6. BIOMEDICAL LAW AND ETHICS

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Professional discipline

6.1 The headline-grabbing disciplinary proceedings against Dr Susan Lim reached the Court of Appeal (*Lim Mey Lee Susan v Singapore Medical Council* [2012] 1 SLR 701 ("*Lim Mey Lee (CA)*")) in the year under review on applications for orders to quash the constitution of a disciplinary committee set up after a first disciplinary committee had excused itself in the face of a challenge by Dr Lim that they had demonstrated apparent bias; as well as a prohibition order against further proceedings against her. The challenges were dismissed; and proceedings against Dr Lim are ongoing at the time of writing.

6.2 Dr Lim had been treating a female patient of the Royal Family of Brunei until the patient passed away in the middle of 2007. After her death, officials from the Ministry of Health, Brunei ("MOHB") informed Professor Satku, Singapore's Director of Medical Services, that Dr Lim's invoices to Brunei for services rendered in 2007 were, in their view, too high. Prof Satku invited the MOHB to write officially to the Ministry of Health, Singapore ("MOHS"), which was done. This triggered an investigation by the MOHS, in which Prof Satku was involved. After investigations were completed, the MOHS issued a complaint to the chairman of the Singapore Medical Council's ("SMC") complaints panel. The chairman of the Complaints Panel in turn progressed the matter to the complaints committee, which in turn made an order that a disciplinary committee be convened to formally hear the matter ("1st DC"). After the prosecution's case closed, Dr Lim informed the 1st DC that she would be making a submission that there was no case to answer. The 1st DC fixed a time-table for written submissions to be made, followed by oral submissions. Slightly more than a month before the oral submissions were due to be heard, one of the 1st DC's members passed away. A new member was appointed. Twenty days later, when parties turned up to make oral submissions, the 1st DC announced that it had made its decision. On the basis that the 1st DC had demonstrated itself to have prejudged the matter, Dr Lim requested that it excuse itself. The 1st DC did so, after ascertaining that the prosecution had no objection to Dr Lim's request. Shortly after, the SMC purported to "revoke" the appointment of the 1st DC that had excused itself and then to appoint a second disciplinary committee ("2nd DC"). This was achieved by purportedly seeking the consent of the members of the

SMC through (bar one exception) e-mail. The e-mails did not explain why the 1st DC had excused itself. The e-mails did state, however, that approval would be assumed if no objection to the proposed course of action was received. Both decisions were carried without any objection that was filed within time (one objection was filed outside the deadline).

6.3 The applicable statutory framework was the Medical Registration Act (Cap 174, 2004 Rev Ed) ("MRA"). The MRA was amended in 2010, but the amended MRA is not applicable to the case.

6.4 The Court of Appeal in *Lim Mey Lee (CA)* held that once a complaint has been lodged, the statutory mechanisms set out in Part VII of the MRA take effect as a matter of course. The SMC has no discretion but to progress a complaint in accordance with Part VII. In the present case, the excusal of the 1st DC did not terminate proceedings and it did not discharge the complaint committee's order for the complaint to be investigated by a disciplinary committee. The following consequences flow from this premise. First, it was neither necessary nor proper for the matter to be remitted back to the complaints committee to decide again whether a formal inquiry should be ordered. The court was not persuaded that the immediacy requirement pursuant to s 41(3) of the MRA required a fresh order by the complaints committee. The requirement was satisfied as long as the 2nd DC was constituted in short order after the excusal of the 1st DC.

6.5 Second, the SMC was not obliged to engage in a consultative decision-making process with its members, although the procedural and substantive requirements of the MRA had to be met. Therefore, formal approval was necessary, but the SMC could decide how that approval was to be obtained. In addition, it was irrelevant whether the SMC members had in fact read or considered the e-mails sent. The SMC was entitled to treat a non-response from its members as consent.

6.6 Third, the SMC was not obliged to inform members of the reasons why the 1st DC had excused itself; nor did it err in describing the revocation of the 1st DC as being purely procedural.

6.7 Fourth, it was impossible for there to be a conflict of interest between Prof Satku's role as Director of Medical Services (in which he invited MOHB to write in formally so that their complaint could be investigated formally) and as Registrar of the SMC (in which he oversees the disciplinary process). It was only in the appointment of the membership of a disciplinary committee that the SMC had discretion. However, no allegation had been made that the 2nd DC's members were biased.

6.8 Fifth, the SMC was compelled to institute the 2nd DC and could not be prohibited on *Wednesbury* grounds of unreasonableness.

6.9 Finally, the court added important observations relating to one of the key issues in the substantive dispute. It held that where a service provider and a client agreed on fees, and if services were rendered in accordance with the agreement, no issue of overcharging would usually arise regardless of how high the fees were. However, overcharging can still arise if the service provider pads his bills, or over-services his client. In other words, in order for a medical practitioner to be guilty of "overcharging", it appears that the court will require evidence of impropriety on the part of a medical practitioner, not just the mere fact that his bills were high by market standards.

Negligent advice and informed consent

6.10 The importance of obtaining informed consent was underscored by the Court of Three Judges in *Eu Kong Weng v Singapore Medical Council* [2011] 2 SLR 1089 where the court upheld an order of suspension against a medical practitioner for having failed to obtain such consent.

6.11 Yet, the details of what it means to have obtained informed consent remain the subject of some controversy. In the year under review, the High Court in *D'Conceicao Jeanie Doris (administratrix of the estate of Milakov Steven deceased) v Tong Ming Chuan* [2011] SGHC 193 had the opportunity to address the law on negligent advice in two contexts: first, in terms of whether a particular treatment ought to have been recommended and second, whether the medical practitioner had properly explained the risks involved in the recommended procedure.

6.12 On the first issue, the High Court simply applied the test articulated by the Court of Appeal in *Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 ("*Gunapathy*"), effectively intimating its reluctance to enter into detailed analysis of the merits of any medical decision as long as there was a body of opinion that supported such a medical decision.

6.13 On the second issue, the High Court had to consider the applicability of the test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ("*Bolam*") to negligent advice. The High Court noted that in *Gunapathy*, the Court of Appeal accepted that *Bolam* itself did not involve the question of negligent advice. Nevertheless, the Court of Appeal viewed the majority in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 as supporting the application of *Bolam* to

advice, subject to the *caveat* that the issue of the proper advice to be given could not be abdicated to the medical profession entirely. A judge should be at liberty to rule that advice should have been given if a particular risk was substantial and there was no cogent clinical reason why disclosure of the risk was not made.

6.14 The High Court, citing *Gunapathy*, rejected the plaintiff's argument that the test should be drawn closer to the more objective test propounded by the Canadian Supreme Court in *Reibl v Hughes* (1980) 114 DLR (3d) 1, which held that a doctor had a duty to warn his patient of the material risks inherent in the proposed medical treatment. In turn, a risk was material if, in the circumstances of the case, (a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or (b) if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it. It would seem, therefore, that the position in Singapore presently is that the determination of whether a particular risk ought to have been disclosed will remain primarily an issue of medical judgment assessed by reference to whether a respectable body of medical opinion would support the non-disclosure in the circumstances.

6.15 Related to this issue, on the facts, were two interesting questions. The first was whether the medical practitioner was obliged to convey the risk of a certain medical procedure in percentage terms. The High Court accepted expert evidence that it was more important for the risk to be conveyed in relative terms, and that in fact some medical practitioners prefer not to convey risks in quantitative terms. The High Court did, however, caution that it may be a breach in some cases not to convey the risk in percentage terms, and particularly where the patient would understand a risk presented in percentage terms. Although in this case the High Court was of the view that the patient would have understood the risk if presented in percentage terms, he had been sufficiently warned of the severity of the risk of the procedure in question.

6.16 The second question was whether it was necessary for a medical practitioner to warn the patient of all the major morbidities that might possibly result. The High Court held that it was sufficient if the main risks of the procedure were conveyed and that a medical practitioner, could in his judgment, decide how much to disclose so as to ensure a rational choice. This is because presenting a comprehensive list of possible morbidities might convey a false sense of risk. The outcome in this case was certainly sensible: it may not make much difference how death results as long as the overall risk of complications arising from the procedure is properly conveyed. In other cases, particularly where death does not result, the answer may be less straightforward. A patient might

be willing to accept some injuries, but not others. A categorical approach, in obliging medical practitioners to disclose only the "main risks", may not fully vindicate the potential of the informed consent doctrine to protect the interests of patients.