of organisational breach of duty. In doing so, its reasoning was independently prescriptive of the failings and reasonable expectations of CGH's follow-up arrangements for X-ray reporting and recording keeping for accountability, rather than constrained by examining expert opinion of what should have been put in place by the hospital. This lends weight to the views of some commentators that the *Bolam/Bolitho* standard of care for professionals does not apply with equal force to the evaluation of healthcare system design and implementation.[6] Here, it appears that the Court of Appeal was prepared to undertake its own evaluation of the adequacy of the measures taken, perhaps on the basis that the analytical exercise is not constrained by unique professional competencies. This was notwithstanding that there was expert professional opinion adduced by the defendants on the issue in this case.[7] Nevertheless, as the Court of Appeal did not explicitly address its mind to the legal question of whether a *Bolam/Bolitho* professional standard should apply to a hospital's primary organisational duty to provide a reasonable system of care, the point remains arguable.

(2) Proof of causation and statistical evidence

6.12 Causation was also the crux of the appeal in *Armstrong, Carol Ann v Quest Laboratories*[8] ("*Armstrong*"). The widow of a melanoma

6 See Andrew Grubb & Michael Jones, "Institutional Liability" in *Principles of Medical Law* (Ian Kennedy & Andrew Grubb eds) (Oxford University Press, 2nd Ed, 2004) ch 8 at para 8.65.

7 *Noor Azlin v Changi General Hospital* [2019] 3 SLR 1063 at [117].

8 [2020] 1 SLR 133.

patient sued the pathologist ("the respondent") and the receiving laboratory for negligence in diagnosing her deceased husband's skin biopsy as benign when it was in fact malignant. The breach of duty deprived the deceased patient of an opportunity for earlier surgical removal of the lymph nodes that would have arrested the spread of the cancer and prevented his death. The plaintiff's case was therefore that the pathologist's negligent diagnosis had caused her husband's death, and the action was, accordingly, a loss of dependency claim.

6.13 On appeal, the trial judge's finding of breach of professional duty was upheld. While counsel for the respondent tried to argue that the finding of non-malignancy was finely balanced, the Court of Appeal noted that none of the expert pathology witnesses called supported the view that the biopsy sample was conclusively benign. Even the respondent's expert witness acknowledged that the extensively ulcerated lesion and increased cellularity precluded the specimen from being classified as benign. Therefore, the *Bolam/Bolitho* test was not even engaged as there was no material difference of expert opinion on which the respondent could base his diagnosis. Finally, even if there was some obstruction of view in the original slide he examined, the onus was on the respondent to obtain deeper cross-sections from the same biopsy specimen to confirm his diagnosis, which he failed to do.

6.14 The bulk of the judgment in *Armstrong* was devoted to the question whether this negligent diagnosis, and consequent delay in treatment, caused the deceased patient any loss. As a preliminary point, the court rejected the respondent's submission that the *Bolam/Bolitho* test applied in evaluating professional expert evidence on the question of causation. The former was developed to accommodate reasonably held differences of professional opinion that guide medical practice (a normative question), and mitigating incentives towards defensive medicine (a policy concern). In contrast, questions of causation are largely retrospective inquiries to determine whether the defendant's breach of duty bore a sufficient relationship of cause-and-effect to the loss in order to satisfy the "but-for" test for factual causation, and whether such losses should be attributed as a matter of responsibility to that cause. They do not engage the same concerns that undergird the *Bolam/Bolitho* test for standards in diagnosis and treatment.

6.15 It should be mentioned that there is, however, one exception to this dichotomy where the causal inquiry follows breaches of professional duty that involve omissions to act. In such a scenario, the causal inquiry involves the hypothetical question of what a defendant would have done if she had not committed the breach by omission. In the very same case

of *Bolitho v City and Hackney Health Authority*[9] that refined the *Bolam* test, the defendant doctor had negligently failed to attend to a child who subsequently suffered a total respiratory collapse and eventually died. In answering the question whether this negligent omission caused his death, the issue arose whether the defendant would have, in the counterfactual world, intubated the child and thus prevented his death. The House of Lords held that causation could be established *either* by proving that the defendant would in fact have intubated the child, *or* that she should have. This latter inquiry is determined by the *Bolam/Bolitho* test, and is justified on the basis that it would be unfair to allow a defendant to escape liability by arguing that the damage would have happened anyway by reason of some other counter factual negligence on her part.[10] The exception has nevertheless been criticised as introducing incoherence into the dichotomy between the normative and the factual.[11]

6.16 It was not disputed that the delay between September 2009 and January 2012 allowed the unchecked spread of the patient's melanoma to his lymph nodes. This then led to distal metastasis spread via his blood stream, and ultimately, his death. The respondent's principal challenge on causation was that the patient's fate was already determined, irrespective of negligent diagnosis. He argued that there was already a spread of his melanoma in September 2009, albeit that such melanoma remained dormant until they became detectable in August 2013 when a PET scan detected distal metastasis in other parts of his body. The court ultimately rejected the respondent's expert's hypothesis of dormancy on the ground that in all the circumstances, dormancy of the distal melanoma spread was improbable. This was based on the characteristics of the patient's primary tumour, the significant length of the hypothesised dormancy and preference for the appellant's expert witness's experience in dealing with melanoma.

6.17 Following from this, the court was persuaded that the deceased would have agreed to sentinel lymph node biopsy ("SLNB") and possible completion lymph node dissection. SLNB would have been effective therapy for the patient given that all the melanoma cells would have been confined to the sentinel lymph nodes at that early stage of the melanoma. The court rejected the respondent's expert evidence and the underlying scientific literature on the grounds that the study cited was not pertinent

9 [1998] AC 232.

10 *Bolitho v City and Hackney Health Authority* [1998] AC 232 at 240, *per* Lord Browne-Wilkinson.

11 See R Goldberg, "Causation and Defences" in *Principles of Medical Law* (A Grubb *et al* eds) (Oxford University Press, 3rd Ed, 2010) ch 6 at paras 6.51–6.52.

to the efficacy of SLNB, and did not involve patients with primary tumours that were of the same profile as the deceased's.

6.18 Finally, the court considered whether the patient would have achieved a complete cure if he had been diagnosed and treated in a timely fashion. The respondents argued that there was statistical evidence that between 30.3% to 60% of patients with similar melanoma characteristics experienced relapses within five years of initial treatment. The court again rejected the statistical evidence proffered on various grounds that questioned their probity. For example, one study was faulted for its unrepresentative size, while another was distinguished on the ground that the characteristics of the cohort studied differed from the specific nature of the deceased's melanoma (which the court found would have been completely removed by SLNB). The early removal of the patient's melanoma, which was confined to his infected sentinel lymph nodes, should therefore be taken as an equivalent to a cure. Consequently, the court set aside the trial judge's finding of a loss of four years of life expectancy, and remitted the question of what the patient's life expectancy in the aftermath of a cure from melanoma would have been.

6.19 The decision is noteworthy for its specific advisory regarding the use of statistical evidence in medical negligence, and the important distinction between fact and belief probability.[12] While statistical evidence might indicate a percentage likelihood that a defendant's conduct caused or did not cause damage, this does not automatically satisfy the test for causation on a balance of probabilities. The statistical evidence has to be weighed for its probity (or belief probability) based on its reliability and applicability to the facts in issue.[13] This was repeatedly illustrated in *Armstrong*,[14] where the court doubted the probity of statistical evidence proffered by the respondent's expert witnesses when assessed on its inherent rigour and applicability to the particular circumstances of the patient's melanoma.

6.20 Unfortunately, because the court was satisfied that the patient would have been cured but for the negligent delay in diagnosis and treatment, there was no reason to resolve the applicability of the loss of

12 See *Armstrong v Quest Laboratories* [2020] 1 SLR 133 at [94]–[97]. Fact probability relates to a piece of probabilistic evidence that speaks to the existence or non-existence of a causal connection. Belief probability is the degree of *overall* strength and credibility attributed by the decision maker to the fact probability evidence.

13 See also *Wardlaw v Farrar* [2003] 4 All ER 1358 at [35], where Brooke LJ observed that while judges may place appropriate weight on statistical evidence, they must not ignore the effect of other evidence that might put a particular patient in a particular category, regardless of the probabilities.

14 See para 3.12 above.

chance doctrine in medical negligence in Singapore. This was therefore left for a more appropriate case in the future.

(3) Medical futility

6.21 In *Goh Guan Sin v Yeo Tseng Tsai*[15] ("*Goh Guan Sin*"), the plaintiff suffered bleeding in her brainstem as a complication of surgery she underwent to remove a benign brain tumour that was pressing against her brainstem. The bleeding in her brainstem caused further irreversible brain damage which resulted in her entering a persistent vegetative state ("PVS"). Acting by her litigation representative, she sued her neurosurgeon ("the first defendant") and the National University Hospital ("NUH"), where the surgery was performed. Her initial claim of medical negligence spanned her pre-operative care, the period during surgery, and her post-operative care and treatment. At the start of trial, the plaintiff dropped her negligence claims in respect of the surgery, and discontinued allegations of negligence during the pre-operative stage by the end of the trial. Thus, her post-operative care and treatment became the focus of the deliberations in the judgment. In this respect, the plaintiff claimed that the defendants were negligent in (a) failing to adequately monitor and care for her after the removal of her tumour; (b) misreading the first computed tomography ("CT") scan after her surgery and diagnosing a significant intra-axial haematoma (bleeding within the brain itself); (c) failing to remove the haematoma; and (d) failing to advise the family of the option of removing the haematoma. Instead of (d), the first defendant and his team only advised the plaintiff's family of the need to perform an external ventricular drain ("EVD") procedure to reduce the acute pressure that had built up in the plaintiff's brain after the main surgery.

6.22 Allegations of negligence regarding the post-surgical monitoring and care, the interpretation of the first CT scan after the main surgery and diagnosis of a significant intra-axial haematoma were dealt with under the *Bolam/Bolitho* standard of care. In each instance, the judge concluded that the first defendant and his team had reached logically defensible positions regarding the frequency of monitoring, interpretation of the CT scan and resulting diagnosis. These mainly factual findings were arrived at after a meticulous examination and analysis of the voluminous expert and other evidence in this case.

6.23 The judge's findings on the surgical team's decision to offer only an EVD, which the plaintiff's family members agreed to, and not to mention or perform an evacuation of the extra-axial haematoma

15 [2019] SGHC 274.

(bleeding within the skull but outside the brain tissue) are of particular interest. The plaintiff's prognosis after the main surgery was poor as she suffered intra-axial bleeding in the pons, the largest structure in the brain stem. The plaintiff's expert witnesses considered that removing the extra-axial haematoma was reasonable even though it entailed increased risk, given that this offered the chance of recovery and avoiding ending up in a PVS. The defendant's expert witnesses disagreed on the degree of increased risk of further brain damage and death, but considered that evacuation of the extra-axial haematoma depended on the individual surgeon's risk appetite and philosophical values on whether preserving life or avoiding PVS was more important.[16]

6.24 As the Physician's Pledge under the Singapore Medical Council's *Ethical Code and Ethical Guidelines*[17] ("SMC ECEG 2002") was to "maintain due respect for human life",[18] the judge reasoned that the first defendant and his surgical team could not be faulted for taking the conservative path to prevent death. He stated:[19]

> In my view, *a doctor cannot play God. His solemn duty is to have 'respect for human life'*. If the choice is between: (a) risking the Plaintiff's life with a high chance of death to evacuate the extra-axial haematoma, without any certainty of this surgical manoeuvre improving her prognosis of PVS; and (b) inserting an EVD to alleviate her symptoms of Cushing reflex to save her life, though she would remain in a PVS albeit without having to face the additional high risk of death through the evacuation of the haematoma, then the First Defendant cannot be faulted for having chosen the latter. [emphasis in original]

6.25 This led to the second issue of whether the first defendant had failed to obtain informed consent from the patient's family members to only perform the EVD and forgo evacuation of the extra-axial haematoma. The facts established that a member of the surgical team explained the EVD procedure to the plaintiff's family members, but did not inform of the latter option, as the surgical team had decided against it. The plaintiff's daughter signed the consent form authorising the insertion of the EVD. In spite of this, the court held that obtaining the family's consent was good manners but *not* a strict legal requirement unless they had legal authority to do so – citing common law authorities from the UK[20] and Singapore.[21] The plaintiff's daughter who signed the consent form was only appointed her court deputy some two years later. Given the urgent need to reduce intra-cranial pressure and the absence of any family member with legal

16 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [253]–[256].
17 2002 Ed.
18 Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2002 Ed) at p 2.
19 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [258].
20 *Re T (adult: refusal of medical treatment)* [1992] 3 WLR 782 at 787.
21 *Re LP (adult patient: medical treatment)* [2006] 2 SLR(R) 13 at [4].

authority to decide, "the legal significance of consent, which could not in any case have been obtained, pales in comparison to the plaintiff's best interests, in this case assessed to be saving her life".[22]

6.26 Secondly, the failure to inform them of the option of removing the haematoma was within the first defendant's prerogative – which depended on the "operating surgeon's philosophy".[23] This was because a patient cannot demand treatment that the doctor considers is not warranted or is averse to the patient's clinical needs.[24] In contrast, a physician's respect for patient autonomy controls in the situation where there is a valid refusal of treatment, even if this is at odds with his clinical judgment that treatment is in the patient's best interests. Here, the first defendant and his team considered removal of the haematoma to be futile – that is, it "would expose the Plaintiff to further risks, including death" – and were therefore not obliged to disclose this futile option to the family.[25]

6.27 Curiously, no mention was made in the judgment of the requirements of the Mental Capacity Act[26] ("MCA"), which was clearly applicable to the administration of treatment to a mentally incapacitated patient like the plaintiff at the time of the EVD procedure. In the absence of legally valid consent from a third party, the first defendant and his team could rely on the s 7 general defence under the MCA. This would confer legal justification for the insertion of the EVD as if they had the patient's own consent, if they reasonably believed that it would be in the plaintiff's best interests for the procedure to be done.[27] However, "best interests" takes on a specific meaning under s 6 of the MCA. That section requires any person determining what an incapacitated person's best interests are to consider, *inter alia*, the latter's:[28]

> (a) past and present wishes and feelings; and
>
> (b) beliefs and values that would be likely to influence her decision if he had capacity.

22 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [284]. The Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2002 Ed) Part C6(2) – which was also cited by the court – also recommends that in the absence of persons with legal authority to make decisions, physicians should proceed according to their best judgment of the patient's best interests.

23 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [287].

24 Citing *R (Burke) v General Medical Council* [2005] 3 WLR 1132 at [50] and [55].

25 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [289].

26 Cap 177A, 2010 Rev Ed.

27 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 7(1)(*b*) and 7(2).

28 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 6(7)(*a*) and 6(7)(*b*).

Finally, the surgeons must also take into account, if practicable, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind and anyone engaged in caring for the person or interested in her welfare.[29]

6.28 As a matter of process, the patient's family, and her daughter in particular, had been extensively involved in the decision-making process prior to the surgery to remove her tumour.[30] They were, however, not consulted on the option to remove the haematoma. Although the matter was of great urgency, there was still time to speak to and get the family's "consent" for the EVD.[31] The failure to notify and consult the patient's family, or, apparently, to even consider matters from the perspective of the patient's beliefs and values,[32] would appear to have had a material influence on the deliberations. The evidence from the family members was that the plaintiff would have wanted to take the chance to remove the haematoma rather than remain in a vegetative state.[33]

6.29 This brings into sharp relief the tension between the best interests standard under the MCA, which places some emphasis on the patient's beliefs and values, and the doctrine of medical futility that was relied on by the court. The latter is a contested concept that seeks to resolve the ambit of a physician's prerogative to *unilaterally* determine or limit what treatments should be offered to a patient or withdrawn. Some medical ethics commentators argue that we should distinguish between quantitative (or physiological) and qualitative futility.[34] The former focuses on the probability of an intervention achieving a particular outcome, and involves a clinical judgment if this falls below a minimal threshold. This concept is less controversial – the medical profession should wield authority to determine acceptable efficacy of treatment. Doctors should not be obliged to offer treatments that will not likely work (even if there is no scarcity of resources), although the probabilities of efficacy are often prone to clinical disagreement.[35] The latter concept of futility focuses on the outcome of medical treatment and asks whether the value of this outcome falls below a minimal level.

29 Mental Capacity Act (Cap 177A, 2010 Rev Ed) ss 6(8)(*a*) and 6(8)(*b*).
30 See *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [6]–[9].
31 See *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [265] and [280].
32 The best interests standard under s 6 of the Mental Capacity Act (Cap 177A, 2010 Rev Ed) embraces the patient's welfare in the widest sense, and not just his medical best interests. This was made clear in *Aintree University Hospitals NHS Foundation Trust v James* [2013] 3 WLR 1299 at [39] and [45].
33 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [286].
34 L J Schneiderman *et al*, "Medical Futility: Its Meaning and Ethical Implications" (1990) 112 *Annals of Internal Medicine* 949–954.
35 N Jecker & R Pearlman, "Medical Futility: Who Decides?" (1992) 152 *Archives of Internal Medicine* 1140.

This notion of futility is more controversial, with some arguing that it is the patient's beliefs and values that should determine if the outcome is worthwhile, not the doctor's philosophical or religious predilections. Others argue that some questions of qualitative futility are within the domain of medical judgment, where there is community consensus of quality of life falling below a minimal threshold.[36]

6.30 Some support for quantitative futility as a unilateral prerogative can be gleaned from *R (Burke) v General Medical Council*.[37] The English Court of Appeal observed that while doctors are obliged to provide artificial nutrition and hydration ("ANH") that would preserve the patient's life where this was in accord with his wishes, this is not always the case. For example, where ANH will actually hasten death, or produce adverse reactions in excess of palliative effects, patients cannot demand such adverse clinical treatment.[38] The pronouncement appears to be based on the assessment that ANH will not, in these circumstances, likely achieve the objective sought but instead promote the obverse. It is *not* based on an assessment of whether the patient's quality of life is worth living under such circumstances as the appellant Burke, suffering from a congenital degenerative brain condition, anticipated he would face. In *Aintree NHS Trust v James*,[39] Baroness Hale supported a conception of medical futility where the proposed treatments are "ineffective" or "of no benefit to the patient".[40]

6.31 The apparent Hobson's choice that faced the plaintiff in *Goh Guan Sin*[41] in addressing the haematoma illustrates the difficulty of applying such a doctrine of medical futility. On one interpretation, the first defendant's assessment to withhold the option of removal could be based on the low probability of success in avoiding a PVS, and correspondingly increased odds of death ensuing.[42] However, the expert evidence on both

36 N Jecker & R Pearlman, "Medical Futility: Who Decides?" (1992) 152 *Archives of Internal Medicine* 1140 at 1142, giving the example of medical treatment that only serves to continue existence in a persistent vegetative state; see also the decision of *Airedale NHS Trust v Bland* [1993] AC 789.

37 [2006] QB 273; [2005] 3 WLR 1132.

38 *R (Burke) v General Medical Council* [2006] QB 273 at [53]–[54].

39 [2013] 3 WLR 1299.

40 *Aintree University Hospitals NHS Foundation Trust v James* [2013] 3 WLR 1299 at [40].

41 See para 6.21 above.

42 The prognosis only became much clearer after the second computed tomography scan was done once the insertion of the external ventricular drain was completed. At that point, it became clear that the haematoma extended beyond the pons to the midbrain and thalamus. Any further intervention at that point in time would have more clearly been quantitatively futile in preventing the descent into a persistent vegetative state: see *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [263]–[265].

sides interpreted the decision at first discovery of the haematoma as one relating to the value of the possible outcomes – whether a PVS was an outcome worse than death.[43] As it would be fair to say that there is still no community consensus on the value of continuing in a PVS, the decision should arguably have been grounded in the patient's values concerning those alternative outcomes; values which her family indicated would be in favour of avoiding a PVS.[44]

6.32 How might one reconcile these tensions between the values of the profession, the individual physician, and the patient's beliefs and values? Certainly, some latitude must be given to a medical professional's assessment of the odds of success or failure of a therapeutic option. However, with respect, in such equivocal circumstances, it would unnecessarily side-line the requirements of the MCA to forgo even discussing the option with the patient's family. Engaging with them would allow the surgical team to understand the issue from the patient's perspective, what her relevant values might be, and therefore what her overall best interests were. It might have altered their perception of the risk-benefit trade off. The result of such a discussion might well have confirmed the surgeon's initial judgment (there is no obligation under s 6 of the MCA to accede to a patient's or family's wishes), but the family members were deprived of the statutory opportunity to be consulted on a matter that directly engaged the plaintiff's values and beliefs, and not merely the efficacy of treatment.[45] An opportunity to work towards a consensus and maintain trust was perhaps lost.[46] In addition, if the family had been appraised of the option, there was also the possibility of persuading another surgeon to undertake the surgical risks in order to help avoid the outcome of PVS that was contrary to the patient's wishes and values. One cannot read the judgment in *Goh Guan Sin* as suggesting that between saving life and avoiding a PVS, only the former is ethically or legally justifiable.

6.33 Notwithstanding these substantive and procedural difficulties with the medical decision-making process, the outcome in the medical

43 See *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [253]–[256]: One of the first defendant's expert witnesses, DW4 Dr Ivan Ng, opined that he would have evacuated the haematoma even though the patient might die as he would then know he had done everything possible to avoid the outcome of a persistent vegetative state. Such a decision had a "philosophical element" and was not a "pure medical decision".

44 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [286].

45 In *Aintree NHS Trust v James* [2013] 3 WLR 1299 at [39], Baroness Hale stated that in considering the best interests under the UK Mental Capacity Act 2005 (c 9), decision makers "must consult others who are looking after him or others interested in his welfare, in particular for their view on what his attitude would be".

46 See N Jecker & R Pearlman, "Medical Futility: Who Decides?" (1992) 152 *Archives of Internal Medicine* 1140 at 1143.

negligence action would not have changed. Even if the first defendant had taken reasonable steps to ascertain the patient's beliefs and values, and a decision to evacuate the haematoma made, the court found that the plaintiff would not be able to prove that she would have avoided a PVS; the expert evidence on the chances of her regaining any functionalities were speculative.[47]

III. Professional misconduct

A. Informed consent

6.34 In *Singapore Medical Council v Lim Lian Arn*[48] ("*Lim Lian Arn*"), a registered medical practitioner ("the respondent") was charged with professional misconduct for acting in breach of the SMC ECEG 2002 by failing to obtain the informed consent of his patient before administering a hydrocortisone injection for treating pain and inflammation in her left wrist. It was alleged that the respondent had failed to advise the patient of the possible risks and complications associated with such an injection, which included post-injection flare, changes in skin colour and skin thinning. Some of the complications did in fact materialise, and the patient suffered skin discolouration and thinning, and a loss of fat and muscle tissue. She then filed a complaint against the respondent.

6.35 The respondent, on the advice of his lawyers, pleaded guilty to the charge of professional misconduct under s 53(1)(*d*) of the Medical Registration Act[49] ("MRA") – that his conduct amounted to such serious negligence that it objectively portrayed an abuse of a medical practitioner's registration privileges. He also admitted to the agreed statement of facts without qualification. The disciplinary tribunal ("DT") accordingly convicted him of the charge and fined him the maximum $100,000. They did not think a suspension was warranted. Although they thought that the undisclosed information was material, there was no evidence that the patient would have declined the injection. Neither did the respondent deliberately suppress the information nor intentionally depart from the professional ethical standards. In addition, although the complications that arose fell within the ambit of reasonable disclosure, the injection was medically appropriate, minimally invasive treatment for the patient and the side effects did not appear to be permanent or debilitating.

47 *Goh Guan Sin v Yeo Tseng Tsai* [2019] SGHC 274 at [309].
48 [2019] 5 SLR 739.
49 Cap 174, 2014 Rev Ed.

6.36 The SMC, having been requested by the Ministry of Health to review the appropriateness of the sentence and other measures to be taken in the light of the DT's decision, brought an appeal under s 55(1) of the MRA in order to review the DT's decision and have the sentence reduced to a fine not more than $20,000. The Court of Three Judges held that there had been a miscarriage of justice in this case as there was no basis for a conviction for professional misconduct, notwithstanding the respondent's plea of guilt.

6.37 The court noted that all the parties in the proceedings appeared to have overlooked the fact that a breach of professional standards *per se* did not necessarily amount to professional misconduct. In *Low Cze Hong v Singapore Medical Council*[50] ("*Low Cze Hong*"), it was held that professional misconduct is made out where there is (a) an intentional, deliberate departure from professional standards; or (b) such serious negligence that it objectively portrays an abuse of a registered medical practitioner's privileges. Only serious breaches warrant disciplinary action; otherwise, an intolerable burden would be imposed on medical practitioners. Nevertheless, the MRA provides a variety of measures to respond appropriately to a patient's complaint and address even technical or minor breaches without the need for disciplinary action.

6.38 Serious negligence requires something more than mere negligence, reflecting indifference to a patient's welfare or professional duties, or an abuse of trust and confidence reposed by a patient in the doctor. In this respect, the court adopted a multi-factorial approach:[51]

> In broad terms, it will be relevant to consider the nature and extent of the misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action. This would depend on a multitude of overlapping considerations including the importance of the rule or standard that has been breached, the persistence of the breach and the relevance of the alleged misconduct to the welfare of the patient or to the harm caused to the doctor-patient relationship.

6.39 In the instant case, the court had considerable doubts whether the respondent did not in fact advise the patient of the relevant risks and complications of the steroid injection. Given the therapeutic options presented to the patient without an endorsement either way, it was improbable for the patient to have made a choice without some discussion of the possible benefits and side effects. The respondent's testimony and medical records indicated that it was his usual practice to discuss these with patients, albeit he could not recall if he specifically did

50 [2008] 3 SLR(R) 612.
51 *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 at [38].

so with respect to the patient in question. His notes did not capture this fact in the particular consultation.

6.40 In the alternative, the evidence and DT's factual findings did not support a finding of professional misconduct. Assuming that there was no discussion of risks and complications, this was a one-off, honest omission in the course of a routine procedure that did not cause any material harm to the patient. The complications of the injection were not permanent or debilitating. The DT itself had found that there was nothing to suggest that the patient would have taken a different course of action had the risks and complications been explained to her. Therefore, there was no causal link between the failure to disclose and explain, and the complications that resulted. Accordingly, the court did not think that there was serious negligence involved that amounted to professional misconduct. In addendum, they also noted that the maximum $100,000 fine was wholly unwarranted if there was indeed misconduct given that the DT had found that the respondent's culpability was on the low end and the ensuing harm limited in nature and extent.

6.41 Three observations are warranted. First, the finding that there was no basis for a conviction of professional misconduct should be compared with the decision in *Low Cze Hong*,[52] where the medical practitioner was sanctioned for failing to obtain his patient's informed consent contrary to the SMC ECEG 2002. There, a charge of failing to obtain informed consent was accompanied by a prior charge of administering inappropriate treatment. Dr Low had recommended invasive surgery to treat neovascular glaucoma in a patient's blind right eye that was causing headaches. In offering "hasty and aggressive" surgical implantation of a Molteno tube, in lieu of non-invasive and less risky treatments to alleviate pressure in the right eye, the doctor had also failed to advise of these other preferred options.[53] The disciplinary committee in *Low Cze Hong* did not engage with the question of why this single instance of inadequate disclosure amounted to serious negligence.[54] The specific argument raised in the appeal was instead that the alternatives and risks were in fact told to the patient.[55] One might infer from this that the mere failure to obtain informed consent can amount to professional misconduct. *Low Cze Hong* can now be interpreted based on the

52 See para 6.37 above.

53 *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [62].

54 See *Singapore Medical Council v Dr AAA*, Decision of the Disciplinary Committee (5 January 2008) <https://www.healthprofessionals.gov.sg/docs/librariesprovider2/published-grounds-of-decision/year-2008/dr-aaa-(2008)---grounds-of-decision.pdf> (accessed June 2020).

55 *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [75].

reasoning in *Lim Lian Arn*,[56] that a failure to advise of non-invasive and less aggressive treatment alternatives, thereby exposing the elderly patient to unnecessary surgical risks without any benefit of restoring sight in the eye in question, amounted to serious negligence. Conversely, *Lim Lian Arn* should also not be read as holding that one-off failures to obtain informed consent *per se* cannot amount to professional misconduct.

6.42 In connection with this, another important point that arises from *Lim Lian Arn* is that the failure to record details on the nature, alternatives and risks in the medical record is not fatal to a defence against the charge of failure to obtain informed consent. The court looks at all the circumstances to determine what in fact happened during the medical consultation. The failure to record disclosures in *Low Cze Hong*'s case that gave rise to an adverse inference was reinforced by the doctor's admission of a lack of knowledge of therapeutic alternatives and his lack of credibility. In contrast, where there is documentary evidence of a practice of disclosure and discussion of alternatives and risk as in the case of *Lim Lian Arn*, this will work in favour of diminishing the seriousness of the negligence in a particular instance giving rise to a complaint, notwithstanding a gap in the medical record.

6.43 Secondly, in discussing what the requirements of informed consent were in this case, the court reasserted that the criteria for relevant, material information that must be disclosed and explained are based on "common sense" along the dimensions of the likelihood and severity of the risks.[57] As the expert testimony did not go into these dimensions of the steroid injection, there was no evidentiary basis to determine what information a reasonable patient in this situation would need in order to make a decision. Notwithstanding this, it is questionable whether the dimensions of likelihood and severity of risk alone are adequate to provide sufficient predictability about what the legal standard of advice requires. In situations like the present, where the patient has a choice among various indicated treatment, some more conservative than others, the personal values of the patient and their perception of the risks in question become important in determining what is material. Here, as some scholars observe, it is not possible to pinpoint one rational standard as perceptions of risk and the value placed on avoiding pain or regaining certain physical amenities vary between reasonable patients.[58] In such situations of *elective* treatments, they argue that all relevant risks

56 See para 6.34 above.

57 Referring to the decision in *Hii Chii Kok v Ooi Peng Jin London Lucien* [2016] 2 SLR 544 at [140].

58 J S King & B W Moulton, "Rethinking Informed Consent: The Case for Shared Medical Decision-Making" (2006) 32 *American Journal of Law & Medicine* 429 at 452.

should be disclosed to patients in a shared decision-making approach. This allows the individual patient's values and preferences to shape the evaluation of the benefits and risks of the therapeutic options, which is a dialogical process.[59] The downside of such a standard are the various costs entailed in supporting such a decision-making approach. Thus, the early US cases that developed the informed consent doctrine recognised this inherent uncertainty in the reasonable patient standard and granted physicians some discretion in determining what material information to disclose based on sound medical judgment – the therapeutic privilege.[60] Another consequence of this uncertainty is that doctors may understandably respond by making fuller disclosure of all the known risks and complication in order not to fall on the wrong side of the reasonable patient standard.

6.44 This leads to the third issue discussed in *Lim Lian Arn*.[61] The court refuted the notion that the requirements of informed consent would encourage defensive medicine. Defensive medicine refers to the situations where doctors take a certain course of conduct, not in the patient's best interest, but in order to avoid legal liability. However, the court considered this phenomenon to be inapplicable to informed consent because disclosing more information to the patient *will not* avoid liability simply because there is a concomitant duty to explain that information. Overloading the patient with treatment related information will simply overwhelm and confuse her and undermine the ability to give an informed consent.

6.45 Be that as it may, the *Hii Chii Kok* standard is articulated as a sequential analytical process. The first relevant step is to determine what material information is needed by a reasonable patient to make a decision. Then, assuming that no exception applies to justify withholding that information, the obligation is to assist the patient by explaining that relevant, material "basket" of information in order to come to an informed decision. The difficulty facing the doctor is that the first stage appears to admit a significant degree of ambiguity about materiality that cannot objectively be demarcated by the likelihood and severity of risks and complications. Therefore, prudence would suggest erring on the side of caution and going further in disclosure in order to manage the perceived risk of being second-guessed later on what counts as material.

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59 J S King & B W Moulton, "Rethinking Informed Consent: The Case for Shared Medical Decision-Making" (2006) 32 *American Journal of Law & Medicine* 429 at 463–464.

60 J S King & B W Moulton, "Rethinking Informed Consent: The Case for Shared Medical Decision-Making" (2006) 32 *American Journal of Law & Medicine* 429 at 443. For example, see *Canterbury v Spence* 464 F 2d 772 at 789 (DC Cir, 1972).

61 See para 6.34 above.

This arises *before* the duty to explain and ultimately advise is engaged. Defensive medicine is not a term of art, and whether or not *apropos* in this aspect of medical practice, the concept seeks to identify a source of liability uncertainty that might undermine the healthcare system and patient's interest in doctors making optimal decisions that will best promote their welfare. The duty to explain, being an aspect of the duty of care, is based on reasonable efforts, and cannot be one that ensures that the patient understands what is at stake in the decision.[62] In this respect, the uncertainties of the reasonable patient standard create a risk that too much information is presented, which despite the reasonable efforts of the physician in explaining them, results in the patient making a sub-optimal decision. This aspect of the *Hii Chii Kok* standard therefore needs to be revisited in order to achieve better clarity in the interests of both doctor and patient.

B. Medical confidentiality

6.46 In *Singapore Medical Council v Soo Shuenn Chiang*[63] ("*Soo Shuenn Chiang*"), another miscarriage of justice was again averted; this time in relation to the professional duty to protect medical confidentiality. The respondent consultant psychiatrist at NUH received a call from a person claiming to be the husband of the complainant. The complainant was a patient of the respondent, who had defaulted on a follow-up appointment at NUH. The respondent acceded to the request and prepared a memorandum containing confidential medical information concerning the complainant, on the ostensible basis that the memorandum was needed to refer the complainant for further assessment by the Institute of Mental Health in order to prevent self-harm as a result of threats of suicide. The memorandum was left with the respondent's clinic staff, who in turn handed it to the caller later that same day. As it transpired, the caller was in fact not her husband, but her brother, who had instead used the memorandum as evidence in Family Court proceedings for a personal protection order brought by her brother on behalf of the complainant's son against her. The complainant then lodged a complaint against the respondent with the SMC pursuant to s 39(1) of the MRA.

6.47 After some investigations, the complaints committee of the SMC ordered a formal inquiry into the matter. The SMC charged the respondent with failing to take appropriate steps to maintain the medical confidentiality of his patient against unauthorised persons, in breach of Guideline 4.2.3.1 of the SMC ECEG 2002. Such conduct was alleged to amount to serious negligence that constituted professional negligence.

62 See *Al Hamwi v Johnstone* [2005] EWHC 206 (QB).
63 [2020] 3 SLR 1129.

The respondent pleaded guilty to this charge and admitted unreservedly to the agreed statement of facts ("ASF"). The DT accordingly convicted him of professional misconduct and fined him $50,000, along with the usual consequential orders. The SMC subsequently appealed against the DT's decision on the ground that the fine was manifestly excessive. As further evidence emerged in the meantime that threw doubt on the factual basis of the conviction, and whether the respondent's conduct in fact amounted to professional misconduct, the SMC eventually also applied to set aside the respondent's conviction and sentence.

6.48 The appeal was eventually heard on the basis of the ASF and a revised expert opinion taking into account the ASF, which was not available to the SMC's expert at the time his report was prepared. The supplemental expert report revised its opinion and considered that the respondent had in fact taken sufficient care in the context of the situation to corroborate the identity of the caller requesting the memorandum, and reasonably ensured that it would not be accessible to unauthorised persons.

6.49 The court allowed the appeal and set aside the conviction and sentence. The agreed facts established, first, that the respondent had a basis to issue the memorandum to her husband and this was not caught by the obligation of confidentiality. Disclosure of a patient's confidential information is justified if it is done to protect the patient or others from harm, even if the patient does not consent.[64] Accepting the expert's opinion, the respondent had good reason to assess that there was a real risk of suicide on the part of the complainant, based on her past medical and psychiatric history, and her default on follow up. The preparation of the memorandum for her husband was a reasonable method to facilitate the assistance of the police or ambulance staff in getting the complainant appropriate medical assessment and treatment.[65]

6.50 Secondly, every doctor is under a duty to take reasonable care to ensure that confidential patient information is not mishandled or released to unauthorised persons. The court used a common law negligence standard to assess the conduct of the physician, which is context specific. In the circumstances under which the respondent was requested to prepare the memorandum, the court found that the respondent had taken sufficient steps to verify the identity of the caller as someone

64 Citing Guideline 4.2.3.1 of the Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2002 Ed), Guideline 2b of the Singapore Medical Council *Guidelines on the Practice of Psychiatry 1997*, Guideline C7(5) of the *Ethical Code and Ethical Guidelines* (2016 Ed) and para C7.2 of the Singapore Medical Council, *Handbook of Medical Ethics* (2016 Ed).

65 Citing s 7 of the Mental Health (Care and Treatment) Act (Cap 178A, 2012 Ed).

appropriate to make the request and receive the memorandum. Factors that were taken into account included (a) the lack of specific information on the complainant's next-of-kin in her electronic medical records; (b) the caller's ability to provide specific details about the complainant and medical history, which matched her electronic medical records; and (c) the reported medical emergency was consistent with the respondent's understanding of the complainant's medical condition. The SMC's expert medical witness also agreed that these facts were sufficient to corroborate the caller's identity. Furthermore, it was not reasonable to expect the respondent to contact the complainant directly in these circumstances to verify the situation or the identity of the caller.

6.51 Finally, the respondent was not negligent in failing to take steps to ensure that the complainant's confidential information was accessed only by authorised persons. In the context of institutional care, the court considered that it was reasonable for the respondent to leave the memorandum with his clinic staff, with instructions to hand it over to the complainant's husband. There was no duty to do so personally, nor could the respondent be held responsible to *ensure* that no unauthorised access occurred. In addition, the respondent could not be responsible for any misuse of the confidential memorandum by her brother, if its release to her husband to protect her interests was justified in the circumstances. As a consequence, the respondent had not breached his duty to maintain medical confidentiality, and there was thus no basis for a charge of professional misconduct.

6.52 *Soo Shuenn Chiang*[66] involved the examination of the respondent's professional ethical responsibilities in relation to his patient's confidential health information. This is distinct from the respondent's private law obligations in relation to confidential health information.[67] It will be interesting to see to what extent the formulation of the professional ethical obligation influences the development of the action for breach of confidence in this context.[68] From one perspective, the scope of the professional ethical obligation in this case maps directly to the public interest exception in breach of confidence – the exemption of disclosures to protect the patient herself from harm, or in her best interests, are justified by an overriding public interest *provided* the steps

66 See para 6.46 above.

67 See *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 519–520, *per* Jeffries J.

68 In *W v Egdell* [1990] Ch 359 at 412, the English Court of Appeal referred to the guidelines issued by the General Medical Council on exceptions to medical confidentiality in making its decision on whether there was a public interest overriding the duty of confidentiality. The question, however, is ultimately one of law, not medical ethics: at 422, *per* Bingham LJ.

taken in making the disclosure are reasonable in order to vindicate that countervailing public interest.[69]

6.53 However, a broader issue arises as to whether a fault-based standard will also be used in determining whether there is a breach of confidence *per se*. Some cases speak generally of confidential information, imparted in situations involving confidence, being disclosed in circumstances where there is a substantial, not trivial, violation of the confider's rights.[70] The question is whether, apart from contract, equity imposes a strict obligation to maintain the confidence on the part of the physician confidant.[71] The requirement of disclosure of confidential information to constitute breach suggests at the very least that there was some voluntary conduct amounting to a disclosure. This can be deliberate or inadvertent; a doctor whose (electronic) medical records are stolen or hacked into cannot be said to have disclosed the confidential information to anyone. It was stolen from him. Recourse, if at all, should be against the third-party interloper. However, in collecting, storing and managing confidential health information, the question is whether the mere fact of disclosure is sufficient to constitute a breach of confidence, rendering the physician *prima facie* liable? Or should the law import a fault requirement, setting the threshold of liability at negligent conduct resulting in a disclosure, as is the case with the professional ethical responsibility?

6.54 There are cases that seem to suggest the latter, but on closer scrutiny reveal that the requirement of negligence was based on an obligation of confidence derived from an implied term in contract[72] or giving rise to an action in negligence,[73] not breach of confidence. Actions in contract or tort may not be adequate solutions for patients whose confidences have not been respected, as it is often difficult to demonstrate tangible detriment – physical or economic loss. Breach of confidence, however, allows recovery for distress.[74] Some commentators advocate for a reasonable belief defence in the misuse of private information (which is a distinct tort[75] developed from breach of confidence).[76] Coherence with the

69 *W v Egdell* [1990] Ch 359 at 424, *per* Bingham LJ; see also *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521, *per* Jeffries J.
70 *X v Y* [1988] 2 All ER 648 at 657.
71 This was asserted by Jeffries J in *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521.
72 *Weld-Blundell v Stephens* [1920] AC 956 at 978–979.
73 *Furniss v Fitchett* [1958] NZLR 396.
74 See *Campbell v MGN* [2002] EWHC 499; *Cornelius v De Taranto* [2001] EMLR 329 and *Lady Archer v Williams* [2003] EWHC 1670 (QB).
75 *OBG Ltd v Allan* [2007] UKHL 21 at [255], *per* Lord Nicholls.
76 See N J McBride & R Bagshaw, *Tort Law* Pearson, 6th Ed, 2018) ch 17 at p 578.

physician's professional ethical obligations under the SMC ECEG 2016[77] would suggest that strict liability in maintaining medical confidentiality would be too onerous for professionals and institutions. However, ideally, this should be structured as part of a defence to a *prima facie* breach of confidence constituted by some form of disclosure. This puts the burden of proving the exercise of reasonable care on the confidant.[78] It would be difficult for patients to demonstrate that the inner workings of the clinic or healthcare institution were deficient in some way.[79]

C. Medical certification of sick leave or light duties

6.55 Since the decision in *Singapore Medical Council v Wong Him Choon*[80] first examined the standard of conduct applicable to the issuance of medical certificates, the year in review witnessed two further decisions in this area. In *Yip Man Hing Kevin v Singapore Medical Council*,[81] the DT convicted the appellant on two counts: (a) that he failed to ensure that his patient was given adequate sick leave in the light of his post-operative condition and occupation; and (b) that he inappropriately certified this patient as fit for light duties. The appellant's patient had fallen from a scaffolding platform and suffered multiple injuries, including a fractured clavicle, several fractured ribs and a 1-cm head laceration. The patient's clavicle was operated on the same day he saw the appellant and was discharged some ten hours later the following day. The appellant issued sick leave for the period of hospitalisation, and thereafter certified his patient fit for light duties upon discharge. This latter assessment was continued after two reviews of the patient three and ten days later. After the patient approached the Humanitarian Organisation for Migrant Economics ("HOME") for assistance with wage compensation issues, a complaint was lodged by HOME in respect of the inadequate sick leave given.

6.56 The appellant argued on the first charge that the medical evidence did not preclude the certification for light duties from the first post-operative day, especially if it would facilitate immediate and active mobilisation of the affected area. In particular, he challenged the DT's preference for the SMC's expert evidence, failure to address the medical literature that supported immediate return to sedentary work, and his own commissioned survey evidence. On the second charge, he argued

77 SMC *Ethical Code and Ethical Guidelines* (2016 Ed) Part C7 at paras (2) and (4).
78 See also the recent pronouncements of the Court of Appeal in *I-Admin (Singapore) Pte Ltd v Hong Ying Ting* [2020] 1 SLR 1130 at [61], *per* Menon CJ.
79 See *I-Admin (Singapore) Pte Ltd v Hong Ying Ting* [2020] 1 SLR 1130 at [62].
80 [2016] 4 SLR 1086.
81 [2019] 5 SLR 320.

that the DT had not properly weighed his own explanation for not having any contemporaneous notes on the discussion regarding the patient's opportunities for light duties at work, nor properly acknowledging the direct evidence from the patient's work supervisor regarding this discussion.

6.57 Applying the threshold test for factual intervention, namely, that it must be reasonably certain that the DT had misread the evidence,[82] the court considered that the appellant's expert's evidence did not support the appropriateness of forgoing sick leave in favour of light duties immediately after the operation. The medical literature relied on by the appellant was the only set of guidelines that appeared to support an immediate return to work, but even these did not contemplate a patient with the multiple injuries that occurred here. Finally, the survey evidence proffered by the appellant was unreliable as it omitted statistical information that was adverse to the appellant's position. On the second charge, the court agreed with the DT's finding that there was no discussion with the patient to ascertain if there were adequate conditions for rest and rehabilitation. The absence of any contemporaneous clinical notes, the lateness of the appellant's assertion that there was such a discussion, the unreliability of the third-party witness and the appellant's ignorance of the fact that the patient had never returned to work after the operation more than adequately supported this finding.

6.58 Based on the appellant's seniority in practice, the court found that he must have been personally conscious of his basic professional responsibility to undertake an adequate assessment of the patient's condition in order to determine whether sick leave was warranted, or if prescribing light duties would have allowed for adequate rest and rehabilitation. He had therefore intentionally and deliberately departed from the standard applicable and was guilty of professional misconduct. In doing so, the court also observed that the DT's approach of bifurcating the applicable standard in respect of sick leave and light duties was apt to confuse. In future, DTs should ascertain what the single applicable standard of conduct is in relation to each charge, even though this single standard might entail two or more courses of conduct which are medically appropriate. The breach of that standard in some respect can then be determined. This should also guide the SMC when framing and particularising the charges brought against medical practitioners.[83]

82 *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [39]–[40].
83 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [65]–[67].

6.59 Interestingly, a different result obtained in *Singapore Medical Council v Looi Kok Poh*.[84] The respondent doctor was charged with prescribing inadequate medical leave to a welder who suffered a crushing injury to the tip of his right middle finger. The latter underwent thenar flap surgery on the injured extremity, which was performed by the respondent as the primary physician. The first charge of professional misconduct brought by the SMC alleged that the respondent deliberately departed from professional medical standards by prescribing inadequate medical leave on the second post-operative day. The second charge related to inadequate medical leave prescribed on the fifth post-operative day. Corresponding alternative charges of professional misconduct were presented on the basis that the inadequate medical leave prescribed constituted serious negligence on the second limb of the *Low Cze Hong* test.

6.60 The DT convicted the respondent and sentenced him to 12 months of suspension from practice for each charge, to run consecutively, but reduced this to six months on account of the inordinate delay in the proceedings. On both charges, the DT accepted the SMC's expert evidence that medical leave ought to be given until the thenar flap had been divided at the second stage surgery. The respondent had ignored (a) the nature of the patient's injury; (b) the recovery needed before the second stage surgery; and (c) his pain scores in formulating his intended plan of one-day post-operative medical leave and seven days of light duties. There was also no evidence that he had taken steps to establish if there were adequate conditions for rest and rehabilitation in prescribing light duties, leaving it to the patient's employer to determine this.

6.61 The SMC appealed against the sentence while the respondent cross appealed against both conviction and sentence. On the first charge, the court held that the DT's finding that medical leave ought to have been prescribed on the second post-operative day until the second-stage surgery was against the weight of the evidence. The SMC's expert had accepted in cross-examination that, in principle, light duties *could* be appropriate depending on the circumstances. This was entirely consistent with the evidence of the other experts called by the respondent. The latter opined that, notwithstanding the thenar flap procedure, the patient could be given light duties that did not require the use of his right hand. Accordingly, the applicable standard of conduct did allow for the prescription of medical leave *or* light duties depending on the circumstances, and did not mandate medical leave.

84 [2019] SGHC 13.

6.62 The next question was whether the respondent departed from this standard. This required proof that the respondent had certified the patient fit for light duties without first ascertaining that there were adequate conditions for rest and rehabilitation under the regime available at his place of work. In determining this, the court held that the nature of inquiry expected of a doctor varied depending on the knowledge he already possessed about the patient's particular work environment and how light duties were actually implemented there. Nevertheless, the doctor must ascertain if the light duties regime is suitable for rest and rehabilitation following the surgical procedure in question, and not rely solely on assumptions based on past experience. On the evidence, the court disagreed with the DT's finding that the respondent had erroneously recalled discussing the provisions for light duties with the safety officer of the patient's employer. There was evidence to corroborate a discussion with a representative from the employer on this issue, and the charge that he had departed from the required standard was not made out. This was reinforced by evidence that the patient had *in fact* performed light duties at his workplace for the period in contention after his discharge.

6.63 Similarly, for the second charge pertaining to the prescription of light duties after the second review on 12 August 2011, the weight of the evidence indicated that the patient's condition was improving. The same standard of conduct therefore continued to apply from the point of discharge, and the court accepted the respondent's evidence (which was corroborated to some extent) that he continued to discuss the availability of light duties with the safety officer at the medical review on 12 August 2011. In contrast to previous cases,[85] there was no convincing evidence that put the respondent's assertion of properly assessing light duties in doubt. The respondent's convictions on both charges were accordingly set aside.

6.64 The court also made observations on the practice of proffering alternative charges according to the two limbs of professional misconduct laid down in *Low Cze Hong*. Where the gravamen of the charge is that a doctor has failed to make adequate inquiries before certifying a patient fit for light duties, resulting in medical certification that is inadequate in type or duration, the charge will more appropriately be framed under the second limb of serious negligence amounting to professional misconduct. However, a charge framed under the first limb based on a deliberate and intentional departure from the applicable standard of conduct would also be appropriate if the doctor ought to have made such inquiries but failed to do so.

85 Namely, *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 and *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320.

6.65 Such a practice would first enhance procedural justice by alerting a medical practitioner to the main thrust of the allegations against him. Secondly, it would ensure greater conceptual clarity in identifying the relevant applicable standard of conduct for charges framed under the first limb of professional misconduct involving deliberate and intentional departures, rather than bifurcating the standard into two distinct parts relating to prescribing adequate medical leave or light duties.

IV. Sentencing in professional disciplinary cases

6.66 There were two professional misconduct cases which required the court to consider the appropriate punishment to be imposed on the respective defendant doctors.[86]

A. Failure to keep adequate records as an aggravating factor

6.67 In *Singapore Medical Council v Mohd Syamsul Alam bin Ismail*,[87] the court, in its *ex tempore* decision, provided several useful guiding points. The respondent was convicted on two charges of professional misconduct by the DT and sentenced to three months' suspension and a fine of $40,000, amongst other orders. In relation to the defendant's charge for failing to keep adequate medical records, the court noted that he operated as part of a rota of doctors assigned to a company's medical centre. He was effectively part of a group practice. This made it all the more important that he kept detailed medical notes so that if a different doctor from the group saw a patient, the latter doctor could depend on the defendant's notes to take over care of the patient. That the defendant failed to keep adequate medical records in such circumstances was an aggravating factor.[88]

B. Lack of remorse as an aggravating factor

6.68 In relation to the defendant's charge for failing to provide adequate clinical evaluation and competent care, the court first applied the sentencing framework set out in *Wong Meng Hang v Singapore Medical*

86 The Court of Three Judges in *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 at [63] also expressed a passing reminder to the effect that even if a defendant submits for a maximum fine to be imposed, a disciplinary tribunal should only impose that sentence if it is justified as a matter of principle.

87 [2019] 4 SLR 1375.

88 *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 at [13].

Council.[89] It concluded that the level of harm caused by the defendant fell into the moderate category because the harm caused was permanent and although the defendant did not directly cause the patient to suffer the condition (which was Fournier's Gangrene), his omission to conduct the necessary physical examination led to a loss of chance to arrest the onset and spread of the condition.[90] The court then found the defendant's level of culpability to be high because the defendant "failed to perform basic and elementary things that any competent doctor ought to have done".[91]

6.69 Furthermore, the court held the defendant's blatant lack of remorse to be a seriously aggravating offender-specific factor. In particular, the defendant refused to participate in the inquiry before the DT, and also did not participate in the proceedings before the court.[92] This position is consistent with how a defendant's lack of remorse is treated in sentencing in criminal cases.[93]

C. Imposition of a fine along with suspension

6.70 For the second charge, therefore, the court would have imposed a sentence of two years' and nine months' suspension. However, the court ultimately affirmed the DT's decision to impose a fine of $40,000 partly because there was no appeal against the fine, and partly because the evidence was that the defendant's principal place of practice was in Johor and his practicing certificate to practice in Singapore was valid until 2019. Thus, the punitive effect of imposing a suspension from practicing in Singapore might well be reduced as against him.[94]

D. Aggregate or consecutive running of individual sentence

6.71 The case of *Yip Man Hing Kevin v Singapore Medical Council*,[95] where the DT *prima facie* imposed ten months' suspension on the defendant, raised two other particularly salient points. The first point relates to whether a defendant should be sanctioned for his or her

89 [2019] 3 SLR 526. For an extensive discussion of this case and the sentencing framework issued therein, see (2018) 19 SAL Ann Rev 82 at 93–104, paras 6.26–6.57.
90 *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 at [15].
91 *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 at [16].
92 *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 at [18]–[19].
93 *Thong Sing Hock v Public Prosecutor* [2009] 3 SLR(R) 47 at [55]–[63].
94 *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 at [20]–[22].
95 See para 6.55 above.

professional misconduct as a whole, that is, for an aggregate sentence to be imposed for all charges, or should an individual sentence be imposed for each charge, before deciding if the sentences should run consecutively or concurrently (where applicable). The DT in this case went with the former as it felt that the three charges the defendant faced "were of similar nature and arose from three examinations that had taken place over a short period".[96] The Court of Three Judges held that "whilst it may not always be necessary for the sentencing court or tribunal to state explicitly what the individual sentence is for each individual charge the defendant has been convicted of, this ought to have been done in the present case".[97] Because of the DT's approach, the court could not tell if the DT was imposing a ten months' suspension per charge and running them concurrently, or that it was imposing some lower term of suspension per charge and the ten-month period was the global term of the sentences running consecutively.

6.72 Although the defendant's three charges related to the same type of failure by him towards the same patient, the court underscored that on each separate occasion, the defendant had a fresh and distinct duty to assess the patient based on the circumstances prevailing at that particular point in time and taking into account changes in the patient's condition when prescribing sick leave or light duties. On this premise, the defendant's failure to issue an appropriate duration of sick leave on each occasion he saw the patient amounted to a separate and distinct default. Accordingly, an individual sentence should be imposed for each occasion and any term of suspension should run consecutively.[98]

E. Inordinate delay of proceedings as mitigating factor

6.73 The court also considered whether the DT was right in ultimately halving the defendant's period of suspension by dint of SMC's almost three-and-a-half years' delay between the defendant issuing his explanation and SMC issuing to him the notice of inquiry. In this regard, the court affirmed the following principles with respect to delay in the institution or prosecution of proceedings as a mitigating factor in professional misconduct cases:[99]

(a) the delay must have been significant;

(b) the delay must not have been contributed to in any way by the offender;

96 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [89].
97 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [90].
98 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [92].
99 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [100] and [104].

(c) the delay must have resulted in real injustice or prejudice to the offender; and

(d) ultimately how much such a delay should mitigate the punishment will still depend on countervailing public interest considerations (such as the need to protect public confidence and the reputation of the medical profession, and the need to protect the public from the potentially severe outcomes arising from the actions of errant members of the profession).

6.74 It is also noteworthy that SMC tried to argue that a material delay due to investigations before a defendant is notified that a formal inquiry would be convened ought to be less mitigating than a material delay that arises between notifying the defendant of a formal inquiry and the issuance of a notice of inquiry. The court, agreeing with the DT, declined to draw such a distinction and opined that while the anxiety and distress might be greater after a defendant is notified that a formal inquiry would be convened, "it would not be right to ignore the consequences of any delay prior to that".[100]

V. Cost orders against the Singapore Medical Council in disciplinary proceedings

6.75 The High Court reiterated the implied ancillary power of a DT, and therefore the High Court on appeal, to order costs against the SMC in *Singapore Medical Council v BXR*.[101] The respondent had been charged with failing to obtain the informed consent of his patient before publishing unanonymised photographs and other medical information about her in a book he published. Unauthorised disclosures of this confidential information were also alleged to have occurred at two other medical conferences. The DT dismissed the charges and acquitted the respondent on the basis that informed consent in writing to use such images and information was in fact obtained, and that this was done in a manner that satisfied the applicable standard in the medical profession. The patient had also not revoked the consent given before publication. In consideration of the principle that costs follow the event, the DT ordered costs in favour of the respondent.

6.76 In dismissing the SMC's appeal against the adverse costs order, the High Court reaffirmed the relevant considerations outlined in its earlier judgment in *Ang Pek San Lawrence v Singapore Medical Council*[102]

100 *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 at [102]–[103].
101 [2019] 5 SLR 904.
102 *Ang Pek San Lawrence v Singapore Medical Council* [2015] 2 SLR 1179 at [55].

("*Lawrence Ang*"). It also made several useful observations on the relevant considerations. First, the principle in civil proceedings that costs follow the event did not apply with the same weight to professional disciplinary proceedings, having regard to the regulatory function of the SMC. An acquittal, while a relevant factor, would not alone justify costs against the SMC. However, the DT in this case was right to award costs against the SMC notwithstanding its regulatory function because the charges were not brought against the respondent on grounds that appeared reasonably sound. There was no objective evidence to support the third and fifth charge concerning disclosures at medical conferences. The SMC's expert opinion on the respondent's professional obligations in obtaining specific informed consent for disclosure of the patient's photographs and medical information was not supported by any authority. Finally, the complaints made by the complainant were vexatious and baseless, and the SMC ought to have ascertained the veracity of her claims before preferring the charges.

6.77 Secondly, the court observed that, contrary to the suggestion by the DT, a decision by a complaints committee to order an inquiry should be *prima facie* reason *against* imposing an adverse costs order on the SMC, particularly where it gives detailed reasons for doing so. Notwithstanding this, the SMC is still under an obligation to independently verify that the grounds of a complaint are reasonably sound. In this case, the complaints committee did not provide any reasons or explanations for its recommendation. Consequently, there was no basis to infer from this alone any reasonably sound justification to proceed.

6.78 Thirdly, an inordinate delay in prosecution of a disciplinary case should also be a factor in deciding on an adverse costs order. Although not explicitly referred to in *Lawrence Ang*, the list of relevant considerations is not closed. If an inordinate delay subjects a medical practitioner to undue stress, anxiety and uncertainty over the outcome, it would only be fair to compensate him by way of costs should he be acquitted. An inordinate delay in this context should be determined based on the factors mentioned earlier.[103] There was inordinate delay in this case given that it did not involve particularly complex factual or legal issues, the respondent did not contribute to this delay in any way, and a natural inference that the respondent consequently suffered undue anxiety and distress.

103 See para 6.73 above.

6.79 Finally, on the factor of financial prejudice,[104] the court rejected consideration of the cost of unnecessary litigation as this would be akin to double counting in determining whether to make an adverse costs order.

104 *Ang Pek San Lawrence v Singapore Medical Council* [2015] 2 SLR 1179 at [55(e)].