6. BIOMEDICAL LAW AND ETHICS

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Medical negligence

6.1 The major medical negligence case in 2009 was the highly publicised *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168, an unfortunate case in which a patient who was donating her kidney to her husband died shortly after undergoing the surgical procedure termed Left Hand Assisted Laparoscopic Nephrectonmy ("HALDN").

6.2 By way of background, the left kidney, which was being donated, is connected to three central systems – the bladder, the aorta and the inferior vena cava. To remove the left kidney, the different tissues attached to these systems must be dissected from the left kidney. Once done, the tissues must then be secured. At the material time, this was usually done by securing the tissues with clips known as Hem-o-lok clips.

6.3 After the deceased indicated that she wanted to donate her kidney to her husband, she attended a surgical assessment. She was assessed to be in "good" health and psychologically fit for the transplant. It was then explained to the deceased "in layman terms" the advantage of HALDN over open surgery but there was no discussion of robotic laparoscopic nephrectomy as this was not standard practice. She was warned that there was no certainty that the transplant would be successful.

6.4 The renal transplant took place on 16 February 2005 at around 0855 hours. In accordance with standard procedure, Hem-o-lok clips were used to secure the left renal vein and renal artery. There was not much dispute that the clips were properly secured at the end of the surgery. The evidence was that it would have been obvious if the clips had not been locked properly because blood would have otherwise spurted out in dramatic fashion at a rate of 300–500mls per minute. Following the transection of the left renal vein and arteries, the left kidney was extracted and prepared for transplant. The surgery ended at about 1150 hours.

6.5 The deceased was thereafter transferred from the operating theatre to the recovery room for continuous monitoring. At 1330 hours,

the deceased was visited by one of the doctors who had performed the surgery and it was found that her vital parameters were normal. There was no indication that she was suffering any blood loss. At 1410 hours, the deceased was transferred to the general ward, a process that finished around 1430 hours. Her vital signs were checked by a nurse and another doctor and found to be in good order. It was not disputed that, despite having been put on hourly monitoring, the deceased was not visited at 1530 hours.

6.6 Sometime around 1600 hours, it was discovered that the deceased had become unresponsive. The hospital was alerted, and resuscitation efforts commenced. After about 50 minutes of trying, it was decided that further resuscitation would be futile and the deceased was pronounced dead.

6.7 A number of issues were raised by the plaintiff as to the adequacy of the standard of care provided by the hospital and the doctors in relation to the pre-operative advice given, the surgery itself and the post-operative care given. The judge easily dismissed many of these claims, and the focus here is on two points of law.

The standard of care in medical cases

6.8 The first legal issue in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 pertains to the applicable law for assessing the standard of care in medical negligence cases. The learned judge correctly held that the applicable law for assessing liability in medical negligence cases was that laid down in the Court of Appeal decision in *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 ("*Gunapathy*"), which in turn was based on the court's reading of the combined effect of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118 and *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 3 WLR 1151, [1997] 4 All ER 771. The court in *Gunapathy* essentially held that a doctor would not be held negligent as long as there was a respectable body of medical opinion supporting his actions. In order to qualify as representative of a responsible body of medical opinion, however, the opinion had to: (a) consider the comparative risks and benefits relating to the matter; and (b) it had to be defensible in the sense that the medical opinion had to be internally consistent and not fly in the face of known medical facts or advances in medical knowledge.

6.9 The learned judge in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 quite rightly acknowledged that this highly deferential approach has been severely criticised in Australia and Canada. Indeed, the special deference accorded to medical testimony has been the subject of academic criticism locally (see Disa Sim, "*Dr Khoo*

James & Anor v Gunapathy d/o Muniandy and Another Appeal: Implications for the Evaluation of Expert Testimony" [2003] Sing JLS 39; Kumaralingam Amirthalingam, "Judging Doctors and Diagnosing the Law: *Bolam* Rules in Singapore and Malaysia" [2003] Sing JLS 125; and Paul Tan, "The Doctrine of Informed Consent – When Experts and Non-Experts Collide" [2006] 1 Sing JLS 148). Notwithstanding such criticism, the learned judge felt bound by *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024, it being a decision of the highest court. Having referred to such criticism, the learned judge did not, however, indicate which view she preferred and why.

Causation in medical cases

6.10 By far the most interesting legal issue that arose for determination in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 was whether the failure of the hospital to monitor the deceased hourly (a practice the court found to be reasonable and acceptable) had caused or materially contributed to the deceased's death.

6.11 It was not disputed that if the bleeding from the deceased's left renal artery had been "fast and furious", any resuscitation effort would have been futile, no matter how expeditiously undertaken. Whether the bleeding could be said to have been "fast and furious" depended on whether it could be proved that the clips had slipped from the left renal artery at one go, rather than gradually. It was on this factual point that the experts differed. The hospital's expert opined that the clips placed over the left renal artery could only have been either completely "on" or "off" and could not have slipped gradually over a period of time because the high blood pressure running through the renal artery would have rapidly forced open the clips if they had somehow become loose. The plaintiff's expert opined otherwise.

6.12 The learned judge dealt with the evidential dispute in two ways. First, she dismissed the respective conclusions reached by the experts on both sides as merely "theories and speculations" because "*all* the experts in this case neither had personal knowledge of nor experience with the slippage of Hem-o-lok clips applied to the renal artery" [emphasis in original]: see *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 at [238].

6.13 With respect, it is not immediately clear why it should matter that the experts did not possess personal knowledge or experience with the specific circumstances in this case. It is not unusual that the courts reconstruct historical events based on the more likely version of what happened even where there were no witnesses to the incident or absent

persons with intimate knowledge of what happened. If the court is unable to decide which version of events offered by either party is more likely, then the party who bears the burden of proof fails. There would have been nothing inherently impossible or unusual in the court arriving at a view as to whether, given how the clips operate and the blood pressure of the artery, the clips were more likely to have slipped gradually or come off at one go. Indeed, it could only be one or the other.

6.14 Second, having found that the evidential dispute could not be decided either way, the learned judge held that (*Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 at [240]):

> [I]t would be sufficient on the authority of *McGhee v National Coal Board* [1973] 1 WLR 1, for it to be shown that NUH's failure to monitor the deceased in Ward 43 after 1430 hours made the risk of death to the Deceased more probable.

6.15 *McGhee v National Coal Board* [1973] 1 WLR 1, of course, is the House of Lords decision that endorsed the proposition that a defendant may be held liable for his breach of duty if the breach materially increased the risk of injury occurring or otherwise materially contributed to the occurrence of the injury, even if it could not be shown that but for the breach, the injury would not have occurred. The facts in that case were that the plaintiff had contracted dermatitis as a result of exposure to brick dust at his work place, which he could not wash off before going home because his work place failed to take the reasonable precaution of providing washing facilities. It is vital to appreciate that there was medical evidence in that case showing an association between the length of time a person is exposed to the brick dust and the risk of contracting dermatitis. Indeed, washing was the only means of removing the risk of further injury. The present state of medical evidence, however, did not go as far as explaining precisely how dermatitis was caused – it could not demonstrate that had adequate shower facilities been installed, it would have definitely prevented dermatitis. While such evidence would have failed the orthodox but-for test, their Lordships were prepared to hold that in some limited circumstances, a more relaxed test of causation was appropriate. Lord Wilberforce ([1973] 1 WLR 1 at 6) held:

> But the question remains whether a pursuer must necessarily fail if, after he has shown a breach of duty, *involving an increase of risk of disease*, he cannot positively prove that this increase of risk caused or materially contributed to the disease while his employers cannot positively prove the contrary. In this intermediate case there is an appearance of logic in the view that the pursuer, on whom the onus lies, should fail – a logic which dictated the judgments below. The question is whether we should be satisfied, in factual situations like the present, with this logical approach. In my opinion, there are further

> considerations of importance. First, it is a sound principle that where a person has, by breach of a duty of care, *created a risk, and injury occurs within the area of that risk*, the loss should be borne by him *unless he shows that it had some other cause*. Secondly, from the evidential point of view, one may ask, why should a man who is able to show that his employer should have taken certain precautions, because without them there is a risk, or an added risk, of injury or disease, and who in fact sustains exactly that injury or disease, have to assume the burden of proving more: namely, that it was the addition to the risk, caused by the breach of duty, which caused or materially contributed to the injury? In many cases, of which the present is typical, this is impossible to prove, just because honest medical opinion cannot segregate the causes of an illness between *compound causes*. And if one asks which of the parties, the workman or the employers, should suffer from this inherent evidential difficulty, the answer as a matter of policy or justice should be that it is the creator of the risk who, ex hypothesi must be taken to have foreseen the possibility of damage, who should bear its consequences. [emphasis added]

6.16 *McGhee v National Coal Board* [1973] 1 WLR 1 was subsequently applied in *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 ("*Fairchild*"). In that case, the plaintiffs had developed *mesothelioma* caused by exposure at work to asbestos dust. All the employees had been exposed to asbestos dust during periods of employment with more than one employer. In each case, the claimant sought damages against the defendants who, in breach of their duty to protect the employee from the risk of contracting the disease, had exposed him to substantial inhalation of asbestos dust or fibres. It was common ground that the mechanism initiating the genetic process which culminated in *mesothelioma* was unknown, that the trigger might equally probably be a single, a few or many fibres, and that once caused the condition was not aggravated by further exposure but that the greater the quantity of fibres inhaled the greater the risk of developing the disease. In other words, it was likely that the fibre or fibres causing the *mesothelioma* in each plaintiff was likely to have come from only one employer's workplace. Nevertheless, their Lordships held all the defendants liable on the basis that each of their breaches materially contributed to the risk of *mesothelioma* occurring.

6.17 *McGhee v National Coal Board* [1973] 1 WLR 1 ("*McGhee*") and *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 can only be properly understood when contrasted with the decision in *Wilsher v Essex Area Health Authority* [1988] AC 1074 ("*Wilsher*"), in which a premature baby negligently received an excessive concentration of oxygen and suffered *retrolental fibroplasia* leading to blindness. The medical evidence demonstrated that this could occur in premature babies who have not been given excessive oxygen, and there were four other distinct conditions which could also have been causative of the

fibroplasia. The House of Lords endorsed Lord Brown-Wilkinson's dissent in the Court of Appeal ([1987] QB 730 at 779), which were in the following terms:

> To apply the principle in [*McGhee*] to the present case would constitute an extension of that principle. In the *McGhee* case there was no doubt that the pursuer's dermatitis was physically caused by brick dust: the only question was whether the continued presence of such brick dust on the pursuer's skin after the time when he should have been provided with a shower caused or materially contributed to the dermatitis which he contracted. There was only one possible agent which could have caused the dermatitis, *viz*, brick dust, and there was no doubt that the dermatitis from which he suffered was caused by that brick dust. In the present case the question is different. There are a number of different agents which could have caused the RLF. Excess oxygen was one of them. The defendants failed to take reasonable precautions to prevent one of the possible causative agents (*eg* excess oxygen) from causing RLF. But no one can tell in this case whether excess oxygen did or did not cause or contribute to the RLF suffered by the plaintiff. The plaintiff's RLF may have been caused by some completely different agent or agents, *eg* hypercarbia, intraventricular haemorrhage, apnoeas or patent ductus arteriosus. In addition to oxygen, each of those conditions has been implicated as a possible cause of RLF. This baby suffered from each of those conditions at various times in the first two months of his life. There is no satisfactory evidence that excess oxygen is more likely than any of those other four candidates to have caused RLF in this baby. To my mind, the occurrence of RLF following a failure to take a necessary precaution to prevent excess oxygen causing RLF provides no evidence and raises no presumption that it was excess oxygen rather than one or more of the four other possible agents which caused or contributed to RLF in this case. The position, to my mind, is wholly different from that in [*McGhee*] where there was only one candidate (brick dust) which could have caused the dermatitis, and the failure to take a precaution against brick dust causing dermatitis was followed by dermatitis caused by brick dust. In such a case, I can see the common sense, if not the logic, of holding that, in the absence of any other evidence, the failure to take the precaution caused or contributed to the dermatitis.

6.18 There is thus a conceptual distinction between *McGhee v National Coal Board* [1973] 1 WLR 1 ("*McGhee*") and *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 ("*Fairchild*") on the one hand, and *Wilsher v Essex Area Health Authority* [1988] AC 1074 ("*Wilsher*") on the other. As further explained in *Bailey v Ministry of Defence* [2000] 1 WLR 1052, the former cases may be considered "cumulative causes" cases in the sense that while it could not be definitively ascertained that exercising reasonable care would in and of itself have prevented the injury, there was nevertheless sufficient evidence that the failure to exercise reasonable care did materially

enhance the risk of the injury happening. Put another way, exercising reasonable care would have reduced the risk of the injury happening. Whether or not the risk of injury is enhanced by the breach is a question that needs to be decided by the court in consultation with the scientific evidence available. This class of cases may be distinguished from the one in which *Wilsher* falls, where even if the negligent act had not taken place, the risk of injury would have remained the same. The relaxed causation requirement in *McGhee* and *Fairchild* was undoubtedly motivated by the unfairness of dismissing the claims on the basis that medical science was not sufficiently advanced to identify the precise cause of the injury, but the relaxed causation requirement is controlled by the need to prove that the risk of such injury was enhanced by the breach.

6.19 The difficulty in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 did not stem from some inherent limit to existing medical knowledge. Rather, causation could not be proved either way because the learned judge did not resolve the conflicting medical evidence that had been presented as to how the clips slipped. The latter issue is logically anterior to determining whether the breach materially enhanced the risk of death. If it could be proven that the clips had slipped off at one go, the evidence was clear that even if the breach had not taken place, the resuscitation would have always been too late. As in *Wilsher v Essex Area Health Authority* [1988] AC 1074, the risk of death would have remained the same in that scenario. The failure to monitor the deceased on the hour could only have materially contributed to the risk of her death if the clips had slipped off gradually. This was a critical finding of fact that the learned judge needed to make.

6.20 Put another way, it was at least possible in *McGhee v National Coal Board* [1973] 1 WLR 1 ("*McGhee*") for remedial steps to have been taken. If showers had been provided on-site, it would have reduced the risk of injury occurring by minimising the length of time that the worker was exposed to the brick dust. Whether or not hourly monitoring would have reduced the risk of death in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 depended on how fast the bleeding was. To impose liability in the absence of a factual finding in this regard represents a departure from *McGhee*. It also effectively reverses the burden of proof – whereas any other plaintiff would have failed in these circumstances, the effect of the judgment is to shift the burden of proof to the hospital to prove that its failure would have made no difference to the outcome of the resuscitation efforts of the deceased.

6.21 It is true that courts nowadays appear more willing to hold responsible parties who breach their duties, even if it cannot be proven that had the breach not taken place, the injury would not have occurred. Taking *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 and

McGhee v National Coal Board [1973] 1 WLR 1 one step further is another House of Lords decision, *Chester v Afshar* [2005] 1 AC 134 ("*Chester*"). There, liability was established for the negligent failure to warn of the risk of paralysis inherent in an elective lumbar surgical procedure despite the patient's inability to testify that she would have refused the surgery if she had been duly warned. Despite recognising the obvious that the patient's claim could not be based on conventional causation principles since "to expose someone to a risk to which that person is exposed anyhow is not to cause anything" (*Chester* [2005] 1 AC 134 at [81], *per* Lord Hope), "justice" required the patient to be compensated. The broad policy favoured by their Lordships was that the law's function was to vindicate breaches of rights and duties, and to deny relief just because it could not be definitively ascertained whether the patient would have refused the surgery would render hollow the duty to obtain informed consent.

6.22 No matter how broadly one reads *Chester v Afshar* [2005] 1 AC 134 ("*Chester*"), the critical feature of the case is that the patient may have refused the surgery had she been warned of the risks of surgery, which, importantly, was merely elective. In circumstances where it could be proven that the patient would not have refused the surgery – perhaps because it was life-saving – the decision would almost certainly have been different. *Chester*, therefore, does not license granting relief where the evidence is that it would have made no difference to the plaintiff one way or the other. The situation in *Surender Singh s/o Jagdish Singh v Li Man Kay* [2009] SGHC 168 is precisely this – until it could be proven that the clips had slipped off gradually, the failure to monitor hourly as required would have made no difference to the deceased's chances of survival.

Professional discipline

6.23 The prosecution of medical practitioners for failure to properly prescribe or manage the prescription of Subutex continues to raise legal issues. In the year under review, an application was brought by Dr Chai Chwan in *Chai Chwan v Singapore Medical Council* [2009] SGHC 115 for leave to apply for judicial review under O 53 r 1(2) of the Rules of Court (Cap 322, R 5, 2006 Rev Ed) to quash disciplinary proceedings that had been brought against him in respect of his prescribing practice of Subutex. There were two sets of complaints as to Dr Chai's "prescribing practice", one relating to 2003 and the other to 2004. Among the more significant challenges brought against the proceedings, were the following.

Failure of Complaints Committees to complete their preliminary inquiries within time

6.24 First, Dr Chai submitted that the Complaints Committee failed to complete its preliminary inquiry within three months from the date the complaints were laid before it, and that, subsequently, the various decisions of the respective chairmen of the Complaints Panels in 2003 and 2004 to extend time constituted an unreasonable exercise of their discretion in the *Wednesbury* sense. This was because there was no evidence that the chairmen had applied their minds as to whether the matter was truly complex or difficult. This argument was based on the sparseness of the application, which was matched by the scantiness of the reasons stated for granting the extensions of time. The court, however, accepted the evidence of the chairmen of the Complaints Panel that the reason the process took so long was because of the large number of patients involved and the need to ensure that each charge was sustainable. This is, in some respects, similar to the Court of Appeal's decision in *Registrar of Vehicles v Komoco Motors Pte Ltd* [2008] 3 SLR(R) 340 in which the administrative authority in that case delivered a relatively short letter explaining its decision. Yet, the court was not willing to infer that the complaint had not been adequately considered.

Disciplinary Committee inquiring into matters not raised by the complaints

6.25 Second, Dr Chai argued that the charges went beyond the scope of the complaints, contrary to s 40(1) of the Medical Registration Act (Cap 174, 2004 Rev Ed). It had been decided in *Tan Tiang Hin Jerry v Singapore Medical Council* [2000] 1 SLR(R) 553 that the latter provision limited the power of the Complaints Committee to inquire into matters that were extraneous to the complaints before them. On the facts in the present case, it was submitted the charges did not only concern his "prescribing practice" but had been extended into looking at the "management" of his patients. This, according to Dr Chai, far exceeded the scope of the complaints. In respect of the extraneous matters, Dr Chai contended that he had not been given the opportunity to explain them and he consequently raised the breach of natural justice as a ground for the leave application.

6.26 The court found, as a matter of interpretation, that the subject matter of the charges did not exceed the substance of the complaints. Although the complaints primarily raised concerns about Dr Chai's "prescribing practice", while the charges speak of the lack of a "management plan", the court found that under the Singapore Medical Council's Ethical Code, there is a clear linkage between the prescribing practice of medical practitioners and the provision of a management

plan for each prescription made. Moreover, the court found that, based on his own written replies to the Complaints Committee, Dr Chai was keenly aware that the complaints touched on the lack of management plans for patients to whom he was prescribing Subutex.

6.27 As a matter of procedure, the court observed that even if the Complaints Committees had considered extraneous matters not contained in the complaints, it was premature to do so by way of an application to quash the charges. The proper forum to consider this was at the disciplinary hearing; and such an opportunity was provided under reg 23(4)(*b*) of the Medical Registration Regulations (Cap 174, Rg 1, 2000 Ed).

Delay in appointing the Disciplinary Committee

6.28 The third argument Dr Chai raised was that the Disciplinary Committee was appointed only two years after the Complaints Committee had made an order for a formal inquiry to be held, in apparent violation of s 41(3) of the Medical Registration Act (Cap 174, 2004 Rev Ed). The court held that the requirement is merely directory and not mandatory. The late appointment of the Disciplinary Committee, being an irregularity, did not automatically nullify the appointment as long as there was no demonstrable prejudice of a substantial nature.