Published on e-First 26 July 2019

6. BIOMEDICAL LAW AND ETHICS

Tracey Evans **CHAN**
LLB (Hons) (National University of Singapore), LLM (Harvard);
Associate Professor, Faculty of Law, National University of Singapore.

Prem Raj **PRABAKARAN***
BEng (Mechanical) (Hons) (National University of Singapore),
LLB (Hons) (National University of Singapore), BCL (Oxon);
District Judge, State Courts of Singapore.

Introduction

6.1 In the year under review, the High Court deliberated on a diverse range of issues spanning international surrogacy, loss of chance and organisational duties of care in medical negligence, and reviewed the sentencing framework for medical professional misconduct.[1]

International commercial surrogacy

6.2 The legal and policy status of international surrogacy arose for consideration in the case of *UKM v Attorney-General*.[2] A Singapore gay man ("the appellant") procured the reproductive services of a surrogate ("M") in the state of Pennsylvania, USA, and a male child was borne by the surrogate with an embryo derived from his gametes and those of an anonymous oocyte donor. The appellant was stated under Pennsylvania law to be his father, and M, his mother. M agreed under a gestational surrogacy agreement ("GSA") to relinquish her parental rights over the child and not oppose any application to obtain permanent residency or citizenship status for the child in Singapore. When the appellant and his partner brought the child back to Singapore, his application for Singapore citizenship was rejected. He then brought an application to adopt his biological son, born out of wedlock, under s 3 of the Adoption of Children Act[3] with M's consent. This was principally motivated by a desire to strengthen his application, on the Ministry of Social and

* The views expressed in this article are those of the authors alone. They do not represent the views of the State Courts of Singapore.

1 There was one other related High Court decision that interpreted the scope of ss 13(*a*) and 17(1)(*e*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) on the unauthorised practice of medicine: see *Neo Ah Luan v Public Prosecutor* [2018] 5 SLR 1153. This case is reviewed at paras 13.93–13.101.

2 [2019] 3 SLR 874.

3 Cap 4, 2012 Rev Ed.

Family Development's ("MSF") advice, for his son's Singapore citizenship or permanent residency.

6.3 The District Court rejected the appellant's application under s 3 of the Adoption of Children Act on the grounds that the welfare of the child did not require it (he would still be well cared for and educated in a supportive environment), and an adoption order would subvert the public policies against surrogacy and granting unmarried persons access to assisted reproductive treatments ("ART").[4] The court also declined to sanction payments made pursuant to the GSA under s 11 of the Adoption of Children Act as it would amount to sanctioning commercial surrogacy and the commodification of the child.[5]

6.4 A three-member panel of the High Court allowed the appeal. The court considered that an adoption order would ultimately be for the welfare of the child because it would render the appellant a parent of his otherwise illegitimate son for the purposes of Art 124(1) of the Constitution of the Republic of Singapore[6] ("the Constitution") and therefore render the child eligible for citizenship by registration. Becoming a citizen would stabilise the child's long-term care arrangements and provide a sense of security vital to his well-being and development. However, the court has a discretion under s 3 of the Adoption of Children Act to make the order, and this is power is subject to any public policy relevant to the institution of adoption. The Adoption of Children Act is "an instrument for the establishment of new families and parental relations", and any attempt to undermine the institutions of family and parenthood should be resisted.[7] After considering a number of potential countervailing public policies in relation to surrogacy, parenthood within marriage, planned parenthood by singles through ART or surrogacy, and the formation of same-sex family units, only the last withstood forensic scrutiny on the criteria of authority, clarity and relevance. The court found that such a public policy specifically against the formation of same-sex family units was well founded based on Parliamentary statements by the executive and statutory provisions in the Penal Code[8] and the Women's Charter,[9] although nothing in the Adoption of Children Act itself supported such as policy. Making an adoption order in this case would violate such a policy.

4 *Re UKM* [2018] SGFC 20 at [33]–[34].
5 *Re UKM* [2018] SGFC 20 at [39].
6 1999 Reprint.
7 *UKM v Attorney-General* [2019] 3 SLR 874 at [97].
8 Cap 224, 2008 Rev Ed.
9 Cap 353, 2009 Rev Ed.

6.5 Nevertheless, in balancing the competing considerations relating to the welfare of the child and the countervailing public policy against same-sex family units, the court was not persuaded that the appellant deliberately sought to violate any law, nor this particular public policy, with culpable intent. The "statutory imperative to promote the welfare of the Child … is not only intrinsically weighty, … but is also supported by the evidence".[10] The court therefore made the adoption order sought, and also sanctioned payments made to M under the GSA on the ground that they were made with a sincere intent to benefit and promote the welfare of the child in question, and there was no demonstrable public policy against surrogacy.[11]

6.6 The last foregoing finding is the most pertinent to this chapter. The court noted that surrogacy is only addressed legally in Singapore via the prohibitions on assisted reproductive service licensees from carrying out surrogacy arrangements, irrespective of whether they are altruistic or commercial, traditional or gestational.[12] This regulatory stance is reinforced by the provisions of the Status of Children (Assisted Reproduction Technology) Act[13] ("SCARTA"), which envisages only the gestational mother carrying the child in her own right as parent. The SCARTA also does not offer any means of transferring parental rights to a commissioning couple in a surrogacy arrangement. However, the court was not prepared to find that there was a clear public policy against surrogacy locally or abroad for a number of reasons. First, the use of surrogacy services here or abroad was not criminalised. Second, there was no authoritative statement from the Executive concerning a settled policy position on surrogacy – gestational, commercial or otherwise. In fact, the executive had clearly indicated that it had not yet decided on a position because of the sensitivity and delicacy of the issue, especially in relation to international surrogacy.[14]

6.7 Further indication of this unsettled position was the revelation by the guardian in this case that between 2008 and 2018, there were 14 cases of adoption overseen by MSF that involved the use of surrogacy. Ten of these cases were supported, while the remaining were pending. All involved married couples, and the available evidence indicated that there were payments involved although the MSF did not require the production of the surrogacy agreements. The odds are that all these cases involved some form of commercial surrogacy overseas,

10 *UKM v Attorney-General* [2019] 3 SLR 874 at [248].
11 *UKM v Attorney-General* [2019] 3 SLR 874 at [240].
12 See Ministry of Health, "Licensing Terms and Conditions on Assisted Reproduction Services" (26 April 2011) at para 5.48(b), issued under s 6(5) of Private Hospitals and Medical Clinics Act (Cap 248, 1999 Rev Ed).
13 Cap 317A, 2015 Rev Ed.
14 *UKM v Attorney-General* [2019] 3 SLR 874 at [174]–[175].

and the government had nonetheless been willing to accommodate such international surrogacy arrangements notwithstanding its local prohibition on ART services facilitating surrogacy. The court therefore concluded that there was no definitive evidence of a concluded policy on surrogacy, whether locally or internationally – the prohibitions in the Licensing Terms and Conditions for Assisted Reproductive Services[15] could merely indicate an interim position locally while allowing adoptions based on international surrogacy on a case-by-case basis. This specific policy consideration therefore did not feature in the exercise of discretion under s 3 on whether to make an adoption order in this case.

6.8 The decision in *UKM v Attorney-General* demonstrates the inadequacy of regulating the use of reproductive technologies solely via service provision restrictions in a world where medical tourism opens up new options to patients who have the means. Leaving matters as they stand in relation to ART-facilitated surrogacy arrangements opens up disparities that will eventually be called into question – such as the *de facto* accommodation of commercial surrogacy abroad for Singaporean married couples, while prohibiting access to other local couples without such financial means.[16] Apart from surrogacy, another disparity emerges in relation to the prohibition against unmarried or same-sex couples from accessing ART services, and the public policy against the formation of same-sex family units. A lesbian couple who travels overseas for ART services would not have faced the same barriers as the appellant and his partner to setting up a same-sex family unit so long as one of them bears the child. The gestational mother in a lesbian relationship (if domiciled in Singapore) would be considered the mother of the child born in Singapore as a result of a fertilisation procedure performed overseas under s 6 of the SCARTA. Albeit illegitimate, the lesbian mother may nevertheless apply to register her child as a citizen without the need for an adoption order under Art 124(1) read with para 15(1) of the Third Schedule to the Constitution. This provides that for the purposes of Pt X of the Constitution, references to a person's father or parent shall be construed as references to his mother if he is illegitimate.

6.9 These current disparities in terms of the legal or policy status of various types of surrogacy arrangements, and the status of the children born of ART services elsewhere for the purposes of citizenship

15 26 April 2011.

16 The court found the current *ad hoc* practice of accommodating international surrogacy inconsistent with finding a public policy against surrogacy locally as it would suggest a "wholly unpalatable" double standard favouring those with the means to access surrogacy overseas: *UKM v Attorney-General* [2019] 3 SLR 874 at [177].

highlights the need for a more coherently articulated ethical and legal position in Singapore in relation to the provision of ART to facilitate surrogacy arrangements elsewhere. The regulatory licensing route does not mandate the regulator to offer specific justifications or rationales for the prohibition (apart from the broad statutory basis for the regulatory power),[17] nor involve Parliamentary oversight and debate where these rationales can be evaluated. Interested married and unmarried persons seeking access to surrogacy services are left to wonder under what circumstances returning couples and their surrogate borne children will be conferred citizenship in Singapore, and whether foreign legal instruments conferring parenthood or adoption status will be recognised. As Cohen points out, it is difficult to work out the implications on the granting of citizenship or permanent residency status without understanding the precise rationale for the prohibition of surrogacy ART service licensees.[18] The court discussed various ethical and social concerns with surrogacy, encompassing concerns about the resulting child's welfare, corruption of social values such as human dignity and autonomy, and the exploitation of surrogates.[19] Any of these could support both extraterritorial criminalisation of citizens' access to international surrogacy services and a denial of citizenship to returning children. However, some justifications such as those based on consequentialist concerns over the corruption of domestic social values may countenance local prohibition because of its greater corrupting effect, but not extraterritoriality.[20]

6.10 The status quo seems to suggest that notwithstanding prohibitions on access to local ART services, married couples with the means to do so may ultimately lawfully circumvent local regulatory proscriptions and achieve the same end result they desire via commercial surrogacy arrangements in jurisdictions that permit the practice. However, for same sex male couples seeking commercial surrogacy overseas, they have been put on notice by the decision in *UKM v Attorney-General* that their attempts to circumvent the ART restrictions via adoption may no longer be looked on as favourably given the court's recognition of a public policy against the formation of same-sex family units. Lesbian couples, however, do not appear to face

17 See s 6(2) of Private Hospitals and Medical Clinics Act (Cap 248, 1999 Rev Ed) – the power is exercisable if the Director of Medical Services "thinks fit to impose" terms and conditions.

18 I Glenn Cohen, "Medical Tourism and the Creation of Life: A Study of Fertility Tourism" in *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) ch 9 at pp 391 and 418.

19 *UKM v Attorney-General* [2019] 3 SLR 874 at [180]–[184].

20 I Glenn Cohen, "Medical Tourism and the Creation of Life: A Study of Fertility Tourism" in *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) ch 9 at p 396.

similar difficulties. The status quo is ripe for policy and legislative review.

Medical negligence

6.11 There were two decisions on medical negligence in the year under review. Both involved allegations of professional negligence resulting in a delay of cancer diagnosis and treatment. In *Carol Ann Armstrong v Quest Laboratories Pte Ltd*[21] ("*Armstrong*") the widow of a melanoma patient sued the pathologist and the receiving laboratory for negligence in diagnosing her deceased husband's skin biopsy as benign when it was in fact malignant. The action was accordingly a loss of dependency claim. This deprived the deceased patient of an opportunity for earlier surgical removal of the lymph nodes that would have arrested the spread of the cancer and prevented his death. The plaintiff's case was therefore that the pathologist's negligence had caused her husband's death.

6.12 Conflicting expert dermatologist testimony indicated that different pathologists might have diagnosed the patient's specimen as benign or malignant depending on the extent of the histological features of the biopsy specimen. The court, however, found the pathologist negligent on the basis that, in spite of these differences of opinion, the specimen slide in question was clearly not normal healthy tissue, although insufficiently deep to reveal all the histological features of the ulceration. It therefore called for further examination. Had he then examined the other deeper specimens of the ulcerated tissue on hand, he would have made a diagnosis of malignant melanoma.

6.13 This finding led to a second clash of expert oncologist opinion over the appropriate cancer staging at the time the negligent diagnosis was made, which implicated the likely chances of survival had there been timely clinical intervention. The plaintiff's expert considered that at the time of negligent diagnosis, the patient's cancer was at stage "T2b", which indicated a 68% chance of ten-year remission. The defendant's expert considered the appropriate staging to be "T2b, N2a", with an additional likelihood of a spread of dormant cancer cells elsewhere through the blood, with a dimmer prospect of a less than 50% chance of remission. The court accepted the former expert opinion, apparently on the basis that the it was less probable for the cancer to be dormant given that there was evidence that it was spreading through the lymphatic system. On this basis, the court inferred that a fair estimate was that the patient would have probably lived for eight years after proper diagnosis,

21 [2018] SGHC 66.

twice as long as he in fact did. The claim for loss of dependency was therefore assessed on this footing.

6.14 Interspersed in this process of reasoning was an *obiter dictum* that, if relevant, the court would have preferred the minority position in the House of Lords decision in *Gregg v Scott*[22] that loss of chance should itself be actionable damage in the medical negligence context. There was however no reasoning offered for this preference. On the facts of *Armstrong*,[23] there was arguably no need to resort to loss of chance framing of actionable damage. The negligent diagnosis resulted in the delay of treatment. This delay allowed the melanoma to spread to five sentinel lymph nodes, which, according to one expert, was unprecedented in his experience.[24] Thus, timely diagnosis and intervention would have prevented the spread of the cancer, which is physical damage. On this basis, a consequential loss of life expectancy (and corresponding loss of dependency) could be claimed without the need to recognise pure loss of chance as actionable damage in itself, given that the court ultimately preferred the plaintiff's expert's opinion that on balance, "Dr Tan's negligence … probably caused [the patient] to die years earlier than he would have".[25]

6.15 There are also various policy concerns over a move to loss of chance as actionable damage in the medical context, which were not explored. In particular, as much of medicine is increasingly evidence based and probabilistic, a reconsideration of the incongruity of all-or-nothing damage *versus* loss of chance would have to be resolved. At present, proof of causation of damage on a balance of probabilities represents the current balance between the interests of plaintiffs and defendants.[26] Circumvention of such existing control mechanisms by recognising loss of chance would have far reaching implications.[27] For Baroness Hale in *Gregg v Scott*, admitting loss of chance as actionable damage itself would entail a fundamental shift to recharacterise all cases involving probabilities of cure or remission as loss of chance, resulting in far fewer cases of successful claimants receiving full recovery. After all, why should only plaintiffs be entitled to recharacterise actionable damage?[28] The liability implications for the healthcare system could also be disabling. Such a drastic step was therefore better left for

22 [2005] 1 AC 176.
23 See para 6.11 above.
24 *Carol Ann Armstrong v Quest Laboratories Pte Ltd* [2018] SGHC 66 at [14].
25 *Carol Ann Armstrong v Quest Laboratories Pte Ltd* [2018] SGHC 66 at [19]. See *Gregg v Scott* [2005] 2 AC 176 at [207], *per* Baroness Hale.
26 See also *Tabet v Gett* [2010] 265 ALR 227 at [58]–[59], *per* Gummow ACJ.
27 This was recognised by the Court of Appeal in *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [123]–[124] in rejecting a claim for loss of autonomy.
28 *Gregg v Scott* [2005] 2 AC 176 at [223]–[225].

parliamentary consideration and resolution.[29] An appeal in this case is pending and it will be interesting to see if the Court of Appeal will deliberate and resolve this issue as a matter of Singapore law.

6.16 In *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd*[30] ("*Noor Azlin*") the plaintiff was diagnosed with Stage I lung cancer after a biopsy on 16 February 2012. Pursuant to standard treatment involving the removal of the relevant lobe of the lung and adjuvant chemotherapy, this cancer was reclassified as Stage IIA non-small cell lung cancer. She alleged that there were negligent delays in detecting her cancer by the series of doctors – a respiratory specialist and two accident and emergency ("A&E") physicians – that she saw at Changi General Hospital ("CGH") between 2007 and 2011, before the advice to undergo a biopsy in February 2012. In addition, she alleged that CGH failed to provide a reasonably safe system of care in the way it handled follow-up for abnormal radiological findings within its X-ray reporting system – in which an X-ray is sent for analysis and interpretation by a radiologist, who then prepares a report of the results and sends it to the attending physician for follow-up action. As a result, she claimed that her cancer was allowed to go undetected and untreated. This allowed the cancer to deteriorate, aggravating and prolonging her suffering, and resulting in her losing a better medical outcome.

6.17 The plaintiff tried to frame the claim as a failure to reasonably advise her of a "not insignificant" risk of cancer, thus invoking the *Hii Chi Kok* reasonable patient standard instead of the *Bolam-Bolitho* standard of a responsible body of medical opinion applicable to medical diagnosis and treatment. The court rejected this attempt. The non-disclosure of the risk of cancer was rooted in a diagnostic judgment that the plaintiff's presenting complaints were not likely caused by cancer, and therefore advised and treated her accordingly. The reasonableness of these decisions therefore fell to be decided by the *Bolam-Bolitho* test.

6.18 The plaintiff alleged that her respiratory specialist, Dr Imran, was negligent in his diagnosis and failing to properly follow her up in order to confirm that diagnosis. The plaintiff was referred to Dr Imran after an opacity in her right lung was first noticed on a chest X-ray done by the CGH A&E Department in October 2007. Dr Imran ordered a second chest X-ray in November 2007, and concluded that there was no obvious nodule in her right lung and that the opacity appeared to be resolving. It was therefore likely to be an infection or inflammation. The court held that Dr Imran's analysis of the plaintiff's chest X-rays and

29 *Gregg v Scott* [2005] 2 AC 176 at [90]. See also *Tabet v Gett* [2010] 265 ALR 227 at [102], *per* Crennan J.

30 [2019] 3 SLR 1063.

diagnosis was reasonable, being properly based on the lack of respiratory symptoms, difficulty in observing the opacity, and other features of her medical history. However, the court found him negligent in not arranging for a follow-up consultation to ensure that the opacity on the X-ray had indeed resolved; in fact, no expert witness was called to support this failure to arrange for follow-up.

6.19 Next, the court's reasoning in respect of the claims against the A&E physicians contains a useful exposition of the general standards expected of doctors in the emergency medicine context. As emergency medicine fulfils a specific role in the healthcare system, providing frontline healthcare in situations of acute medical scenarios, the court articulated five relevant considerations in evaluating the conduct of emergency medicine physicians:[31]

> (a) It is reasonable for A&E physicians to adopt a "targeted approach" to treatment, focusing on diagnosing and treating the immediate acute condition rather than providing a general screening of the patient.
>
> (b) Nonetheless, A&E physicians are still expected to "make reasonable enquiries, take a history from the patient, conduct basic investigations and take reasonable care in reaching their diagnosis".
>
> (c) A&E physicians' responsibilities should be assessed in the context of the emergency conditions under which they operate, and the team- and shift-based system of work.
>
> (d) As there are a large number of junior doctors in the A&E department with less experience, it is necessary for them to "to discuss their cases and seek approval of their intended treatment with a senior doctor on duty".
>
> (e) When A&E doctors reasonably suspect that the patient has an underlying health issue that they are unable to fully investigate or diagnose, they should send the patient for follow-up or advise her to do so.

6.20 Thus, in respect of the third defendant Dr Yap who saw the plaintiff on 29 April 2010, the court found that he was reasonable in his diagnosis that the plaintiff's complaints were not related to the nodule visible on her chest X-ray given all the relevant circumstances, in particular the nodule's apparent stability as compared to the earlier X-rays done. It was also reasonable for him to send the X-ray for reporting by a radiologist, and leave it to be followed-up pursuant to

31 *Noor Azlin v Changi General Hospital* [2019] 3 SLR 1063 at [85].

CGH's X-ray reporting system. Even if he was mistaken in his diagnosis, he had discharged his duty as a junior doctor at the time by seeking confirmation from the senior emergency physician on duty.[32] Likewise, in respect of the plaintiff's consultation with the fourth defendant, Dr Soh, about a year later on 31 July 2011, the court found that he was not negligent in missing the presence of the nodule in the mid-zone of the right lung on her chest X-ray as he was properly focusing on the plaintiff's presenting complaint relating to pain in the *left* lower rib cage. This was consistent with his duties as an emergency physician and it was also reasonable for him to rely on the hospital's X-ray reporting system to follow up on any incidental findings. Finally, like Dr Yap, he also confirmed his diagnosis and treatment plan with the senior doctor on duty.

6.21 Notwithstanding the finding of professional negligence on Dr Imran's part, the plaintiff's claim against him failed because she failed to show that this lack of follow-up caused her any loss. After a careful review of the clinical expert evidence, the court was not persuaded that the plaintiff's nodule was in fact cancerous in the period between 2007 and July 2011. This was largely because of the relatively stable and slow growth of the nodule as it appeared on X-ray images. Therefore, she was treated at the earliest possible time when the biopsy was first done in February 2012. There was accordingly no untreated lung cancer, unnecessary suffering or loss of a better medical outcome.

6.22 Finally, the claim against the hospital focused on the allegation that there was a failure to provide a safe system of care in relation to the provision of radiological facilities and services. Routine reporting of X-rays was not implemented in the hospital until 2010, but there was no evidence adduced to demonstrate that this was substandard or otherwise unreasonable in the healthcare industry. The reporting system implemented in 2010 was considered reasonable in terms of its features and processes. The court was also prepared to infer that the X-ray reporting and subsequent follow-up was in fact done on the plaintiff's April 2010 and July 2011 X-rays even though there was no direct evidence of this. Both these X-ray reports were prepared a day after her attendance at CGH's A&E and both recommended follow-up – at the least to monitor stability of the nodule.[33] However, on a final note, the court did find that the system was negligently defective in not having a process in place to inform the plaintiff of the results of X-ray reports, even if internal decisions were presumably taken that follow-up was, in spite of the reports' recommendations, not necessary. This prevented the plaintiff from being "informed of her condition and tak[ing] the

32 Citing *Wilsher v Essex Area Health Authority* [1987] 1 QB 730 at 774.
33 *Noor Azlin v Changi General Hospital* [2019] 3 SLR 1063 at [93] and [105].

decision as to whether to return to the Hospital for consultation, seek a second opinion elsewhere or to do nothing".[34] Nevertheless, this breach was, likewise, of no consequence as the court had ultimately found no causation of damage or loss as the plaintiff's nodule was on the balance benign between 2007 and 2011.

6.23 The decision in *Noor Azlin* is notable in two respects. The articulation of the specific duties and expectations of emergency medicine physicians will be welcome clarification for the specialty. In particular, incidental findings in the course of treating acute medical conditions need not be fully pursued and can be reasonably be dealt with by way of referral. However, this reasoning should not be carried too far into other medical specialties where the same contextual constraints of time and expertise are not at play. In such situations, there may rightly be greater expectations of doctors or specialists in investigating and advising the patient of such incidental findings.

6.24 Secondly, the case probably reflects the first time that a hospital's institutional duty to provide a safe system of care was evaluated under the tort of negligence here and found wanting. It is not clear from the reasoning whether a *Bolam-Bolitho* standard of care was also applicable to this type of negligence, which moves away from identifying carelessness traceable to a particular individual, and instead focuses on the organisational system put in place to deliver team-based care.[35] The court did express its agreement with one of the expert witnesses who considered the CGH system of X-ray reporting to be reasonable, but there was no discussion of expert opinion when it found the system unreasonable in not having a patient notification procedure in place.[36] In this type of instance, it is not apparent that all the considerations that led the Court of Appeal in *Hii Chii Kok v Ooi Peng Jin London Lucien*[37] to preserve the *Bolam-Bolitho* profession-centred standard in respect of diagnosis and treatment are applicable. Decisions on the design and implementation of systems co-ordinating care in a healthcare institution are not necessarily decisions made in the exercise of professional judgment nor even by a medical professional, and properly take into account other factors like staffing levels and other resource constraints. The argument has therefore been made that, akin to the provision of medical advice, it must be for the court to determine

34 *Noor Azlin v Changi General Hospital* [2019] 3 SLR 1063 at [121].
35 See *Robertson v Nottingham Health Authority* [1997] 8 Med LR 1 at 13.
36 *Noor Azlin v Changi General Hospital* [2019] 3 SLR 1063 at [117] and [119]–[120].
37 [2017] 2 SLR 492 at [100]–[102].

if an institution has been in breach of its duty to provide a safe system of care, and *Bolam-Bolitho* is only "tangentially relevant".[38]

6.25 Finally, the result of the organisational failure in this instance was arguably a failure to advise on how the plaintiff ought to manage her incidental finding. A distinct causal inquiry should logically follow into what the plaintiff would likely have done if she had been so informed, in order determine if the delay in diagnosis and treatment could have been avoided or mitigated. Given the court's finding that she did not have cancer at the relevant periods to begin with, this was moot. The plaintiff's appeal to the Court of Appeal was allowed on 26 February 2019. This decision will be reviewed in the next Ann Rev.

Professional misconduct

6.26 *Wong Meng Hang v Singapore Medical Council*[39] ("*Wong Meng Hang*") involved two registered medical practitioners, who practised at an aesthetic clinic: Dr Wong Meng Hang ("Dr Wong") and Dr Zhu Xiu Chun ("Dr Zhu").

6.27 On 30 December 2009, Dr Wong was scheduled to perform a liposuction procedure on his patient. Shortly before the procedure, he asked Dr Zhu to assist him and to monitor the patient. No anaesthetist was present. Instead, Dr Wong managed the sedation of the patient himself. To this end, he used an anaesthetic drug[40] – a potent sedative that can rapidly depress the airway, impede respiration, and cause the recipient's blood pressure to fall ("the Drug"). The instruction sheet provided by the Drug manufacturers stated that the Drug should only be administered by physicians trained in anaesthesia or in the management of patients under intensive care. Both doctors were not qualified or trained as anaesthetists or intensivists. They therefore lacked the necessary qualification and expertise to administer the Drug safely or in accordance with the manufacturer's instruction sheet. Despite this, they proceeded to administer the Drug to the patient at the start of the procedure. To compound matters, they administered the Drug using a complex technique of continuous intravenous infusion by titration. This technique called for an even greater need of relevant expertise because it prolonged the effects of the Drug. Both doctors accepted that the use of this sedation technique was complex, and that they did not have the training or expertise to employ it.

38 Andrew Grubb & Michael Jones, "Institutional Liability" in *Principles of Medical Law* (Ian Kennedy & Andrew Grubb eds) (Oxford University Press, 2nd Ed, 2004) ch 8 at para 8.65.

39 [2019] 3 SLR 526.

40 This was the drug Propofol.

6.28 The patient's sedation was carried out in an "appalling"[41] manner because of the doctors' incompetence in using the Drug. As and when the patient showed any signs of movement, discomfort, or response to pain stimulation, Dr Wong would instruct Dr Zhu to increase the dosage of the Drug. The dosage administered was excessive, and it caused the patient to enter a state of deep sedation to the point of general anaesthesia (*viz*, a state of unconsciousness from which a patient cannot be aroused, even by painful stimulation).[42] Neither doctor was able to recognise the signs of this happening, given their lack of training.

6.29 The procedure itself was also performed incompetently, with Dr Wong inadvertently causing multiple puncture wounds to the patient's intestines. These went unnoticed because the patient was in a state of general anaesthesia[43] and did not show any signs of pain.

6.30 After the procedure, Dr Zhu left the procedure room with Dr Wong's consent. Dr Wong proceeded to close the patient's surgical wounds and then left the room to use the toilet. While he was in the toilet, the patient was not in the care of any doctor or nurse for at least five minutes. Guidelines prevailing at this time[44] stated that a patient under sedation must have his circulation and respiration monitored closely. In the period the patient was left unattended, he developed an airway obstruction and suffered asphyxia leading to cardiac arrest. He was then discovered to have collapsed, and an ambulance was called. Dr Wong accompanied the patient to the hospital. On arrival at the A&E department of the hospital, the patient was found to be without a pulse. Dr Wong told the A&E doctors that the patient had only been given pain medication and local anaesthesia but no sedation. Dr Wong's false statement showed he knew that it had been improper for him to have administered the Drug. The patient died subsequently.

6.31 The events leading to the inquiries before the disciplinary tribunal appear below:

Date	Event(s)	Remarks
4 January 2012	Coroner recorded the patient's death as a medical misadventure, and that he had "died of the effects of asphyxia due to airway	-

41 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [10].

42 *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 at [7].

43 See para 6.28 above.

44 Academy of Medicine, *Guidelines on Safe Sedation Practice for Investigation and Intervention Procedures* (December 2002): *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [12].

	obstruction secondary to intravenous Propofol [*ie*, the Drug] administered"	
13 February 2012	Coroner's findings referred to the Singapore Medical Council ("SMC")	-
13 November 2013	Notices of complaint sent to both doctors	-
11 May 2015	Doctors notified of decision to convene a disciplinary tribunal ("DT") for inquiry	-
9 February 2017	Doctors served formal notices of inquiry	Lapse of nearly five years since matter was referred to the SMC
11 August 2017	Inquiries before the DT	-
22 September 2017		

6.32 Before the DT, each doctor pleaded guilty to a charge of professional misconduct under s 53(1)(*d*) of the Medical Registration Act[45] ("MRA").

6.33 In *Low Cze Hong v Singapore Medical Council*,[46] the Court of Three Judges had accepted that there were at least two limbs of professional misconduct:

	Professional misconduct
Limb 1	There is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.
Limb 2	There has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

6.34 The charges against both doctors in *Wong Meng Hang*[47] were framed under Limb 2.[48] The DT ordered that:

45 Cap 174, 2014 Rev Ed.
46 [2008] 3 SLR(R) 612 at [37].
47 See para 6.26 above.
48 See para 6.32 above.

(a) Dr Wong be suspended from practice for 18 months; and

(b) Dr Zhu be suspended from practice for six months.

6.35 Dr Wong appealed against his sentence. The SMC appealed against both doctors' sentences.

6.36 The decision of the court in *Wong Meng Hang* is significant as it set out:

(a) the main objectives of sentencing in disciplinary proceedings;

(b) a four-step sentencing approach to sentencing a doctor whose misconduct caused harm to a patient; and

(c) the threshold that must be met for the making of an order striking off an errant doctor from the register of medical professionals.

Main objectives of sentencing in disciplinary proceedings

6.37 The court noted that:[49]

> … broader public interest considerations are paramount [in disciplinary proceedings] and will commonly be at the forefront when determining the appropriate sentence that should be imposed in each case.

These considerations include the:

(a) need to uphold the standing and reputation of the medical profession;[50]

(b) need to prevent an erosion of public confidence in the trustworthiness and competence of members of the medical profession – "in whom the public and, in particular, patients repose utmost trust and reliance in matters relating to personal health, including matters of life and death";[51]

(c) need for general deterrence, "to create awareness in the public and more particularly among potential offenders that punishment will be certain and unrelenting for certain offences and offenders";[52]

49 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [23].
50 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [23].
51 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [23].
52 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [25].

(d) need for specific deterrence (especially in cases involving recalcitrant offenders), to discourage the particular offender from committing future offences;[53]

(e) need to punish the errant doctor for his professional misconduct;[54] and

(f) need to protect the public who are dependent on doctors for medical case.[55]

6.38 The court added that the primacy of these public interest considerations[56] in the sentencing inquiry in disciplinary proceedings meant that other considerations that might ordinarily be relevant to sentencing – such as the doctor's personal mitigating circumstances and the principle of fairness to the offender – did not carry much weight. Indeed, the doctor's personal mitigating circumstances and the principle of fairness to the offender might even have to give way entirely to ensure that the countervailing public interest considerations are sufficiently met.[57]

Sentencing a doctor whose misconduct caused harm to patient

6.39 The court then set out a four-step approach to sentencing a doctor whose misconduct caused harm to a patient.

Step 1: Identifying level of harm and culpability to evaluate seriousness of offence

6.40 The first step requires an evaluation of the seriousness of the doctor's offence by having regard to two principal parameters: harm and culpability.[58]

Harm (actual and potential)

6.41 Harm refers to the type and gravity of the actual harm or injury caused to the patient and to society by the commission of the offence. Such harm includes:[59]

53 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [25].
54 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [25].
55 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [75(a)].
56 See para 6.37 above.
57 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [24] and [44].
58 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [30].
59 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [30(a)].

(a) bodily injury;

(b) emotional or psychological distress;

(c) serious economic harm;

(d) increased predisposition to certain illnesses;

(e) loss of chance of recuperation or survival; and

(f) death.

6.42 The weight to be given to the actual harm occasioned will be greater the more direct the connection between the specific type of harm occasioned and the misconduct.[60]

6.43 Apart from actual harm, regard may also be had to the potential harm that could have materialised. But potential harm should only be taken into account if there was a sufficient likelihood of the harm arising. It would not be appropriate to consider every remote possibility of harm for the purposes of sentencing.[61]

Culpability

6.44 Culpability refers to the degree of blameworthiness disclosed by the doctor's misconduct. Culpability may be assessed by reference to:[62]

(a) the extent and manner of the doctor's involvement in causing the harm;

(b) the extent to which the doctor's (mis)conduct departed from standards reasonably expected of a medical practitioner;

(c) the doctor's state of mind when committing the offence; and

(d) all the circumstances surrounding the commission of the offence.

Step 2: Identifying applicable indicative sentencing range

6.45 Taken together, the parameters of harm and culpability can be structured in a harm-culpability matrix ("the Matrix") – according to which (a) the seriousness of the offence can be assessed; and (b) a starting point for sentencing can be reached.[63] Having regard to the range of punishments that may be imposed by the DT under s 53(2) of

60 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [30(a)].
61 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [30(a)].
62 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [30(b)].
63 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [31].

the MRA (and, in particular, the range of suspension terms that may be ordered), the court set out the following Matrix:[64]

Harm / Culpability	Slight	Moderate	Severe
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

6.46 Using this Matrix, the applicable indicative sentencing range based on the level of harm and culpability identified in Step 1 can be identified.[65] The court pointed out that the Matrix is only applicable where deficiencies in a doctor's clinical care caused harm to a patient. The Matrix does not apply to other forms of medical misconduct, such as:[66]

(a) overcharging;

(b) falsification of medical documents;

(c) inappropriate relations with a patient; and

(d) conduct which lies outside the ambit of a doctor's professional responsibilities to his patient, but which leads to a conviction for a criminal offence implying a defect of character that renders the doctor unsuitable for registration as a medical practitioner.

6.47 The court stressed that this Matrix was only a guide to help sentencing tribunals weigh the relevant considerations in a systematic manner. The Matrix did not displace the duty of a sentencing tribunal to impose the appropriate sentence and depart from the Matrix when appropriate.[67]

64 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [33].
65 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [33].
66 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [36].
67 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [33].

6.48 That said, the court observed that the indicative sentencing ranges set out in the Matrix "are likely to be heavier than sentences that have tended to be imposed in past cases".[68]

Step 3: Identifying appropriate starting point within indicative sentencing range

6.49 The third step involves identifying the appropriate starting point within the applicable sentencing range identified in Step 2. To do this, regard must be had to:[69]

(a) the level of harm caused by the doctor's misconduct;

(b) the errant doctor's level of culpability; and

(c) how the instant case compares to other cases featuring broadly similar circumstances.

Step 4: Adjusting starting point to take into account offender-specific factors

6.50 The fourth step is to consider offender-specific mitigating and aggravating factors that do not relate directly to the offence. Mitigating factors include:[70]

(a) a timely plea of guilt in circumstances that indicate remorse;

(b) having a long unblemished track record and good professional standing; and

(c) an undue delay in the prosecution of the proceedings.

6.51 Aggravating factors include prior instances of professional misconduct, especially where the antecedents bear similarities to the conduct underlying the charge(s) at hand.[71]

Threshold for striking off register of medical professionals

6.52 The court then examined when an errant doctor should be struck off from the register of medical professionals. Drawing from case

68 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [38]. These included the cases of *In the Matter of Dr Amaldass Narayana Dass* [2014] SMCDC 2 and *In the Matter of Dr Fong Wai Yin* [2016] SMCDT 7: *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [39]–[40].

69 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [42].

70 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [43].

71 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [43].

law in Singapore, Australia, Canada, and England, the court held that "the ultimate question is whether the misconduct was so serious that it renders the doctor unfit to remain as a member of the medical profession".[72] According to the court, striking off should be considered where:[73]

> (a) the misconduct in question involves a flagrant abuse of the privileges accompanying registration as a doctor;
>
> (b) the doctor's misconduct has caused grave harm;
>
> (c) the doctor's culpability was especially high, such as where he has acted deliberately and improperly over an extended period of time and in callous disregard of his professional duties and the health of his patient or the general public;
>
> (d) the doctor's misconduct evinces a serious defect of character;
>
> (e) the facts of the case disclose dishonesty on the part of the doctor; and
>
> (f) any of the above factors existed, and the doctor had shown a persistent lack of insight into the seriousness and consequences of his misconduct.

6.53 As a general rule, misconduct involving dishonesty "should almost invariably warrant an order for striking off where the dishonesty reveals a character defect rendering the errant doctor unsuitable for the profession".[74] This would include cases where the dishonesty:[75]

> (a) is integral to the commission of a criminal offence, of which the doctor has been convicted; or
>
> (b) violates the relationship of trust and confidence between doctor and patient.

6.54 In these two circumstances,[76] exceptional circumstances would have to be shown to avoid an order for striking off. In other cases of dishonesty, all the circumstances of the case should be examined to determine whether striking off is warranted – to this end, a list of non-exhaustive factors that should be considered include:[77]

---

72 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [66].
73 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [67].
74 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [72].
75 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [72].
76 See para 6.53 above.
77 *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 at [73].

(a) the real nature of the wrong and the interest that has been implicated;

(b) the extent and nature of the deception;

(c) the motivations and reasons behind the dishonesty and whether it indicates a fundamental lack of integrity or misjudgement;

(d) whether the errant doctor benefited from the dishonesty; and

(e) whether the dishonesty caused actual harm or had the potential to cause harm that the errant doctor ought to have or in fact recognised.

Striking off Dr Wong

6.55 The court held that an order striking off Dr Wong from the register of medical practitioners was warranted for the following reasons:[78]

(a) The most severe harm imaginable was caused: death.

(b) The doctors' actions were the sole and direct cause of the patient's death.

(c) Dr Wong's misconduct evinced a high degree of culpability:

(i) He made the decision to administer the Drug, although neither he nor Dr Zhu had the training or experience to do so – and therefore embarked on a procedure that he knew he was not qualified to undertake.

(ii) The doctors administered the Drug using a complex technique they were not qualified or trained in.

(iii) The procedure itself was not performed satisfactorily by Dr Wong.[79]

(iv) The patient was left unattended after the procedure, when his respiration should have been monitored continuously. The doctors' failure to render post-procedure treatment was directly causative of the

78 *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 at [82]–[91].

79 See para 6.29 above.

> patient's death. Dr Wong had also accepted that "medical attention could have been provided in time to prevent the patient from asphyxiating to death" if he had adequately monitored the patient after the procedure.
>
> (v) Despite the extreme danger the patient was in, Dr Wong preferred his own interest and lied to the A&E doctors to protect himself rather that attempt to equip the A&E doctors with all information to enable them to try and save the patient.

6.56 According to the court, "Dr Wong's misconduct was among the worst of its kind and [it] must be punished with a sanction of sufficient severity".[80] Using the Matrix,[81] the applicable indicative sentencing range was the maximum term of three years' suspension or an order of striking off.[82] That said, even the maximum term of suspension was not sufficient in this case:[83]

> … because of the utmost severity of the harm caused by Dr Wong and the very high degree of his culpability [which made his] misconduct … so serious that it clearly rendered him unfit to continue to practise as a doctor.

Given the compelling public interest in imposing the harshest punishment on Dr Wong, mitigating circumstances, such as Dr Wong's early plea of guilt and the SMC's inordinate delay in the proceedings,[84] ultimately carried no weight in the sentencing analysis.[85]

Increasing Dr Zhu's term of suspension

6.57 Dr Zhu's term of suspension was tripled to 18 months. Her misconduct had caused death, but her degree of culpability was assessed as "medium". Her actions were also less serious than Dr Wong because:[86]

> (a) unlike Dr Wong, who was in charge of the procedure, she had only been tasked to assist in the procedure and had acted under Dr Wong's direction;
>
> (b) she was in no way responsible for the multiple intestinal puncture wounds inflicted by Dr Wong on the patient;

80 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [92].
81 See para 6.45 above.
82 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [95].
83 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [98]–[106].
84 See para 6.31 above.
85 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [99].
86 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [108].

(c) she had left the procedure room with Dr Wong's permission, and did not know that Dr Wong would then leave the patient unattended; and

(d) she had not acted dishonestly.

As with Dr Wong,[87] Dr Zhu's personal mitigating circumstances were overridden by the public interest in upholding public confidence in the medical profession. The court noted that the sentence imposed on her "must also serve as a strong deterrent to other junior doctors faced with the wholly improper actions of their seniors".[88]

87 See para 6.56 above.

88 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 at [111].