Foo Chee Boon Edward *v* Singapore Medical Council
[2020] SGHC 24

Case Number	: Originating Summons No 7 of 2019
Decision Date	: 31 January 2020
Tribunal/Court	: High Court
Coram	: Sundaresh Menon CJ; Andrew Phang Boon Leong JA; Woo Bih Li J
Counsel Name(s)	: Lin Ming Khin, Gan Guo Wei, Tanaya Shekhar Kinjavdekar and Kwok Chong Xin Dominic (Charles Lin LLC) for the appellant; Philip Fong Yeng Fatt, Sui Yi Siong (Xu Yixiong) and William Khoo Wei Ming (Eversheds Harry Elias LLP) for the respondent.
Parties	: Dr Foo Chee Boon Edward — Singapore Medical Council

Professions – Medical profession and practice – Professional misconduct

31 January 2020

Sundaresh Menon CJ (delivering the judgment of the court *ex tempore*):

Background

1 The appellant, Dr Foo Chee Boon Edward ("Dr Foo"), is a general surgeon who has been in practice since 1983. Before the Disciplinary Tribunal ("DT"), Dr Foo faced three charges, which included a charge of failing to keep clear and accurate medical records ("the charge"). Dr Foo pleaded guilty to the charge and the DT imposed a term of three months' suspension in that respect. It is that charge alone which forms the sole subject matter of the present appeal.

2 We begin with a brief outline of the salient facts. The patient first consulted Dr Foo on 18 January 2012 at Parkway East Hospital. She was referred to Dr Foo by one Dr Roger Heng. Dr Foo diagnosed the patient with rectal cancer and discussed various treatment options with her. These were documented in a clinical case note, along with, among other things, Dr Foo's physical findings and the results of the various tests conducted on the patient.

3 It is not disputed that during this initial consultation, Dr Foo did explain the material risks and possible complications of the treatment options to the patient. However, he was unable to obtain the patient's consent at that time as she had expressed financial concerns regarding immediate admission to Parkway East Hospital. He advised her to seek urgent admission to a restructured hospital instead.

4 On 24 January 2012, the patient contacted Dr Foo again to seek treatment under him. Dr Foo was overseas at the time and therefore advised the patient to contact Dr Heng. On the following day, Dr Heng conducted various tests on the patient. On 26 January 2012, he documented her written consent for two procedures to be carried out by Dr Foo and himself, namely, a "Total Hysterectomy and Anterior Resection". The two procedures are more fully described as a Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy and a Lower Anterior Resection ("LAR") but it does not seem to us that anything turns on the slight difference in the terms in which it was described in the relevant forms.

5 The procedures were performed on 31 January 2012. Subsequently, the patient developed

complications and passed away on 4 February 2012.

The charge and the decision below

6 We turn to the charge against Dr Foo that is before us.

7 The charge essentially states that Dr Foo's *documentation* was inadequate in two respects:

(a) It failed to record his advice as to the material risks and possible complications of the procedures, including the additional risks of operating on an underweight patient; and

(b) He failed personally to record the patient's consent to undergo the procedures.

8 As we have stated above, Dr Foo pleaded guilty to the charge. In sentencing, the DT came to the view that Dr Foo's breach could not be seen as a minor or technical one. Furthermore, the sentencing objectives of general and specific deterrence were said to be relevant. According to the DT, the charge therefore warranted a suspension of six months, which was then reduced to three months due to the Singapore Medical Council's ("SMC") inordinate delay in prosecuting the case.

The appeal

9 Dr Foo appealed to us, initially against the sentence only. While the parties now agree that the conviction itself ought to be set aside because the high threshold for disciplinary action to be taken has not been crossed, we think it is important to set out the events which led to these belated developments.

10 As we have observed, initially, Dr Foo had only appealed against the sentence imposed by the DT. He contended that an appropriate sanction would be a fine of not more than $15,000. The SMC, however, vigorously defended the three months' suspension.

11 Having read the written submissions, it was clear to us that both parties were not alive to the possibility of the conviction itself being unsafe. This caused us some concern as based on the facts and evidence, it did not seem to us that any inadequacy in Dr Foo's documentation rose to the level of professional misconduct warranting the imposition of disciplinary sanctions. While the DT did not have the benefit of our judgment in *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 ("*Lim Lian Arn*"), the parties' submissions were filed after that decision had been published. In *Lim Lian Arn*, we made clear that the threshold to be crossed before misconduct may be found is a high one. As a general rule, mere negligence would not be enough. It would be relevant to consider the nature and extent of the misconduct, the gravity of the foreseeable consequences and the public interest in pursuing disciplinary action (*Lim Lian Arn* at [37]–[38]).

12 In the present case, the charge can only be sustained if Dr Foo's conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner. This describes the disciplinary threshold applicable to negligent, as opposed to wilful, breaches and is explicitly stated in the charge itself.

13 Accordingly, we directed the parties to file further written submissions on whether the relevant threshold had been crossed for the charge ("the Question"). We set out below the points which we had raised to the parties for their consideration.

The Question

14 The first point which we observed was that there is a material distinction between a charge for a failure to *document* the risks of the procedures and for a failure to *advise* the patient about the same. At the risk of stating the obvious, the latter failure would almost invariably be more serious when compared to the former. This is because a failure to *advise* the patient of relevant and material risks might potentially mean that *the patient's informed consent had not in fact been obtained*.

15 Second, it appeared to us that there was in fact a fair amount of documentation of the discussion between Dr Foo and the patient during the initial consultation on 18 January 2012. Dr Foo had, for instance, documented his advice to the patient of the possible treatment options and the preferred option. He had also, among other things, recorded the patient's diagnosis, the physical findings and the results of the tests.

16 Third, in so far as Dr Foo's failure to record the patient's consent was concerned, we observed that Dr Heng did in fact document her consent on 26 January 2012. We further note that he then informed Dr Foo that the pre-admission procedures had been completed. Dr Heng himself is a senior practitioner and was the co-surgeon for the procedures. Furthermore, at the material time, Dr Foo was overseas and there was some degree of urgency given the patient's condition.

17 Fourth, on the evidence before us, there was nothing to suggest that Dr Foo's alleged failure of documentation amounted to a persistent failure. As we observed in *Lim Lian Arn* at [34], both the 2002 and 2016 editions of the SMC's Ethical Code and Ethical Guidelines ("ECEG") emphasise that it is serious disregard of or persistent failure to meet the relevant standards that may lead to disciplinary proceedings.

18 Finally, it also appeared that no harm ensued from the particular breach in question, given the absence of any nexus between the facts relating to this charge and the patient's death.

Summary of the parties' revised positions

19 As stated above, Dr Foo now seeks to set aside the conviction on the basis that the applicable threshold has not been crossed. To its credit, the SMC is now taking the same position. As the parties' responses largely overlap, we set out the points which are accepted by both parties.

20 In essence, the parties agree that the inadequate documentation in this case is limited to a fairly narrow category of information. In addition, as far as the documentation of consent is concerned, Dr Heng had already documented the patient's consent on 26 January 2012 (although the SMC still maintains that there was a duty on Dr Foo to personally document the patient's consent, a point which we return to later). The parties also agree that there is no evidence that the failure of documentation represented a persistent failure on the part of Dr Foo, or that there was actual or potential harm arising from this particular breach. Finally, Dr Foo's conduct in this respect could not be said to be due to an indifference to the patient's welfare.

Our decision

21 Having considered the parties' revised positions, we are strengthened in our initial view that there was no basis for the charge to have been brought in the first place. In our judgment, the relevant threshold was not crossed on the facts and evidence before us, for all the reasons canvassed above. In the circumstances, we set aside the conviction on the charge and the sentence imposed.

22 We make two final observations.

23 First, we note that Dr Foo has been found liable for two other charges of professional misconduct in respect of his management of the patient. As neither party has appealed against the DT's decision in respect of those charges, nothing in this judgment displaces those convictions and sentences and we make no comment on them.

24 Second, we observe that the SMC maintains its position that Dr Foo ought to have personally re-documented the patient's consent to undergo the procedures, notwithstanding Dr Heng's documentation of her consent. This is said to be on the basis that he was the principal surgeon for one of the two procedures (namely, the LAR procedure). As the LAR procedure was within his speciality, and carried significant risks, it is said Dr Foo ought to have documented consent personally as well.

25 We have some doubts as to the correctness of this position. The starting premise which is undisputed is that Dr Foo had already explained the relevant risks of the procedures to the patient on 18 January 2012. The patient did not provide her consent to the procedures at the time owing to financial concerns. Because he was overseas when the patient later contacted him again for treatment, he entrusted Dr Heng to attend to the relevant documentation which included the patient's written consent. It is not disputed that the patient's consent was then documented and that she was provided with the requisite information before she signified her consent. In the circumstances, her consent was a sufficiently informed one. In these circumstances, we find the SMC's position difficult to understand or accept. At the very least, it seems to be an exceedingly technical position.

26 We also note that under the 2016 ECEG, it is contemplated that a medical practitioner may delegate consent-taking to other team members. That being the case, we are unable to understand why Dr Foo could not validly delegate the *documentation* of the patient's consent to his co-surgeon Dr Heng, who we reiterate, is also a senior practitioner. Guideline C6(8) of the 2016 ECEG states:

> You must either take consent personally or if it is taken for you by a team member, you must, through education, training and supervision of team members, ensure the quality of the consent taken on your behalf. In any case, you must ensure adequate documentation of the consent taking process where this involves more complex or invasive modalities with higher risks.

27 Nevertheless, for the purposes of this appeal, it is not necessary for us to arrive at a concluded view on this issue. We therefore leave this issue for a future occasion where the parties may make their submissions with the benefit of the foregoing observations.

28 For the costs below, the DT ordered Dr Foo to pay to the SMC 90% of its costs and expenses given that he had unsuccessfully contested the two other charges brought against him. We see no reason to disturb the costs order below. As for the costs of the appeal, having regard to the parties' initial positions, we order the parties to bear their own costs. The usual consequential orders, if any, shall apply.

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