5. BIOMEDICAL LAW AND ETHICS

Paul TAN
LLB (Hons) (National University of Singapore);
Advocate and Solicitor (Singapore).

Introduction

5.1 The year 2008 proved especially rich for students of biomedical law and ethics. The courts handed down a series of important judgments applying, for the first time, the provisions prohibiting and punishing the donor, recipient and middlemen involved in the commercial trading of organs. The High Court also articulated helpful guidelines on the ambit of "professional misconduct".

Organ trading

5.2 The ethical complexities of organ trading have been publicly discussed for some time now (see (2006) 7 SAL Ann Rev 93 at 96–98, paras 5.12–5.18) but it was only this year that legislation strictly forbidding organ trading was tested in a trio of cases. This review will focus on just those cases arising out of the same transaction involving the high-profile Mr Tang Wee Sung who was suffering from kidney failure and sought to purchase a kidney through a middleman. There was no dispute by Tang, the middleman or the prospective donor that the transaction was in violation of, *inter alia*, s 14(1) read with s 14(2) of the Human Organ Transplant Act (Cap 131A, 2005 Rev Ed) ("HOTA"):

> 14. —(1) Subject to this section, a contract or arrangement under which a person agrees, for valuable consideration, whether given or to be given to himself or to another person, to the sale or supply of any organ or blood from his body or from the body of another person, whether before or after his death or the death of the other person, as the case may be, shall be void.
>
> (2) A person who enters into a contract or arrangement of the kind referred to in subsection (1) and to which that subsection applies shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $10,000 or to imprisonment for a term not exceeding 12 months or to both.

5.3 The first to be sentenced was Sulaiman Damanik ("Sulaiman") who had agreed to sell his kidney for approximately 150m rupiah (S$23,700). Sulaiman was also convicted with another donor, Toni, who had previously sold his kidney to one Juliana Soh and who was now a low-level liaison assisting in making logistical and transport

arrangements for Sulaiman and Tang. Toni was paid approximately S$3,200. Both pleaded guilty and their sentences are reported in the same decision: *PP v Sulaiman Damanik* [2008] SGDC 175.

5.4 It was revealed in the statements of facts that Tang had engaged a middleman, Wang Ching Seng ("Wang") to procure a living donor. Wang subsequently identified Sulaiman as a potential donor. Sulaiman was approached and, having reached an agreement on the fees, Sulaiman flew into Singapore and was met by Toni. Apart from undergoing medical tests, Sulaiman was also required to attend an interview by the Transplant Ethics Committee ("TEC"), for which Wang coached Sulaiman. Sulaiman thus provided false information to the TEC. In addition, Sulaiman had also made a false statutory declaration to the effect that he had received no money or financial gain to procure his consent to the transplant.

5.5 It was pleaded in mitigation of Sulaiman's sentence that the reason for his entering into the transaction was his need for money to support his family. As his family's sole breadwinner (he was single and living with his parents), he was earning less than S$120 a month as a labourer. That was before he had lost his job in January 2008. When he was approached to sell his kidney for the equivalent of more than 16 years' labour, he saw it as a "God send". According to his counsel, he lacked education and failed to consider that his decision to sell his kidney for a fee was against the laws of Singapore.

5.6 The prosecution argued (at [22]) that the "commercial trade in human organs often involved the exploitation of the poor and socially disadvantaged who are unable to make informed choices and suffer potential medical risks". According to the prosecution, Parliament's ban on organ trading reflected a "clear and unanimous consensus" that organ trading was "morally and ethically wrong", and that Singapore "must not become a hub or a player in organ trading, whether consciously or inadvertently": at [23].

5.7 On the facts of the case, the court held that both Toni and Sulaiman had "knowingly infringed the law, risking life and limb, because of the financial reward that [they] had been promised": at [33]. However, the court then observed that it was "reasonable to infer" that their poverty had led an organ-trading syndicate to "exploit" them such that it "would have been difficult to resist" the offer.

5.8 Organ transplantation itself is neither illegal nor immoral. From the viewpoint of biomedical ethics, the *raison d'être* often cited for a ban on the *commercial* trading of organs is, as the court pointed out, the exploitation of the poor that (allegedly) invariably follows from permitting organs to be traded. As the prosecution put it, the poor who

sell their organs "are unable to make informed choices": at [22]. But to justify a ban on that premise produces an awkward, counter-intuitive result: that one has to punish the very person whom, it is claimed, the ban seeks to protect. In order to justify *this* conclusion, the court has to hold (as it did at [33]) that the organ seller did in fact know what he was consenting to and that he also knew that this was illegal. Yet, if that were so, there would be no need for the ban to protect such sellers.

5.9 Of course, it is possible to make the argument that, for the purposes of criminal law, an intention to commit an illegal act (which is then carried out) is sufficient to warrant punishment; and the requirement of *mens rea* in criminal law ought to be distinguished from the possibility that that intention to act is unaccompanied by information as to the downstream consequences of one's action. As a crude example, the law does not require a rapist to understand the physical and psychological harm that his actions would cause to his victims. But this is not an entirely satisfactory resolution to the conundrum because the offence in question consists in the *agreement* to participate in an arrangement to sell one's organs. Can it fairly be said that a person who is not in a position to make an informed decision has, by definition, agreed to enter into such an arrangement?

5.10 At this point, a more promising approach might be to recognise that the word "exploitation" might be too loosely used to describe the condition in which organ sellers often find themselves. It clearly cannot be that all organ sellers are inherently incapable of making an informed decision. The Human Organ Transplant Act (Cap 131A, 2005 Rev Ed) would otherwise be an unsympathetic, even self-contradictory, legislative move that punishes the very persons it seeks to protect. Perhaps the "exploitation" resides in the fact that the only persons who would agree to sell their organs are those looking for a way out of their poverty trap; in other words, it is the temptation created by the significant payment (relative to one's present income) for one's organs that is exploitative. But the desire for a better economic life drives everyone to engage in activities we may not otherwise engage in – such as working long hours, often at the expense of our own health as well. In fact, the suggestion that payment for an organ constitutes exploitation leads to the counterintuitive conclusion that the more one pays the donor, the greater the exploitation. Indeed, this was what the District Court observed in *PP v Wang Chin Sing* [2008] SGDC 268 in rejecting the argument that Wang, the middleman, had not exploited the donor. The court held (at [45]) that "the allegation that [the donor] is well compensated could also be interpreted as an inducement for [the donor] to participate in this illegal scheme".

5.11 In truth, the exploitation, if any, is that organ sellers do not sell their kidneys at a price commensurate with their sacrifice. Although the

fee offered appears substantial at first blush, the "profit" donors allegedly make is illusory. Donors often find that the fee earned is insufficient even to pay for their own medical care post-operation. But the solution to this is not to ban organ trading; it is to regulate it so that sellers are paid a sum that, at minimum, ensures that they have the means and resources to properly recover from their operation.

5.12 At the other end of the spectrum is Tang, who could afford to pay his middleman $300,000 to secure a kidney. Tang, too, pleaded guilty, and was sentenced to a $7,000 fine. This low sentence was the result of mitigating factors as well as the application of judicial mercy that the District Court felt was appropriate given Tang's medical condition: *PP v Tang Wee Sung* [2008] SGDC 262.

5.13 Much of the discussion in Tang's case is fertile ground for analysis from the perspective of criminal law. For present purposes, it is sufficient to highlight the following two mitigating factors that the court took into account:

> (a) The donor was someone who *chose* to sell his kidney for profit; and there was no evidence of exploitation (*PP v Tang Wee Sung* [2008] SGDC 262 at [18] and [51(c)]).
>
> (b) The main disapproval in banning organ trading focuses on the middlemen who profit from illegal organ trading and not the dying patient in need of a transplant or the poor, socially disadvantaged donor (*PP v Tang Wee Sung* [2008] SGDC 262 at [20]).

5.14 What explains the apparent contradiction between characterising the donor as "poor and socially disadvantaged" on the one hand, and "someone who chose to sell his kidney for profit" on the other?

5.15 Again, we see the ethical tussle that has followed a blanket ban on organ trading. Everyone has sympathy for "the basic instinct of kidney failure patients to try to live" (at [34]). But how do we justify a lower punishment for the person who is the very reason that the black market for organ trading exists? It is the recipient of the organ who starts the ball rolling by instructing the middleman to secure a kidney for him. It is the recipient who provides the funds with which the middleman is then said to use to "exploit" the disadvantaged donor. Having bought the gun and the bullets, should the buyer be allowed to plead that he did not pull the trigger?

5.16 In order to justify a light sentence, the court must find that the donor has not been exploited; that he was "someone who chose to sell his kidney for profit". Otherwise, the exploitation is easily traced back to

the buyer. It would be to deny common sense if it could be argued that the buyer's desperation to live is not the primary driving force behind the existence of the black market. There would be no supply if there was no demand.

5.17 Yet, to sentence the buyer on the assumption that the seller has not been taken advantage of, runs into two major contradictions. First, this undermines the central basis for banning organ trading, which is to prevent the supposed exploitation of the socially disadvantaged. Second, if in fact the donor has made a free choice to sell his kidney for profit, in clear violation of the law, *he*, too, ought to be subject to heavy sanction in the same way that the middleman is subject to heavy sanction for profiting from his crime: see the reasoning in *PP v Wang Chin Sing* [2008] SGDC 268; affirmed on appeal *Wang Chin Sing v PP* [2008] SGHC 215.

5.18 The unhappy truth is that the present ban on organ trading achieves little of its stated objectives. Instead, the law punishes donors for participating in their own "exploitation". While trying to avoid this unpalatable conclusion, the court has sought to justify sentences at the lower end of the range by arguing that they are incapable of truly understanding the consequences of their actions. But, as stated, such a justification should lead to the conclusion that no offence has been committed in the first place.

5.19 Even a more restrictive definition of "exploitation" in terms of the coercive prompting of money is problematic. As long as it is recognised that the donor is capable of and does exercise free choice in selling his organ, it is up to the donor to set his price. It seems odd that the recipient should be punished at all for simply matching those demands. Furthermore, logic would seem to dictate that in relation to a donor otherwise capable of exercising free will, exploitation would occur only if the donor is forced to accept a price that is too low. However, by defining "exploitation" in terms of the economic incentive to part with one's kidneys, the counter-intuitive result is that the more the buyer pays, the greater the exploitation.

5.20 Thus, the ban on organ trading appears to benefit only one party – the middleman. This seems hardly the moral or ethical situation that Parliament intended when it enacted the ban. To this end, the Health Minister's remarks that some form of organ trading might be considered in the future is encouraging (see Judith Tan & Esther Tan, "Let's not Rule Out Organ Trading Yet, says Khaw", *The Straits Times* (14 July 2008); see also Salma Khalik, "Organ Transplant Law to Include Reimbursing Donor", *The Straits Times* (29 September 2008)). One positive step in this direction is the Ministry's move to allow people who donate their kidneys to receive monetary compensation from the

recipient and to regulate the quantum of compensation so that donors are not short-changed (see Salma Khalik, "Law to Change so Kidney Donors can be Compensated", *The Straits Times* (2 November 2008)).

Professional discipline

5.21 In a comprehensive explication of the standard to which doctors would be held in professional misconduct proceedings, the High Court moved unambiguously towards a stricter standard, consistent with recent jurisprudence in major jurisdictions.

5.22 In *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612, the High Court of Three Judges heard an appeal from a decision of the Disciplinary Committee ("the DC") of the Singapore Medical Council ("SMC"). The charges arose from a complaint lodged by one Toh Seng, in relation to Dr Low carrying out an invasive surgical procedure on his blind right eye performed just two days after an initial consultation. The first charge was that Dr Low knew or ought to have known that the treatment he performed was inappropriate, whilst the second charge was the failure to obtain informed consent.

5.23 The background may be briefly stated. Dr Low is a consultant ophthalmologist and was first approached by Toh Seng on 26 June 2002. Prior to consulting Dr Low, Toh Seng had been treated for glaucoma in both eyes by Dr Peter Tseng for almost ten years. He had been blind in his right eye for many years and his left eye was nearly totally blind. On 4 June 2002, after having just consulted Dr Low, Toh Seng sought treatment from Dr Tseng for intra-ocular pressure in his right eye, for which Dr Tseng prescribed Gutt Timpilo and Gutt Trusopt eyedrops and Diamox tablets. When Dr Tseng saw Toh Seng again on 5 and 18 June 2002, Toh Seng's intraocular pressure had dropped within the normal range (20mmHG).

5.24 For some reason, Toh Seng approached Dr Low not long after, complaining of severe headaches and pain in his right eye. Dr Low diagnosed Toh Seng to be suffering from neo-vascular glaucoma with raised intra-ocular pressure of 58mmHG in the right eye, three times the pressure of a normal eye. Dr Low was informed of the fact that Dr Tseng had been treating Dr Low for glaucoma. Dr Low, however, recommended cataract surgery for Toh Seng's left eye and a trabeculectomy (glaucoma drainage surgery) with a Molteno tube implant for the right eye. It was in respect of the right eye that the disciplinary proceedings were instituted.

5.25 Toh Seng subsequently suffered an extrusion of the Molteno tube in August 2002 and, after consultations with Dr Low and others,

removed the tube in September 2002. A year later, Toh Seng filed a complaint with the SMC against Dr Low.

5.26 The principal allegation against Dr Low was that his recommended surgery was inappropriate because the standard practice, as a first line of treatment, was to: (a) optimise the anti-glaucoma medication for the patient; and (b) if medical therapy is found to be unsatisfactory, to offer the patient other non-invasive procedures such as laser syclophotocoagulation. Flowing from this was the second allegation against Dr Low, which was that he failed to obtain informed consent of the patient because he did not sufficiently explain other treatment or surgical options and did not sufficiently explain the risks, side-effects and nature of the surgery.

5.27 The Disciplinary Committee found as follows:

> (a) It was not appropriate to recommend therapy, especially invasive therapy, to patients with chronic medical conditions without seeking input from the patient's primary doctor, especially in the absence of an emergency.
>
> (b) It was not appropriate to reject a proper trial of medication in a patient with a non-functioning organ (with limited risk of side-effects), especially when an invasive procedure was being considered.
>
> (c) It was not appropriate to reject other forms of therapy on the grounds that the doctor was not familiar with them or not available in their institution when such therapy was available elsewhere.
>
> (d) There was no evidence that other treatment options were discussed, especially when the treatment is elective.

Standard of professional misconduct

5.28 Dr Low was charged under s 45(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed), which permits the sanction of a medical practitioner who has been found guilty of "professional misconduct". Relying on the SMC Ethical Code and Ethical Guidelines (January 2002) ("the SMC Ethical Code"), Dr Low's argument was that "professional misconduct" should be equated strictly to "infamous conduct", which in turn, had been judicially defined as involving "some moral turpitude, fraud or dishonesty or such persistent and reckless disregard of duty".

5.29 The High Court correctly rejected the definition of "professional misconduct" proposed by Dr Low. As it pointed out, the SMC Ethical Code simply states that professional misconduct is only

"akin" to "infamous conduct in a professional respect"; and then goes on to adopt the broad definition found in *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750 that as long as a medical man in the pursuit of his profession has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, it is open to a disciplinary tribunal to find him guilty of infamous conduct in a professional respect.

5.30 This is also consistent with Parliamentary intent, which in 1998, intentionally amended the Act so that the phrase "infamous conduct in a professional respect" was substituted with the less restrictive phrase, "professional misconduct".

5.31 Summarising recent case law on this point, the High Court held (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [37]) that professional misconduct could be made out in two circumstances:

> (a) where there was an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; and
>
> (b) where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

5.32 Three observations may be made. First, both formulations suggest that professional misconduct will rarely, if ever, be found against a person who is merely negligent; this perhaps being something that a civil court in a civil trial might be more apt to resolve: at [29]. Thus, as stated in the SMC Ethical Code, it is only "serious disregard or persistent failure" to meet the requisite standards that will lead to disciplinary proceedings. Gross negligence may, however, suffice if accompanied by indifference to, or lack of concern for, the welfare of the patient: see *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197. Moral turpitude or fraud is not, however, required.

5.33 Second, although the first formulation in para 5.31(a) appears to give almost exclusive consideration to the medical community to determine what those standards are, this is clearly not the case. In fact, the High Court (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [30]) cited a passage from *McKenzie Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 that in unequivocal terms held that the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances. Apart from taking into account medical practice, patient interests and community expectations – including the expectation that professional standards are not permitted to lag – are to be considered.

5.34 This is clearly a sensible approach; and may signal a reluctance of the court to cede questions of professional standards entirely to the medical community. Whether this will mean that the medical-community-centred definition of professional negligence articulated in *Khoo James v Gunapathy d/o Muniandy* [2002] 2 SLR 414 will be tweaked remains to be seen. (On criticisms of the test, see Paul Tan, "The Doctrine of Informed Consent – When Experts and Non-experts Collide" (2006) 1 Sing JLS 148.)

5.35 Third, the conduct complained of should, in general, bear some connection with the profession. As Lord Esher MR held in *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750 at 761, "the question is, not merely whether what a medical man has done would be an infamous thing for any one else to do, but whether it is infamous for a medical man to do." Again, this definition is entirely logical since it seems hardly the place for a disciplinary committee to be sanctioning a member of its own profession for something that he did in his own private capacity and for which he has, in all probability, already been punished; or in respect of which other avenues of redress are more suitable.

5.36 Unfortunately, the law is somewhat muddled in this respect by the decision of *A County Council v W (Disclosure)* [1997] 1 FLR 574, in which the court held that a doctor, who had sexually abused his daughter, could be liable for professional misconduct. The justification cited in support of this decision is that "the duty of a doctor to himself, if not to his profession, exists outwith the course of his professional practice" and that "in such cases of moral turpitude … public reputation of the profession may suffer and public confidence in it may be prejudiced" (see *John Roylance v General Medical Council (No 2)* [2000] 1 AC 311 at 331–333, reproduced in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [28]). But this may well be the thin end of the wedge because every instance of misbehaviour by a professional may quite legitimately be viewed as bearing on the reputation of the profession. Would, for example, a civil wrong (negligent driving or breach of contract) be something that a disciplinary tribunal could try? If so, would this not put medical practitioners in the invidious position of settling any dispute in order to avoid an adverse finding? In this regard, the position taken in the legal profession should be studied: see, for example, *In re an Advocate and Solicitor* [1950] 16 MLJ 113; and *Re Howard E Cashin* [1989] 3 MLJ 129 (both cases holding that the disciplinary process should not be used as a platform to resolve civil disputes).

The High Court's decision on the first charge of inappropriate treatment

5.37 Having set out the law, the High Court considered Dr Low's arguments on the facts. First, Dr Low submitted that it was wrong of the DC to have evaluated his conduct by reference to "patients with chronic medical conditions" generally because, even though Toh Seng had been treated for chronic angle-closure glaucoma, he (Dr Low) had diagnosed Toh Seng with acute neo-vascular glaucoma, which was intractable to medical therapy.

5.38 The High Court rejected this "myopic assertion" and held that it was incumbent on Dr Low to seek input from Dr Tseng given Toh Seng's ten-year history of being treated by Dr Tseng. On the facts of the case, the High Court had no difficulty reaching this conclusion because the treatment prescribed by Dr Low was not to cure neo-vascular glaucoma, as he purported, but simply to reduce intra-ocular pressure, which was precisely the condition Dr Tseng had been treating Toh Seng for: at [44]–[47].

5.39 But Dr Low's argument raises a question that might require careful investigation in future cases. No one can or should dispute the sensibility of a doctor conferring with another especially when a patient is first consulting him after years of treatment by the other – and all the more so where the patient is consulting the second doctor for the same or similar condition. But what if the diagnosis by the second doctor is truly different such that, assuming the second diagnosis is correct, it would not ordinarily make sense or be especially beneficial to consult the first doctor?

5.40 Indeed, the High Court suggested that, as a matter of principle, its holding that a physician should seek the opinion of his patient's previous physician may have limited application in cases where:

(a) The ailments being treated were unrelated to each other (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [55]);

(b) Invasive therapy was not being recommended (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [54]);

(c) The ailment being treated was not chronic (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [54]); and

(d) It would be impractical to take a detailed medical history such as in cases of emergency (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [54]).

Assessing conflicting expert evidence

5.41 The High Court then turned to the medical expert evidence in order to determine if the DC was correct in finding that Dr Low's treatment was appropriate. Much turned on the specific facts but the lesson that is worth noting is the way in which the court dealt with the conflicting expert evidence. The court made two points clear at [68] of its judgment (*Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612). First, it would be rare for the court to overturn the judgment of the DC given that it was a body made up of medical professionals who would be in the best position to scrutinise the medical reports prepared by the experts. Second, to the extent the court should review the decision of the DC in its preference for one expert over another, the court will be careful to analyse if the expert has the relevant experience in the area in which he has testified (citing *Sakthivel Punithavathi v PP* [2007] 2 SLR 983). In this regard, the court found that Dr Low had no relevant expertise at all in the treatment of glaucoma; his specialty was instead in paediatric opthalmology.

The High Court's decision on the second charge of the lack of informed consent

5.42 The court's decision in respect of whether Dr Low had obtained informed consent from Toh Seng for the surgery was largely fact-bound. It found that there was no credible evidence that Dr Low had explored other options with Toh Seng. The court, however, endorsed the DC's conclusion (reproduced at *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR 612 at [83]), which:

> … stresses the critical importance of patients understanding all options available, and the risks and benefits of these options, especially when treatment is elective.

5.43 This formulation is entirely sensible in that it recognises a contextual approach to determining whether informed consent has been obtained.

5.44 What is perhaps most interesting is how the court dealt with a consent form that Toh Seng had signed attesting that he had "been fully informed of the possible risks of operation or infection". The court essentially agreed with counsel for the Singapore Medical Council, who characterised the consent form as being merely a formality and that even Dr Low had regarded it as such. Indeed, the court went further to state that the fact that Dr Low did not produce the consent form until some two-and-a-half years after being asked about it by the Complaints Committee could lead to an adverse inference being drawn against Dr Low.

5.45 It is undoubtedly correct that while the signing of a consent form may be used as evidence to show that the patient had made an informed consent, it should not be regarded as conclusive if, in reality, the relevant information had not been presented to the patient. In such cases, it would be surprising if anything turned on whether the medical practitioner himself had regarded the consent form as a mere formality.

5.46 Perhaps one way to prevent consent forms from being mere formalities is to have a more detailed consent form, where the risks and benefits of the procedure (including those of the alternatives discussed) are printed legibly and in plain English so as to ensure a minimum level of disclosure. Such detailed consent forms are frequently employed in relation to medical trials in Singapore hospitals and have proven successful in avoiding complaints of non-disclosure or lack of informed consent subsequently.