5. BIOMEDICAL LAW AND ETHICS

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Introduction

5.1 Considering that the last truly significant medical law case, *Khoo James v Gunapathy d/o Muniandy* [2002] 2 SLR 414, was decided almost five years ago, the year under review produced an unusual number of interesting and novel developments in the law both in and out of court. The general direction of these developments appears to be focused on recognising the autonomy of the individual patient, and giving effect to his deliberate choices.

Recognising autonomy

Anticipatory decisions of previously competent persons

5.2 *Re LP (adult patient: medical treatment)* [2006] 2 SLR 13 ("*Re LP*") concerned a diabetic who admitted herself into hospital and was eventually diagnosed as suffering from "right foot infection with gangrene of her right big toe and several superficial burn wounds over her left foot". The patient refused to consent to the amputation of her right leg, although she agreed to amputate her right toe. When her infection then spread to the left leg she continued to insist that her doctors "save her legs at all costs". At this time, there was still no immediate danger of her dying from the infection. Soon after, however, the patient went into septic shock and lapsed into a coma. There was uncontroverted evidence that the patient would die if her legs were not amputated. The hospital applied, *ex parte*, for a declaration that an operation amputating her legs would be lawful.

5.3 Choo Han Teck J found that he had the jurisdiction to grant the application, and did grant the declaration, notwithstanding that the patient had purportedly declared to her son that she would "rather die than lose her legs". In so far as the medical law question was concerned (*ie*, whether to grant the declaration), Choo J held as follows (at [11]):

> I am of the view that the evidence indicated that the statements made by [the patient] before she lapsed into a coma regarding her preference to death over losing her legs, were probably made without the benefit of medical advice of impending death. I could not say, on the evidence before me, that [she] had clearly and expressly refused her consent to the surgical

> operation now intended by the doctors, knowing that it was the only treatment to save her from impending death. Further, I was satisfied that the proposed surgical operation would be in her best interests.

5.4 Two aspects of this case are worth highlighting, although a more extensive discussion may be found in Paul Tan, "When Death Knocks, Who Will Answer and What Will They Say?" (2006) 18 SAcLJ 493 ("When Death Knocks").

5.5 By far the most novel contribution that *Re LP* has made to the development of medical law in Singapore is its assumption that the courts will, in principle, honour the anticipatory decisions of a previously competent person. This is so even where, as in *Re LP*, the patient has indicated a refusal to accept life-*saving* treatment. On its face, this goes beyond the ambit of the Advance Medical Directive Act (Cap 4A, 1997 Rev Ed) ("AMD"), which only envisages the refusal of life-*sustaining* treatment when the patient is already terminally ill.

5.6 *Re LP*, however, imposes an evidential burden that the court will look for a "clear and express" indication that the anticipatory decision was made in the knowledge that this was the only treatment that could save the patient from impending death. The question that future cases will have to decide is just how high this evidential burden is. Will it require patients to have foreseen the precise circumstances of their imminent death when they declare that they would rather die than be treated? Would statements such as "I don't want to be hooked up to any machine" suffice? What if such indications were made in social settings and in the absence of medical advice? While the evidential bar cannot be set too low because it is necessary for the court to assure itself that the patient in question did intend to forsake treatment, setting the evidential bar too high will also thwart many perfectly valid wishes and in the process undermine the very purpose of recognising anticipatory decisions.

5.7 A second aspect of *Re LP* worth highlighting is the court's approach in the absence of such clear and express anticipatory decisions. Most common law jurisdictions currently adopt either the "substituted judgment" test or the "best interests" test. While Choo J decided the case on the basis of the latter test, it is not entirely clear if he also rejected the former. As suggested in "When Death Knocks", it is possible that the reason Choo J did not apply the substituted judgment test was because, on the facts, there was no reliable evidence of what the patient would have wanted. Only the patient's son was able to testify as to what she had said, and even then there was no evidence that she meant literally what she purportedly said.

5.8 The decision as to which test to adopt ultimately depends on whether one views the sanctioning of the refusal of medical treatment as primarily a medical issue or an ethical and moral one. Under the "best interests" test, the predominant inquiry is on the medical utility of the proposed treatment, although as Choo J correctly held in *Re LP*, it may be possible to take into account factors such as the family's interests. On the other hand, the "substituted judgment" test's focus is on vindicating the dignitarian concerns of formerly competent patients.

5.9 In truth, neither model is satisfactory for two reasons. First, the two tests imply an inevitable tension between the subjective desires of the patient and his objective medical diagnosis. As explained in "When Death Knocks", this need not be so, especially since most persons make decisions based on what is in their best interests. As such, borderline evidence of the patient's subjective desires may be reinforced by objective medical analysis as to whether the treatment will be successful, and *vice versa*. Second, regardless of which test is adopted, both produce only very rough approximations of what the patient might want. Even the "substituted judgment" test must ultimately rely on what others think the patient has said about her critical interests. If the public can be educated about the need to leave clear instructions as to how they would prefer to be treated should they become incompetent, that would go a long way in assisting their families, the hospitals and the court decide whether to permit or withdraw medical treatment (and what sort of treatment) when the need arises.

5.10 Among other things, *Re LP* serves to highlight what is only going to be an increasingly common dilemma: whether and how to treat incompetent patients. While *Re LP* may have confirmed the legitimacy of anticipatory decisions, legislative change is necessary to bring the issue into public consciousness. Moreover, while some of us will be able to draft lengthy expositions as to how we would like to be treated if we became incompetent, the same may not be true for many. It is in this respect that the recent attention given to the AMD is salutary. Even so, more needs to be done. The AMD is currently very narrow in that it applies only when a patient is terminally ill, whereas there is an infinite range of medical possibilities that might confront an incompetent patient. It is also unclear whether the AMD allows doctors to discontinue feeding a patient, thereby quickening the patient's death. Unless the AMD's ambit is widened and its provisions refined, its practical utility will soon diminish.

5.11 Another welcomed legislative change is afoot. It was announced recently that Parliament would be studying the feasibility of allowing individuals to appoint guardians who would be able to make decisions on their behalf should they become incompetent. While it is not yet certain whether one will also be allowed to delegate the making of medical decisions, there is no reason not to permit it. Indeed, the said announcement is long overdue. In 1999, the Singapore Academy of Law had already published a report proposing that advance powers of attorney be given statutory force for currently competent persons in the event that they become incompetent. Such a move, the report added, was justifiable on the basis of the principles of autonomy and self-determination: see *Civil Inquiries into Mental Incapacity: The Report of the Sub-Committee of the Law Reform Committee of the Singapore Academy of Law for the Review of Proceedings under the Mental Disorders and Treatment Act (Cap 178)* (Singapore Academy of Law, November 1999) at pp 50–54.

Organ trading

5.12 There has been much public interest, reflected in letters to the forum page of *The Straits Times*, in relation to whether organ trading ought to be allowed. Space constraints do not allow a fully-fledged exposition that this topic deserves, but a few preliminary observations may be apposite.

5.13 The general notions about organ trading have been summarised as follows (see James Stacey Taylor, *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (Ashgate Publishing, 2005) at pp 1–2):

> To many persons markets [in human organs] have a whiff of sulphur about them. Market systems are, in the view of many, mechanisms that enable the strong to prosper at the expense of the weak, where everything is reduced to the lowest common cash denominator, and from which human feeling, sentiment and spirituality is absent. And markets in human organs are, in these persons' eyes, the very worst face of this morally bankrupt system. Such markets are frequently described in terms of the greedy rich and the exploited poor, so much so that a cursory glance at discussions of them might lead the casual reader to think that 'the rich, tired of gold plating their bathrooms and surfeited with larks' tongues, had now idly turned to collecting kidneys to display with their Fabergé eggs and Leonardo drawings.'

5.14 Organ trading raises the age-old clash between patient autonomy, which is an important principle in biomedical ethics, and social values. Another aspect of organ trading is the consequentialist argument that a market would secure more organs for saving lives if organ trading was allowed.

5.15 Generally, in itself, few can argue against any principle that confers a right to choose, or a right to decide to donate one's organs. It is only where one's decision affects the rights of others that legal and ethical problems arise. Caution might also be justified on the basis that the decision-maker is not truly autonomous in his choices. In the case of organ trading, it is often argued that the voluntariness of the vendor to sell his organ is vitiated by the coercive prompting of poverty. It is true that wealthy people would not likely be selling their organs – only destitute people who have no assets other than their organs and bodies would find it necessary to sell their own organs. As Taylor observes, it is somewhat misguided to stop the poor from selling their organs just so that they can preserve their autonomy. People who tire of bread from sheer abundance may not appreciate how sweet it tastes in the mouth of the destitute. Of course, from a sociological perspective, the right question would be to ask, "What can be done to alleviate poverty?" Unfortunately, allowing organ trading will not ameliorate poverty; but neither will banning it accelerate assistance to the poor. As long as the poor remain destitute enough to want to sell their kidneys, an insistence on preserving autonomy may possess an air of importance but its significance is doubtful. And if the time comes when the poor are not so destitute that they are constrained by economic necessity, the central justification for banning the trading of organs will be equally irrelevant.

5.16 The issue is, however, more morally complex. The validity of an organ trading market has wider moral implications than just the market itself or the act of trading. For instance, if there is a ready market would a close relative of a needy patient avoid any responsibility and just direct the patient to buy the needed organ from the market? It may also be argued, as Kant did, that a man cannot both be the property of his body parts and still be the property owner, and, consequently, he is not "entitled to sell his limbs for money ... for otherwise all the man's limbs might be sold off": see Immanuel Kant, *Lectures on Ethics*, (Peter Heath trans) (Cambridge University Press, 1997) at p 127. In addition to ethical questions of providing a market for organ trading as an alternative to conventional altruistic systems, there is the further question of which market is more ethically justifiable, namely, a regulated or an unregulated one.

5.17 Even though from a utilitarian viewpoint, organ trading appears to make sense in so far as it purports to increase the number of organs available for transplant, utilitarian philosophers might be divided as to whether the risk of a trading market developing a secondary black market is a risk worth assuming. Indeed, there are some strong economic arguments against a market system: see the discussion in David L Kaserman & A H Barnett, *The US Organ Procurement System: A Prescription for Reform* (AEI Press, 2002) at ch 4.

5.18 It is unlikely that an answer exists that will accommodate the concerns of the proponents as well as the opponents of organ trading. Whatever the final position might be, one can only hope that it is one that is reached more by reason rather than by sentiment: on the latter point, see in general, Choo Han Teck, *Law and Morality in the Age of Bioscience* (Marshall Cavendish, 2006), especially at ch 4.

Professional ethics

Research ethics

5.19 As Singapore continues its aggressive push to be a biomedical research hub, ethical standards will have to be vigilantly policed. This is especially necessary if Singaporeans are to be encouraged to subject themselves to medical experiments. It is in this context that the infamous Prof Simon Shorvon incident is particularly illustrative.

5.20 Shorvon came to Singapore in December 2000 as Director of the National Neuroscience Institute ("NNI"). He was also the principal lead investigator of a project to study the genetic influences in Singapore's three principal ethnic population groups with regard to disease susceptibility and drug responsiveness to, among others, Parkinson's disease. Only a few months after Shorvon began work on the project, complaints surfaced that he (and his researchers) had obtained confidential information on his patients without their knowledge or consent; and that he had prescribed or altered the medication of the patients without their knowledge or consent.

5.21 An internal inquiry panel was formed and it generated a report concluding that "the research was carried out in serious breach of ethical guidelines which are applicable in Singapore as well as internationally". A committee of inquiry set up by the Ministry of Health ("the MOH committee") soon followed to review the process of ethics approval, confidentiality and informed consent procedures and to make recommendations for any lapses found. Interestingly, when the MOH committee issued its report in March 2003, its conclusions were different from NNI's and no personal censure of Shorvon was made. It was only after

NNI's report was provided to it that it issued a supplemental letter on 3 April 2003 criticising Shorvon. The matter eventually went before the Singapore Medical Council ("SMC") and 30 charges were preferred against Shorvon. Thirteen of those charges alleged that Shorvon had compromised the best interests of the test patients by altering their medication; another 13 charges alleged that Shorvon failed to obtain the patients' informed consent for the research; two charges were for failing to obtain ethics approval from the relevant hospitals and another two charges were in relation to Shorvon accessing the patients' medical data without approval. The SMC found that all the charges were made out.

5.22 In the meantime, this issue came to the attention of the UK's General Medical Council ("GMC"). Among other things, the GMC invited reports from various experts, all of which were supportive of Shorvon. In particular, a report was tendered by one Prof Williams, whom the SMC and the GMC regarded as being independent and having the requisite expertise. His report was also supportive of Shorvon. Eventually, the GMC decided to cancel any further inquiry, concluding that even if it were possible to surmount the logistical problems of rehearing the case in its entirety, the likely conclusion, given Prof William's report, would be that it could not be said beyond reasonable doubt that Shorvon's conduct amounted to serious professional misconduct. The SMC sought judicial review of the decision to cancel the inquiry but was unsuccessful: see *R (on the application of the Singapore Medical Council) v General Medical Council* [2006] EWHC 3277 (Admin). While the actual decision of the court was based on narrow administrative law grounds, there is a hint that the court was sceptical even as to the merits of the various findings against Shorvon. For instance, in [12.4] and [13] of the judgment, the court emphasised the "highly charged language" employed in the NNI report, almost as if it doubted the objectivity of the report.

5.23 It is not entirely certain how and why the UK experts, the GMC and even the UK court could arrive at a conclusion that was diametrically opposed to the conclusions of the SMC and the NNI. The temptation to paint the difference in opinion as cultural relativism may be inaccurate given that even the MOH report was initially favourable (or at least, not unfavourable) to Shorvon.

5.24 Regardless of the reasons for the cleavage in perspective, it will be important to address that difference so that researchers can conduct their studies without having to fear accusations of professional misconduct and patients can consent to such experiments knowing that the law unambiguously protects their rights and interests.

Disciplinary hearings

5.25 In *Hennedige Oliver v Singapore Dental Council* [2007] 1 SLR 556, a dentist was found by the disciplinary committee of the Singapore Dental Council ("the DC") to be guilty of professional misconduct for failing to obtain the informed consent of his patient before carrying out a mini-implant procedure on one of her teeth. After dismissing the dentist's allegation that the DC was biased, Tan Lee Meng J allowed his appeal. The case itself was focused on the credibility of the complainant and the dentist rather than the more intricate legal question of what constituted proper informed consent, a question that remains unanswered: see Paul Tan, "The Doctrine of Informed Consent – When Experts and Non-experts Collide" [2006] Sing JLS 148.

5.26 Nonetheless, it is important to emphasise two aspects of Tan J's judgment. First, Tan J endorsed *Tan Sek Ho v Singapore Dental Board* [1999] 4 SLR 757 at 764, [10.1], where Amarjeet Singh JC held that even though such appeals to the court were by way of rehearing, much deference would be accorded to the professional opinion of the disciplinary committee. It is not immediately obvious that the courts should hear such appeals *de novo*, especially in the light of s 47(3) of the Dentists Act (Cap 76, 2000 Rev Ed), which provides that "the High Court shall accept as final and conclusive any finding of the Disciplinary Committee relating to any issue of ethics or standards of professional conduct unless such finding is in the opinion of the Court unsafe, unreasonable or contrary to the evidence".

5.27 Be that as it may, and this is the second point, there can be no doubt that Tan J's application of the presumption of innocence is beyond reproach. Referring to *Yeo See Koon Jimmy v PP* [1994] 3 SLR 539, Tan J reiterated that however tenuous the defence may be, the burden still lies on the Prosecution to prove its case, and that in discharging that burden it is insufficient to point to the inadequacies of the defendant's testimony as long as reasonable doubts remain in the Prosecution's case. On this point, see the elaboration in *PP v Mohammed Liton Mohammed Syeed Mallik* [2007] SGHC 47 at [4].