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Understanding Health Law
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Introduction

Health law is based on two ethical principles that make the medical profession special. First, there is the humanitarian duty of skilled and knowledgeable members of society to respect the life and health of their patients. In short, a doctor must focus on the benefit of any proposed treatment to the patient, weighed against possible harm. Secondly, there is the duty to respect the autonomy of individual patients – their right to choose whether and what treatment to receive (to the extent that they have the requisite physical and intellectual capacity to do so). This principle of autonomy grounds both the doctrines of consent and of confidentiality of consultations and records.

The Hippocratic Oath states: "I will prescribe regime for the good of my patients according to my ability and judgment and never do harm to anyone"

The common law that we have inherited is founded on the protection of personal interests, the most fundamental of which is bodily integrity. Any invasion of bodily integrity is ordinarily classed as an assault, for which compensation is payable. Doctors however form a special class of persons, licensed not to kill, but to heal, with our consent.

A privilege and a monopoly

Once we understand that doctors form a special class of persons, we can see why the law regulates the status and privileges of doctors. The law gives doctors a monopoly[1], with any unauthorised person who practises medicine or holds himself out as a medical practitioner being liable to a fine not exceeding $100,000.00 or imprisonment for up to 12

[1] Medical Registration Act section 13: *Subject to section 55, no person shall practise as a medical practitioner or do any act as a medical practitioner unless he is registered under this Act and has a valid practising certificate; and a person who is not so qualified is referred to in this Act as an unauthorised person.*
Section 55 exempts ship's surgeons from this registration requirement.

months[2]. In Singapore's context an exception has had to be made for practitioners of traditional Malay, Chinese or Indian medicine, so long as they do not represent themselves to be medical practitioners.

Doctors therefore have an ethical and legal obligation to achieve and maintain acceptable standards of skill and knowledge. This applies both to general practitioners and to specialists, to whom a special accreditation process applies[3]. They are even expected to keep an eye on their brethren, to be their brother's keeper: if in the course of treating or attending to a fellow doctor they consider him unfit to practise because of his physical or mental condition then they are obliged to inform the Medical Council[4]. Failure to do so is a disciplinary offence. This is in addition to the oversight of the Health Committee, which as its name suggests oversees whether doctors are medically fit to practise.

Doctors are also given the right and responsibility of issuing certificates relating to medical status[5]. A doctor who permits someone who is not a registered medical practitioner to issue medical certificates will be guilty of infamous or improper conduct[6]. Often the certifying role of doctors is carried out at the instance of the patient and with his consent, as for example when a medical certificate is sought to excuse attendance at school or office. However, from society's perspective, doctors are also relied on to certify a person's status for the purpose of some restraint or imposition. One example is the role of medical officers (i.e. doctors employed by the Government) to certify fitness of convicted persons to undergo caning[7] . Another example is the role of a registered medical practitioner in sending a person under his care who he believes to be of unsound mind or to require psychiatric treatment to a medical officer at a mental hospital for treatment[8]. Thereafter, a person may be detained at the mental hospital for a period of

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[2] Medical Registration Act section 17
[3] Medical Registration Act section 22 and Part V
[4] Medical Registration Act section 56
[5] Medical Registration Act section 15
[6] *Re Lopez Joseph Francis* [1975-77] 1 SLR 445
[7] Criminal Procedure Code section 232
[8] Mental Disorders & Treatment Act section 34

72 hours on the certification of a medical officer, for a further month on the certification of another medical officer and finally for a further period of up to 12 months on the certification of two medical officers examining the patient separately[9]. The judgment of the medical officer that is required for such certification is not purely a medical one, but also includes an assessment of society's interest in being protected from the patient if he is potentially violent[10].

In relation to drug addicts however doctors are spared the ultimate decision-making. While a doctor examines the suspected drug addict, he simply gives the results of his examination to the Director of the Central Narcotics Bureau, who then decides on the appropriate action[11].

In making a report to a third party about the patient, a doctor must take reasonable care to ensure the accuracy of his report. A misdiagnosis for which there were no reasonable grounds and which causes the patient to lose some opportunity may lead to liability in defamation. Although the report will be protected by qualified privilege, this privilege will be lost if the doctor acted recklessly. An illustration of this principle may be found in the case of *Salaysay Joel v Medical Laboratory*[12] .

Both private hospitals and medical clinics have to be licensed under the Private Hospitals and Medical Clinics Act. However, practitioners and pharmacists are exempted from the

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[9] Mental Disorders & Treatment Act section 35

[10] Mental Disorders & Treatment Act section 35(4): *A person shall not be detained at a mental hospital for treatment unless – (a) he is suffering from a mental disorder which warrants the detention of that person in a mental hospital for treatment; and (b) it is necessary in the interests of that person's health or safety or for the protection of other persons that that person should be so detained.*

[11] Misuse of Drugs Act section 37

[12] [1984-5] 1 SLR 461. The plaintiff had to submit a medical report to the Canadian High Commission in support of his application for a visa. His blood test was interpreted by the doctor as showing syphilis when in fact it was a Biological False Positive due to his having had chickenpox. The doctor settled, but the medical laboratory defended itself successfully on the ground that the test itself was accurate, and it bore no responsibility for the doctor's interpretation.

licensing requirements under the Medicines Act[13]. An expression of society's trust in doctors.

The Standard of Care

The common law recognises two basic duties: (1) the duty to take reasonable care not to injure your neighbour; and (2) the duty to do what you have promised to do for reward. Whenever a patient is paying for his treatment, the possibility of liability in contract arises. In most cases, the contract will involve only a duty to use reasonable skill and care but in some cases a particular result may effectively be warranted. This must depend upon the terms of any contract entered into, or on what the doctor actually says to the patient. The Courts will not be quick to accept that a doctor has guaranteed the success of his methods, for the simple reason that in the context of the human body and the current state of medical knowledge such a guarantee would be foolhardy. One can hardly imagine a heart surgeon promising that following the triple-bypass the patient will not suffer a heart attack for a warranty period of five years. But where procedures are intended to bring cosmetic rather than therapeutic benefits, or are tried and trusted, it may be possible that a doctor has actually guaranteed success. There is a Canadian example of this, where a woman contracted with a plastic surgeon to have her nose reduced. He drew her a sketch and assured her there would be no problem and that she would be very happy. In the end, she suffered scarring and deformity. The judge accepted that the surgeon had warranted success, and was in breach of that warranty[14].

In the absence of a contractual warranty however, the implied term to use reasonable skill and care and the duty of care in the general law of tort are essentially identical in the standard imposed on the doctor. The standard of care has been famously expressed in the direction of McNair J. to the jury in *Bolam v Friern Hospital Management*

[13] Medicines Act section 7
[14] *La Fleur v Cornelis* [1979] 28 NBR (2d) 569 (NBSC)

Committee,[15] the well-known *Bolam* test: "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view."

In *Bolam*'s case, the plaintiff was a psychiatric patient who underwent electro-convulsive therapy. Medical practitioners disagreed as to how this therapy should be administered, and the doctor in question had adopted a method that was accepted by some, albeit rejected by others. In other words, his clinical judgment had been reasonable, even though harm to the patient had resulted.

One question that a patient may reasonably ask is whether this approach gives too much room to professionals. What if one practice is obviously better than another? Shouldn't doctors be obliged to strive for the best practice? There are two ways in which the law has developed which respond to this concern.

First of all, the Courts have become more willing to scrutinise the practice relied on by the doctor. Is the practice capable of withstanding logical analysis? Sometimes, a group of professionals may concur in a practice that is in fact a negligent practice. If so, following that negligent practice is no defence. This was firmly established in a decision of the House of Lords, *Bolitho v City & Hackney Health Authority*[16]. Lord Browne-Wilkinson stated:

"…the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that,

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[15] [1957] 2 All ER 118, 122

in forming their views, the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion."[17]

What happened in *Bolitho* was as follows. A two-year old boy was admitted to hospital suffering from respiratory problems. The next day he suffered two short episodes of further respiratory problems. Each time a doctor was called but failed to attend. After the second bout, the boy collapsed, had a cardiac arrest and suffered brain damage. It was agreed that had the boy been intubated he would not have had the cardiac arrest. The doctor who failed to turn up was, not surprisingly, sued for negligence. She admitted negligence in her failure to attend, but persuaded the Court that even if she had attended she would not in the circumstances have arranged for the boy to be intubated. She then adduced expert evidence to show that a decision not to intubate would have been in accordance with a body of responsible professional opinion. This expert evidence was accepted. The claim failed, because even though she had been negligent in not attending, her attendance would not have changed anything. The boy would still not have been intubated, and would still have suffered the cardiac arrest.

The second development has been an increasing emphasis on the need for doctors to fairly and properly disclose the risks involved in any procedure. A balancing is taking place: between the expertise and judgment of the doctor on the one hand and the exercise of free and informed choice on the part of the patient. A doctor may consider a particular risk statistically acceptable, but the patient may take a different view. And it is the patient who will have to live with the consequences if the risk materialises. Nonetheless, the question of how much to tell the patient (in the absence of a specific inquiry, which must be answered truthfully) is a matter of clinical judgment. A Court will rely on expert evidence of what is the accepted and responsible medical practice[18]. But it may nonetheless hold that significant risks (say, any reasonably severe

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[16] [1997] 4 All ER 771
[17] *Ibid* at 778d-g
[18] *Sidaway v Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital* [1985] AC 871

consequence that has a one in twenty or greater chance of arising) should be told to the patient no matter what.

The case of *Sidaway* has been followed in Singapore. In the recent case of *Denis Mathew Harte v Dr Tan Hun Hoe & Anor* Suit No. 1691 of 1999, unreported, the Court, after setting out the principles established in *Sidaway*, held that the risk of testicular atrophy following a varicocelectomy was too remote and negligible for it to be a risk that no reasonably prudent urologist would fail to disclose.

Of course, the more a patient asks, the more the doctor must tell. And a doctor must be alert to the specific situation of his patient. There may be things about the patient which make particular risks unacceptable to him, even though acceptable to others. This is demonstrated by an Australian case, where a 48 year old patient had been almost totally blind in her right eye since she had suffered an injury at the age of nine. Her left eye was normal. The opthalmic surgeon advised her that she could operate on her affected eye to improve its sight. The patient was quite used to living with the use of just one eye. She told the surgeon that she wanted to know all the risks involved. She did not specifically ask whether there was any risk to the sight in her good eye. There was a risk of sympathetic opthalmia affecting her good eye following the operation. The surgeon made no mention of this. If he had told her of this risk, she would not have undergone the procedure to her affected eye. After the operation, sympathetic opthalmia set in her good eye, and within two years she was almost totally blind. The Court held that the surgeon had been in breach of his duty of care in not mentioning the risk of sympathetic ophthalmia, even though it was a low risk[19]. In this particular case, the failure to warn made the surgeon liable in damages for the loss of sight in the good eye, because this particular patient would have refused the operation because of this precise risk.

[19] *Rogers v Whittaker* [1992] 3 Med LR 331; [1992] 109 ALR 625 (High Ct Aus)

Is the standard of care the same for all doctors? What about specialists? Shouldn't they be held to a higher standard? And what about novices, a trainee surgeon for example? Surely we all need to start somewhere? Young doctors and nurses learn on the job, after all. Wouldn't imposing the same standard of care inhibit the process of hands-on training, and so not be in the best interests of the public taken as a whole?

The short answers are that specialists are held to a higher standard, but lack of experience does not lower the standard of care required. Specialists should be held to the standard of care of a reasonably competent practitioner in that field for the simple reason that that is how they hold themselves out. Patients come to them on that basis, and rely on their specialist knowledge and skill. As for novices, well, every patient is entitled to expect that whoever is responsible at each stage of his treatment will exercise the appropriate degree of skill[20]. Unlike an activity like cutting one's hair, for which one may happily prefer the free service of an enthusiastic trainee to an over-priced and jaded stylist, not many patients would happily volunteer to be guinea pigs. This is a general principle in the law of tort – a driver who passed his test yesterday is held to the same standard of care as someone who's been driving for fifteen years[21].

Before leaving this subject, I should mention the potential liability for psychiatric illness suffered by someone very close to a negligently treated patient. In one case a mother, who had to watch her daughter die a painful death following an operation that was both unnecessary and negligently carried out, suffered post-traumatic stress disorder. She recovered against the neurosurgeon who had negligently treated her daughter[22].

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[20] *Wilsher v Essex Area Health Authority* [1986] 3 All ER 801
[21] see for example *Nettleship v Weston* [1971] 2 QB 691
[22] *Pang Koi Fa v Lim Djoe Phing* [1993] 3 SLR 317

Consent

We have already discussed how failure to warn a patient of particular risks may be held to be negligent and so a breach of the doctor's duty of care. More fundamental even than this is the obligation to obtain a patient's consent to the course of treatment proposed. Not to do so is not merely negligent but an invasion of the patient's rights in his body: this makes an operation an assault. If an operation is for amputation of the left leg, and the right leg is mistakenly chopped off, then the patient is entitled to sue in the tort of assault and battery, because he never consented to what was in fact done.

What is required for consent to be real? A good guide is the following formulation: "The patient's consent must be a 'valid' consent, which means that it must be voluntary, the patient must have the mental capacity to understand the nature of the procedure to which he is consenting, and he must have a certain minimal amount of information about the nature of the procedure."[23] This formulation summarises the three key ingredients of consent: voluntariness, capacity and knowledge.

The issue of capacity is one which it may be useful to sketch in a little more detail. First of all, there are cases involving children. At common law the parent of a child has the legal power to give consent for medical or surgical treatment on behalf of his child. In Singapore the age of majority after which parental consent is definitely not required is 21. This is by virtue of the common law, but the same age has been adopted in specific statutes, such as the Voluntary Sterilisation Act, Cap. 347 (with the interesting culturally based exception that should the person who is under 21 and seeking sterilisation be married, parental consent is not required for the sterilisation – although that person would have had to have had parental (or the Court's) consent to have married in the first place). The fact that the age of majority is 21 does not mean that before the age of 21 the parent's consent is always required. Depending on the nature of the treatment proposed

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[23] Jones, *Medical Negligence* (2nd Ed, Sweet & Maxwell, 1996) p284

and the degree of intelligence and understanding of the child, a doctor may rely on the child's own consent. In a well-known English case, the House of Lords held that in appropriate circumstances a child under the age of 16 might give an effective legal consent to medical treatment, including contraceptive treatment, even though the parents had not been consulted and would probably say no[24]. The principle invoked however requires the doctor to exercise his clinical judgment as to the best interests of the child. In the case of contraceptive advice and treatment, the likelihood in any particular case that the child would still have sexual intercourse without contraception - resulting in likely physical or mental harm - would render giving such advice and treatment in the best interests of the child.

A very difficult issue that may arise is where a doctor believes that the best interests of a child are served by a particular course of conduct and the parents disagree. Sometimes the parents are the ones objecting to a particular treatment (eg a blood transfusion). At other times the parents may be demanding life support measures that the doctor does not consider appropriate given the child's condition.

The Courts in the United Kingdom have taken on themselves in exercise of their inherent jurisdiction the task of resolving such disagreements in the case of children. There is also a statutory framework for judicial intervention in the case of adults who lack the necessary capacity. The paramount consideration has been the patient's best interests. While I do not know of any Singapore cases in which directions have been sought from the Court, in my view the Court here would have the same inherent jurisdiction of wardship over minors.

The Royal College of Paediatrics and Child Health has issued guidance to doctors entitled "Withholding or Withdrawing Life-Saving Treatment in Children, a Framework for Practice".

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[24] *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112

At the end of last year a case arose in the UK that captured the world's attention: that of the conjoined twins who were given (to protect the family's privacy) the names of Mary and Jodie. The doctors wanted to separate the twins so as to save one, even though this meant speeding up the death of the other. The parents, for religious reasons, wanted to let nature take its course. Directions were sought from the Court, which concluded that severance was in the best interests of each of the twins. Lord Justice Walker concluded:

"In this case highly skilled and conscientious doctors believe that the best course, in the interests of both twins, is to undertake elective surgery in order to separate them and save Jodie. The surgery would not be intended to harm Mary but it would have the effect of ending her life, since her body cannot survive on its own (and there is no question of her life being prolonged by artificial means or by a heart-lung transplant). The doctors' opinion cannot be determinative of the legality of what is proposed - that responsibility has fallen on the court - but it is entitled to serious respect. In *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, 190 Lord Scarman (with whom Lord Fraser and Lord Bridge agreed) said (in relation to the supply of contraceptives to a girl under 16): "The bona fide exercise by a doctor of his clinical judgment must be a complete negation of the guilty mind which is an essential ingredient of the criminal offence of aiding and abetting the commission of unlawful sexual intercourse." Here the court is concerned with the possibility of the commission of a much more serious criminal offence, that is murder. But in the wholly exceptional case of these conjoined twins I consider that the same principles apply. In *Bland* Sir Thomas Bingham MR (whose judgment was approved in the House of Lords by Lord Goff and a majority of their lordships) was prepared to put the matter very broadly ([1993] AC 789 at p.815): "For present purposes I do not think it greatly matters whether one simply says that that is not an unlawful act, or that the doctor lacks criminal intent, or that he breaches no duty or that his act did not cause death." In this case the doctors would perform a positive act of invasive surgery, but they would do so for the well-intentioned purposes which I have mentioned. The surgery would plainly be in Jodie's best interests, and in my judgment it would be in the best interests of Mary also, since for the twins to remain alive and conjoined in the way they are would be to deprive them of the bodily integrity and human dignity which is the right of each of them. As Thomas J said in the *Auckland* case [1993] 1 NZLR 235, 245,"Human dignity and personal privacy belong to every person, whether living or dying." Much of this judgment has necessarily been rather technical, and I am conscious that some of it may seem rather remote from the deeply troubling dilemma Jodie's and Mary's condition presents. Every member of the court has been deeply troubled by this case, but we have to decide it in accordance with the principles of existing law as we perceive them to apply to this unprecedented situation. I will summarize my conclusions as to the applicable principles as simply as I can.

(i) The feelings of the twins' parents are entitled to great respect, especially so far as they are based on religious convictions. But as the matter has been referred to the court the court cannot escape the responsibility of deciding the matter to the best of its judgment as to the twins' best interests.
(ii) The judge erred in law in equating the proposed surgical operation with the discontinuance of medical treatment (as by disconnecting a heart-lung machine). Therefore the Court of Appeal must form its own view.
(iii) Mary has a right to life, under the common law of England (based as it is on Judeo-Christian foundations) and under the European Convention on Human Rights. It would be unlawful to kill Mary intentionally, that is to undertake an operation with the primary purpose of killing her.
(iv) But Jodie also has a right to life.
(v) Every human being's right to life carries with it, as an intrinsic part of it, rights of bodily integrity and autonomy - the right to have one's own body whole and intact and (on reaching an age of understanding) to take decisions about one's own body.
(vi) By a rare and tragic mischance, Mary and Jodie have both been deprived of the bodily integrity and autonomy which is their natural right. There is a strong presumption that an operation to separate them would be in the best interests of each of them.
(vii) In this case the purpose of the operation would be to separate the twins and so give Jodie a reasonably good prospect of a long and reasonably normal life. Mary's death would not be the purpose of the operation, although it would be its inevitable consequence. The operation would give her, even in death, bodily integrity as a human being. She would die, not because she was intentionally killed, but because her own body cannot sustain her life.
(viii) Continued life, whether long or short, would hold nothing for Mary except possible pain and discomfort, if indeed she can feel anything at all.
(ix) The proposed operation would therefore be in the best interests of each of the twins. The decision does not require the court to value one life above another.
(x) The proposed operation would not be unlawful. It would involve the positive act of invasive surgery and Mary's death would be foreseen as an inevitable consequence of an operation which is intended, and is necessary, to save Jodie's life. But Mary's death would not be the purpose or intention of the surgery, and she would die because tragically her body, on its own, is not and never has been
viable."

More routinely encountered are cases where a patient is temporarily unconscious, perhaps after a traffic or industrial accident, and immediate surgery is necessary. Similar principles are applied to these emergency situations. The doctor should do what is

needed to stabilise the patient, acting in the patient's best interests. Once the patient has regained consciousness he should be consulted about the longer term measures appropriate in his case.[25] It should be remembered that it is only parents (or legal guardians) who can make decisions for a child. There is no general principle by which next-of-kin may make decisions on behalf of a relative. Consulting next-of-kin (for example with elderly patients) is simply a matter of good practice and is a means for the doctor to test and corroborate his views of the patient's best interests. In Singapore we also have the mechanism of "living wills", by which a person who is at least 21 years old and is of and sound mind can execute an advance medical directive stating his desire not to be subjected to extraordinary life-sustaining treatment in the event he suffers from a terminal illness and register this with the Registrar of Advance Medical Directives[26].

Where a person is mentally disordered or of unsound mind and incapable of managing himself, an application should be made by a relative (or a public officer) for the appointment of a committee which will have management of his person[27]. This committee could then make decisions about his medical treatment. This procedure may take time (two to three weeks), and, with an aging population, it may be appropriate for law reform in this area so as to create a simpler statutory framework for doctors and hospitals to seek directions from the court in the case of mentally incapable patients in a situation where, while there is no time for a committee to be appointed, there is also no immediate threat to the patient's life.

It is now standard to have patients sign consent forms before any procedure. Such forms typically include language that extends the procedure to what appears necessary to the

[25] In *Re F* [1990] 2 AC 1 the issue was whether the Court should authorise the sterilisation of a mental patient whose mental age was four. She had formed a relationship with a male patient which probably involved sex. While the relationship was considered pleasurable to her, even beneficial, a pregnancy would be disastrous from a "psychiatric point of view". The House of Lords held that the sterilisation was permissible in these circumstances as it was in the patient's best interests. In the course of his speech, Lord Goff discussed the common law doctrine of agency of necessity, at 77, and its applicability to surgery performed on for example unconscious accident victims.

[26] Advance Medical Directives Act, Cap 4A

[27] Mental Disorders & Treatment Act, Cap. 178

surgeon in the course of an operation should unforeseen circumstances arise. It should be remembered that such extended consent will always be interpreted conservatively. In other words, the doctor should only proceed if it is truly necessary to do so in the patient's best interests. If the additional surgery can be postponed until after the patient has been given an opportunity to make his own decision then that is the proper course of action.

Confidentiality

Confidentiality in the diagnostic process is essential so that patients speak freely and without reserve. The Oath of Hippocrates mentions this virtue of a physician, vowing: *"Whatever I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."* A doctor is responsible for ensuring the confidentiality and security of his medical records. This may be founded in one or more of three ways: first, it may be an express or implied term of the contract between doctor (or hospital) and patient; secondly, it is a general incident of the professional relationship between doctor and patient arising out of the general law of confidence; and thirdly there may be a specific statutory provision, as in for example section 7 of the Termination of Pregnancy Act[28]. The general rule is that disclosure should only be made with the patient's consent. A patient has a legal right to seek an injunction to prevent anticipated disclosure or to seek damages for actual disclosure.

The obligation is not however absolute. Medical records can be disclosed where there is an overriding social or public interest. This has been given statutory force in certain situations. If a doctor considers or has reasonable ground to suspect that a person he is attending is a drug addict he is obliged to notify the Director of Medical Services and the Director of the Central Narcotics Bureau of this fact within 7 days[29]. If a doctor has

[28] Cap. 324
[29] Misuse of Drugs Regulations (Cap 185, Rg 1) Reg 19

reason to believe or suspect that his patient suffers from or is a carrier of specified infectious diseases, then he must report this forthwith to the Director of Medical Services[30]. Hand Foot and Mouth Disease is the most recent addition[31].

Even in the absence of a statutory exception, the common law itself recognises a limiting principle, where disclosure is required in the public interest. The disclosure that is required by the public interest is likely to be a limited one, namely to those with a special interest in the information, rather than disclosure to the public at large. An example of this is the case of *W. v Egdell*[32]. In that case, W. was a patient detained in a secure hospital following an episode in which he had killed five people and injured two others. He was diagnosed as a paranoid schizophrenic. Ten years after his detention commenced, he applied for a transfer to another institution, a step preparatory to an eventual discharge and release. The application was to be heard by a Medical Review Board, and for the purpose of the hearing W. sought an opinion from Dr Edgell. Contrary to the opinion of W.'s attending physician, Dr Edgell opposed the transfer, and considered that W. had a "psycopathic deviant personality". Seeing the report, W. withdrew his application, and the report was consequently not given to the tribunal or to W.'s attending physician. When Dr Edgell discovered this, he decided that he should send his report to the secure hospital in the interests of W.'s continued treatment. The hospital in turn forwarded it to the Home Office, who in due course gave a copy of it to the tribunal when W.'s case came up for periodic review. W. sued for breach of confidence, but lost. The Court held that Dr Edgell's duty of confidence was subordinate to his duty to disclose the results to the authorities responsible for W., if in his view this was necessary to keep them fully informed about his condition and the best course of treatment.

Doctors and the Courts

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[30] Infectious Diseases Act Cap. 137 section 6 and First Schedule
[31] Gazette Notification S397/2000
[32] [1989] 1 All ER 1089

It sometimes happens that medical reports or records are sought, for example under a writ of *subpoena duces tecum*. Given that there may be issues of patient confidentiality, documents sought should not simply be turned over to the lawyers who have obtained the order. Instead, the documents should be released to the Court in the first instance. It is always prudent to seek solicitors' advice on whether an application should be made to set aside the writ of subpoena.

Doctors are also often called upon to give evidence in Court. Although our system is essentially adversarial, the role of expert witnesses is meant to be independent rather than partisan. An expert witness's duty is ultimately to the Court, and this trumps his duty to the party calling him, even if he is a paid expert.

Conclusion

From this short overview of health law in Singapore, I hope that a general understanding of the principles and issues has been gleaned. Many of the topics that I have briefly covered will be revisited by speakers in subsequent talks in this series. But some of the issues raised go to fundamental questions about the dignity of life and individual autonomy. For the busy professional, these are matters too easily brushed aside, but one hopes that among us there are many who seek to cultivate the essentials of a good professional: a caring attitude, thoughtfulness towards and respect for those with whom we come into contact. It is not a coincidence that we speak of a duty of care, rather than simply one of skill or knowledge. When a patient sees something go wrong, if the professional who has dealt with him was abrupt or aloof he is all too likely to seek out a lawyer. But if he has always been treated with care, that feeling of having been respected may well stay his hand.