(2020) 21 SAL Ann Rev 161
(Published on e-First 28 July 2021)

# 6. BIOMEDICAL LAW AND ETHICS

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## I. Introduction

6.1 There was a modest number of decisions in this field in the year under review, presumably, in part, as a result of the disruptions caused by the COVID-19 global pandemic. These decisions considered issues of informed consent in medical negligence and disciplinary proceedings, as well as detailed consideration of sentencing principles, particularly in relation to the power to strike a registered medical practitioner off the statutory register. We also review a case that interpreted the power to extend time for disciplinary inquiries under s 42 of the Medical Registration Act ("MRA").[1]

## II. Medical negligence

6.2 In *Seto Wei Meng v Foo Chee Boon Edward*,[2] ("*Seto Wei Meng*") the deceased's husband acting as the administrator of her estate brought a negligence action against the first defendant, a general surgeon, for a botched liposuction and fat transfer procedure ("the aesthetic procedures"). After the completion of the procedure, the patient's blood oxygen level had dropped to 72%. The first defendant tried unsuccessfully to restore blood oxygen levels for about 40 minutes before the patient suffered a cardiovascular collapse. An ambulance was called eight minutes later and arrived seven and a half minutes thereafter. Unfortunately, despite the efforts of emergency responders and physicians at the hospital where she was subsequently brought, the patient died that same day. The cause of death was a pulmonary fat embolism.

6.3 The deceased's administrators brought a negligence claim against the first defendant, and the corporate managers and owners of the TCS

1 Cap 174, 2014 Rev Ed.
2 [2020] SGHC 260.

Central Aesthetics Clinic where the procedure was performed. The latter claims were stayed as the second and third defendants went into liquidation. The claim alleged negligence in performing the aesthetic procedures, postoperative management of the patient, and a failure to properly advise the patient of the risks of the aesthetic procedures, in particular, the risk of a fat embolism.

6.4 The judge found on the facts and expert evidence that, during the fat transfer procedure, the first defendant had negligently punctured a blood vessel in the patient's thigh with a blunt-tip cannula and injected fat molecules into her bloodstream. This finding seems to be based on the rapid rate of decline in the patient's blood oxygen saturation levels and more pronounced respiratory and haemodynamic deterioration.[3] This was not an accepted risk of the procedure, although fat embolism syndrome can occur in 2–22% of such procedures properly performed. Given the large volume of fat that had entered the patient's bloodstream, this resulted in fat embolism syndrome that caused her death.

6.5 The court also found that the first defendant was negligent in his postoperative care because of his unfamiliarity with the risks of the procedures, inability to identify the possible causes of the patient's drop in blood oxygen saturation level in a timely fashion and consequent delay in calling for an ambulance. The first defendant, however, submitted that as the deceased suffered a fulminant form of fat embolism which was invariably fatal, any shortcomings in postoperative care would not have changed the course of events. The court rejected this argument, observing that fulminant fat embolism was a retrospective diagnosis based on the outcome of the condition, and patients with fulminant fat embolism could still recover with prompt expert resuscitation. More pertinently, the court thought that "a tortfeasor should not be excused on the ground that the chances of a person's survival are slim when the very chance of survival was snatched from her by the tortfeasor's act of negligence".[4]

6.6 This looks very much like loss of chance reasoning, which harks back to the same judge's preference in an earlier decision for the minority judgments in *Gregg v Scott*[5] that supported loss of chance claims in medical negligence even when plaintiffs are unable to show on a balance of probabilities that the breach of professional duty caused them actual loss.[6] In this case, there was no definitive finding by the court that the failure to call for emergency medical support in a timely fashion would

3 *Seto Wei Meng v Foo Chee Boon Edward* [2020] SGHC 260 at [30] and [32].
4 *Seto Wei Meng v Foo Chee Boon Edward* [2020] SGHC 260 at [34].
5 [2005] UKHL 2; [2005] 2 AC 176.
6 *Armstrong, Carol Ann v Quest Laboratories Pte Ltd* [2020] 3 SLR 211 at [16]–[18].

have, on balance, prevented the patient's death. So this ground of liability in respect of negligent postoperative care appears to rest on the lost chance of survival. However, liability also independently rested on negligent performance of the aesthetic procedures themselves, and damages were ultimately assessed in the dependency and inheritance claims on the basis of the whole loss, and not loss of chance.[7] It therefore remains to be seen if loss of chance will be recognised as an independent head of loss if and when the Court of Appeal is called to decide the matter. Although this issue was argued before the Court of Appeal in *Armstrong, Carol Ann v Quest Laboratories Pte Ltd*,[8] it was left open as it did not ultimately arise on the facts.[9]

6.7 Finally, the plaintiff also argued that the first defendant failed to take reasonable care in advising the patient about the risks of fat embolism in the aesthetic procedures. The first defendant claimed that he had discussed the aesthetic procedures with his patient a month earlier, and had disclosed the risks, including fat embolism, to her. His consultation notes however made no reference to that advice. The patient also signed a set of standard consent forms on the day the procedures were performed. The first defendant claimed that he had discussed the content of those forms with the patient, but the forms were only signed by the patient and there was no other documentary evidence to corroborate his account.

6.8 While the court was satisfied that the content of the forms provided adequate disclosure of the risks in discharge of the first defendant's duty to advise, it was not persuaded that the contents of the form were properly brought to her attention. Although the court thought that the patient was certainly capable of understanding the contents of the forms, it found that the forms were only given to the patient on the day of the procedure. She was thus unlikely to have had sufficient time to read and understand their contents in detail. It would have been acceptable if the first defendant had given the patient an opportunity to read the consent forms, asked if she had read and understood the contents, and if she had any questions about them. As there was no other witness or contemporaneous consultation notes to corroborate the first defendant's account of the process of obtaining the patient's consent, the court found that the risk of fat embolism was not adequately brought to the patient's attention and the duty to advise was therefore breached.

7 *Seto Wei Meng v Foo Chee Boon Edward* [2020] SGHC 260 at [64].
8 [2020] 1 SLR 133.
9 *Armstrong, Carol Ann v Quest Laboratories Pte Ltd* [2020] 1 SLR 133 at[192]–[193].

6.9 Nonetheless, on the point of causation, the court found that the patient would have gone ahead with the aesthetic procedures even if she had been properly advised. There was no direct evidence that she would not have consented. The rare incidence of fat embolism, her previous experience with liposuction and her desire to correct the unevenness in her thighs all supported the inference that she would have accepted the risk. The breach therefore did not cause her death.

6.10 Actions in negligence for lack of informed consent tend to revolve around the disclosure of material risks and alternatives. This case is interesting as it engaged the duty to advise in relation to the patient's understanding of the risks and alternatives, in order to make an informed decision. In *Hii Chi Kok v Ooi Peng Jin London Lucien*,[10] the Court of Appeal made clear that disclosure of risks is not sufficient to discharge the duty to advise:[11]

> The ultimate aim is for patients to have sufficient information to understand the consequences of their decision, and to this end, the doctor *must ensure that the information given is presented* '*in terms and at a pace*' *that allows the patient to assimilate it, thereby enabling him to make informed decisions* … [emphasis added]

6.11 The duty is discharged if reasonable steps are taken to that end; there is no requirement to ensure understanding.[12] *Seto Wei Meng*[13] is a timely reminder that it is not enough merely to obtain the patient's signature on a consent form. Where consent forms are used, they should be expressed in language that the patient can comprehend. Reasonable effort must be taken to highlight pertinent risk information contained within the form, and see that the patient has sufficient time to digest that information before making a decision to accept treatment. There should also be an opportunity to ask questions and seek clarification.

6.12 The duty to advise is heightened with respect to aesthetic procedures which are elective in nature, and therefore call for more careful steps to be taken as to the extent of disclosure; or as here, an appreciation by the patient of the risks involved.[14] The Singapore

10 [2017] 2 SLR 492 at [156].]

11 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [156]. See also *Montgomery v Lanarkshire Health Board* [2015] 2 All ER 1031 at [90].

12 *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 at [154]; *Montgomery v Lanarkshire Health Board* [2015] 2 All ER 1031 at [87]; See also *Al Hamwi v Johnston* [2005] EWHC 206 at [69] and the criticisms of that decision in José Miola, "Autonomy Rued OK?" (2006) 14 Med Law Rev 108.

13 See para 6.2 above.

14 Singapore Medical Council, Ethical Code and Ethical Guidelines (2016 Ed) at para B10(4).

Medical Council ("SMC") Ethical Code and Ethical Guidelines ("2016 ECEG") also spell out that there must be a "cooling-off" period between consent and treatment that is proportionate to the invasiveness of the treatment and the risks involved.[15] Finally, the requirement to keep good contemporaneous clinical notes on the informed consent process is also important to corroborate the efforts of the physician in discharging the duty to advise.

## III. Professional misconduct

### *A. Documentation of informed consent*

6.13 In *Foo Chee Boon Edward v Singapore Medical Council*[16] ("*Foo Chee Boon Edward*"), the appellant doctor appealed against his sentence of three months' suspension on a charge of failing to keep clear and accurate records. The appellant had performed an abdominal hysterectomy and anterior resection ("the surgical procedures") for a patient. He initially saw the patient on 18 January 2012, diagnosed her with rectal cancer, discussed various treatment options and their respective risks and complication. However, the patient was not prepared to give consent to proceed on that date, but recontacted the appellant on 24 January 2012. The appellant was overseas at the time and referred the patient to the referring physician. The latter undertook various tests and documented her written consent for the surgical procedures to be carried out by the appellant and the referring physician as co-surgeon.

6.14 The specifics of the charge against the appellant were that he failed to (a) record his advice as to the material risks and possible complications of the surgical procedures, especially on an underweight patient; and (b) personally record the patient's consent to undergo the procedures. Although the appellant pleaded guilty to the charge, at the Court of Three Judges' direction, the appellant and respondent revisited the conviction based on the recent observations of the court in *Singapore Medical Council v Lim Lian Arn*,[17] which was delivered after the original decision to convict by the Disciplinary Tribunal ("DT"). In particular, the appellant sought to set aside his conviction.

6.15 The court allowed the appeal and set aside the conviction as there was no basis for the charge to be upheld (the respondent accepted this

15 Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2016 Ed) at para B10(5).
16 [2020] 4 SLR 1075.
17 [2019] 5 SLR 739.

position as well). In doing so, it highlighted that there was a difference between failure to document the risks of the procedure and failing to inform the patient of those risks. The latter was a more serious infraction as it might deprive the patient of an opportunity to give informed consent.

6.16 Although the appellant had not personally re-documented the patient's consent on 24 January 2012 after his initial consultation and advice on 18 January 2012, this was done by his co-surgeon, who repeated the relevant advice. There was no apparent necessity for the appellant, albeit as lead surgeon, to do so as the 2016 ECEG appeared to countenance the delegation of this responsibility to other clinical team members provided that adequate training and supervision of the delegee, and documentation are adhered to.[18] Though the court left open this particular point, it noted that the appellant did provide the required disclosure and advice during the initial consultation, and there was adequate documentation by his co-surgeon of the same at the subsequent consultation.

6.17 Secondly, the appellant was overseas during the second consultation when consent was in fact taken, and the matter was of some urgency. Third, any failure in documentation did not cause any harm to the patient. On the totality of the facts, the court was not satisfied that the appellant's failure in documentation, if any at all, amounted to such a serious disregard or persistent failure of responsibility as to amount to professional misconduct. *Foo Chee Boon Edward*[19] is another instance of the unravelling of a misunderstanding in medical disciplinary proceedings as to the serious threshold of misconduct required for a conviction under s 53(1)(*d*) of the MRA.

### *B. Jurisdiction and power to strike off*

6.18 The next medical disciplinary case before the court involved, for the first time, a provisionally registered medical practitioner. In *Singapore Medical Council v Chua Shunjie*,[20] the respondent was charged with six instances of misconduct that broadly involved the (a) breach of medical confidentiality; and (b) provision of false information in the context of research publications or applications. In relation to the single charge relating to medical confidentiality, it was alleged that the respondent had written a medical report detailing a patient's medical condition, diagnosis and treatment at the request of the latter's employer without the patient's consent. In relation to the remaining set of charges,

18 Singapore Medical Council, Ethical Code and Ethical Guidelines (2016 Ed) at para C6(8).
19 See para 6.13 above.
20 [2020] 5 SLR 1099.

these involved the respondent making false claims about his institutional affiliation or co-authorship with fictitious persons, in the context of research publications or institutional review board applications for the approval to conduct research studies.

6.19 The respondent pleaded guilty to four charges, while consenting to the two remaining charges on provision of false information being taken into consideration for the purposes of sentencing. He also admitted to the statement of facts without qualification. The DT accepted the respondent's plea of guilt, but was split on the appropriate sentence. The majority of the three-member tribunal imposed a suspension for 18 months, while the dissenting member thought that a striking-off order was warranted. The SMC appealed against the sentence imposed.

6.20 As a preliminary point, the court had to decide whether a DT under the MRA had jurisdiction over non-registered persons. The court answered this in the negative. Section 53(1) of the MRA made clear as a matter of logic that a DT can only make findings in relation to a registered medical practitioner (including a provisionally registered medical practitioner),[21] and not someone who is no longer registered. Secondly, the sanctions that a DT can impose, such as a suspension or striking-off order, make sense only in relation to a registered medical practitioner. Thirdly, s 37A(3) of the MRA also empowers the SMC to prevent anyone from voluntarily deregistering themselves, *inter alia*, where there is evidence of professional misconduct or that formal disciplinary proceedings have been commenced against such registered medical practitioners. To secure the jurisdictional net, the court also recommended that the SMC consider making voluntary deregistration conditional on full disclosure of all relevant facts pertaining to the application for voluntary deregistration.

6.21 Nevertheless, although the respondent's provisional registration order expired before the DT hearing, the court found that such expiry did not lead to the automatic deregistration of the respondent. Upon the grant of provisional registration, a doctor's name remains on the register until (a) successful registration on another register under the MRA; or (b) any one of the circumstances under s 31 of the MRA applies, namely (i) death; (ii) failure to renew a practising certificate for a continuous period not less than two years; or (iii) for sufficient reason at the request of the registered medical practitioner unless an inquiry or proceedings have commenced under Pt 7 of the MRA.[22]

21 Medical Registration Act (Cap 174, 2014 Rev Ed) s 2 read with s 19.

22 These are disciplinary proceedings, health committee inquiries or performance assessments.

6.22 In addition, the SMC has a discretion to remove a provisionally registered medical practitioner under s 32(1)(*cb*) if that provisional registration is cancelled under s 24(2A) of the MRA. This may occur if the conditions for provisional registration have not been complied with, or if the SMC forms the view that the provisionally registered medical practitioner is unfit to practice.[23] Reading these provisions as a whole, the court considered that a provisional registered medical practitioner's name remains on the register, even though his provisional registration has expired, until one of the contingencies provided for under the MRA materialises. Thus, the respondent's name remained on the provisional register as none of the applicable statutory contingencies applied, and he remained amenable to disciplinary proceedings under the MRA. The main consequence of the expiry of provisional registration is, instead, the concurrent expiry of the practising certificate, thus preventing the respondent from performing any of the regulated activities as a provisional registered medical practitioner (even though he remains registered under the MRA).

*(1) Sentencing principles and power to strike off*

6.23 Returning to the issue of sentence, to recap, the majority in the DT ordered that the respondent be suspended for a term of 18 months (among other orders such as the respondent was to give an undertaking to the SMC that he would not engage in similar conduct in future). The majority had considered that the appropriate sentence would be suspension for a term of 36 months, but reduced it to 18 months due to the fact that the respondent was not able to practise during the three-year period when the disciplinary proceedings were ongoing and had to endure considerable stress due to that. The minority in the DT concluded instead that the appropriate sanction was a striking off order.

6.24 The court allowed the appeal by the SMC. It agreed with the minority in the DT, and ordered that the respondent be struck off the register of provisionally registered medical practitioners. The court was of the view that although the respondent's confidentiality charge alone would not justify a striking-off order being made, the respondent's multiple false information charges clearly involved dishonesty on the part of the respondent. Moreover, the court held that no weight could be given to any of the personal mitigating factors raised by the respondent (personal and financial hardships, expression of remorse, and SMC's delay in prosecuting the respondent). Overall, the court found that the

23 A Health Committee can also order removal on the ground of a lack of fitness to practise by reason of physical or mental impairment under s 58(2) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

gravity of the respondent's misconduct called for the harshest possible sentence in order to effect sufficient general deterrence, protect public confidence and uphold the standing of the medical profession.

6.25 There are several noteworthy points emanating from the court's reasoning, which may be of more general application. Firstly, the court stated that imposing a striking off order in the case of a provisional registered medical practitioner is not an empty or meaningless sanction. This is because such an order sets off a number of important professional consequences. For instance, before the practitioner can apply for restoration to the appropriate register, he or she must obtain (a) a statutory declaration accompanied by a statement explaining the grounds for the application; (b) any relevant documents or information required by the SMC; and (c) two certificates of identity and good character signed by registered medical practitioners who are unrelated to the practitioner seeking restoration and have at least ten years' standing.

6.26 Secondly, the court underscored that the four-step sentencing framework that it had previously issued in *Wong Meng Hang v Singapore Medical Council*[24] ("*Wong Meng Hang*") was meant only for cases where deficiencies in a doctor's clinical care caused harm to a patient. The framework was not intended to be applicable to other types of medical misconduct for which different sentencing considerations might be relevant, and for which the appropriate sentences would fall to be determined by reference to other precedent cases. In that regard, the four-step framework had no relevance in the respondent's case, which did not involve situations where his clinical care had caused harm to a patient.

6.27 Thirdly, in assessing the gravity of the respondent's dishonesty, the Court affirmed and applied the analytical framework set out in *Wong Meng Hang v Singapore Medical Council*[25] for dealing with medical-related misconduct involving dishonesty. In particular, there is a presumptive sanction of striking off where dishonesty is integral to a defendant's misconduct, or where the dishonesty violates the relationship of trust and confidence between doctor and patient. Outside of such cases, a striking off order should still be imposed if a defendant's conduct was so serious such as to render him or her unfit to remain a member of the medical profession, barring the presence of exceptional personal mitigating circumstances.

24 [2019] 3 SLR 526.
25 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526.

6.28 Fourthly, relying on cases involving solicitor or lawyer misconduct,[26] the court held that mitigating factors carry less weight in medical disciplinary proceedings than in criminal proceedings. This is because in such cases, public interest considerations such as the need to protect the public and uphold public confidence in the integrity of the profession are paramount and at the forefront in determining the condign sentence to be imposed.

### *C. Extension of time for disciplinary inquiries under Medical Registration Act*

6.29 Finally, the requirement of expeditious investigations under s 42 of the MRA was the subject of judicial review proceedings in *Lee Pheng Lip Ian v Chen Fun Gee*.[27] A complaint was lodged by the SMC against the appellant for offering non-mainstream services which were in breach of the Private Hospitals and Medical Clinics Regulations[28] ("PHMCR"). The Ministry of Health had also refused to renew the appellant's two-year clinic licence for the same reason, and short six-month conditional renewals were granted, provided that the appellant complied strictly with the requirements of the PHMCR. The appellant then applied for leave to commence judicial review proceedings in order to quash the various applications by the Complaints Committee ("CC") to the Chairman of the Complaints Panel ("CCP") for an extension of time to complete the inquiry against the appellant, various orders by the CCP granting an extension of time (there were 13 extensions granted in total), and the decision by the CC to order an inquiry by the DT into the complaint against the appellant. In addition, a prohibiting order was sought to prevent the SMC from referring the matter to the CCP.

6.30 On appeal against the High Court decision refusing leave for judicial review, the Court of Appeal upheld the refusal. In doing so, it found that the three-month period stipulated for CC inquiries under s 42(1) of the MRA did not require that non-compliance invalidate the disciplinary proceedings. Otherwise, there would be further delay in the matter as there was nothing to stop the same complaint being brought before a new CC. Any existing delay would be further exacerbated.

6.31 In addition, applications for an extension of time under s 42(2) of the MRA did not have to be made before the expiry of the initial or extended period of time for investigations, as s 53 of the Interpretation

26 *Law Society of Singapore v Ravi s/o Madasamy* [2016] 5 SLR 1141; *Law Society of Singapore v Kurubalan s/o Manickam Rengaraju* [2013] 4 SLR 91.
27 [2020] 1 SLR 586.
28 Cap 248, Rg 1, 2002 Rev Ed.

Act[29] expressly authorised such out-of-time extensions, and nothing in s 42 of the MRA derogated from this. In addition, a medical practitioner who is the subject of a complaint does not have an independent right to be heard or challenge the CCP's decision to extend time under s 42(2), and the failure to stipulate the specific reasons for granting the extension alone also does not invalidate the inquiry or the exercise of discretion unless there is bad faith or malice. On the facts, there was no breach of s 42(2) of the MRA by the CCP in granting the extensions of time sought by the CC. Any prejudice suffered by the almost four-year period for the CC inquiry under s 42 could be raised in the subsequent DT hearing.

29 Cap 1, 2002 Rev Ed.