Re LP (adult patient: medical treatment)
[2006] SGHC 13

Case Number : OS 38/2006

Decision Date : 23 January 2006

Tribunal/Court : High Court

Coram : Choo Han Teck J

Counsel Name(s) : Chong Fook Choy Christopher (Rodyk and Davidson) for the applicant

Parties : —

Civil Procedure – Jurisdiction – Inherent – Application for declaration on legality of medical treatment – Whether application made ex parte – Whether High Court having jurisdiction to hear such application

Mental Disorders and Treatment – Mental disorders and treatment act – Whether third party can apply for Committee of Person – Whether court can exercise inherent jurisdiction to hear application for consent in absence of Committee of Person

23 January 2006

Choo Han Teck J:

1 This was an urgent application by the Mount Alvernia Hospital, represented by Mr Christopher Chong. In the application, the applicant prayed that this court declares a proposed surgery by the doctors in charge of a patient, Mdm LP, at the hospital, involving the amputation of both legs, below the knee, to be lawful. The patient had no known relative except her 16-year-old son, L, who was present but not legally represented, at the hearing of the hospital's application. The patient is 51 years old and, according to her son, L, worked as a real estate agent. His father is in the Philippines and could not be reached. In any event, the father has scant contact with either LP or L as he is not, and never was, married to LP. L had just completed his "O" level examinations. Though he spoke clearly, calmly, and with a maturity of an adult, he was still a minor. Although such applications ought not normally be made *ex parte*, given the circumstances in the present case, I proceeded to hear the application because there was, in my view, insufficient time for a *guardian ad litem* to be appointed for L. See *St George's Healthcare NHS Trust v S* [1999] Fam 26. I will revert to the issue of jurisdiction shortly.

2 Mdm LP is a diabetic and consulted Dr Tan Mak Yong ("Dr Tan") at the Gleneagles Medical Centre on 13 October 2005. She complained of pain in both feet and told Dr Tan that she had been to the Singapore General Hospital as well as the Tan Tock Seng Hospital where the doctors told her that her right leg had to be amputated. According to Dr Tan, she refused to consent to that operation and wanted her legs saved at all costs. Dr Tan observed that Mdm LP had "right foot infection with gangrene of her right big toe and several superficial burn wounds over her left foot". On 14 October 2005, she was persuaded by Dr Tan to have an amputation of only her right toe. She was discharged on 31 October 2005. Unfortunately, her condition worsened in that the infection in her right leg did not improve and had spread to her left leg by the time she saw Dr Tan again, that is, on 12 November 2005. According to Dr Tan, she was conscious and alert, and again told him to "save her legs at all costs". It did not appear that there was a danger of death at that time. On 21 November 2005, Mdm LP was found to be in septic shock and was "not rousable." Dr Tan was of the view that the patient's comatose state was caused by the septic shock arising from the infection in her legs. He deposed in his affidavit that between 12 November 2005 and 21 November 2005 it was not made known to her that she would die if her legs were not amputated. The patient thus went into a coma

before any such discussion could take place. The doctors tried further operations to remove the infected parts of her legs up to 28 November 2005 without success. Her legs were still infected and Dr Tan deposed that:

> Medically, the only option is to carry out bilateral below knee amputations urgently to improve the chances of the Patient's condition, as the amputation can help in the control [of] the sepsis. If not, the infection will worsen and the Patient will die.

3 The medical opinion of Dr Tan was supported by other qualified specialist doctors including Dr Leonard Koh, an endocrinologist, Dr Lam Mun San, a specialist in infectious diseases, Dr Tan Chai Beng, a neurologist, and Dr Sittampalam Krishnamoorthy, an orthopaedic surgeon. I was satisfied that the medical condition of Mdm LP had become critical and I accept the medical opinion that unless the amputation of her legs was carried out she would soon die. The application before me was necessitated by the doctors' dilemma that on the one hand, they were all of the view that the operation would be in the patient's best interests, and on the other hand, they had not obtained the patient's consent for the surgery, a situation complicated by the patient's previous statement to the doctors to save her legs at all costs. The patient was now unable to give consent by reason of her comatose state. The only relative that the hospital was able to reach was her son, L. There was, therefore, a genuine doubt, so far as the doctors were concerned, as to whether the proposed surgery could proceed. Since this was a matter of life and death, and there was no viable alternative, it was prudent for the hospital to make this application. The doctors had not stated that Mdm LP would regain consciousness after the amputations. That meant that it was possible that Mdm LP might remain in a comatose state indefinitely – without her legs. Would that be worse for her? This question must be answered in context. What could it be worse than? The existence or non-existence of her legs cannot be worse if she never regained consciousness. It might be worse for her son because he would have an unconscious mother without legs; but again, what would that mean in context? Avoiding what might be worse off for her son may not necessarily be in the best interests of the patient herself. The best interests of the family is not to be confused with the best interests of the patient, especially one in the present circumstances where the patient is incapable of being affected by what happens to her family or what her family might feel or go through. It would then be a question of whether living without legs, even in a comatose state, would be in the best interests of Mdm LP? These were all very difficult questions to answer. Opinions in such cases, even among the doctors, might differ, as might between members of a patient's family, and between the family and the doctors. Weighed against the medical possibilities, namely, that without the operation she would likely die, that she might still die in the course of or after her operation, and, that she might live and regain her consciousness, I accept the doctors' opinion that amputation of both her legs would be in Mdm LP's best interests.

4 It will be noted that the application was for a declaration that the surgical operation would be lawful, and not that the court gives consent on behalf of the patient. This was not a directly relevant issue given the way the application was stated, but it was an important point to be considered because the applicant had also asked the court to grant any other relief that it thought fit. Generally, a person who is sufficiently matured is entitled to give or withhold consent to any medical treatment and the doctors are entitled, if not obliged, to respect that person's decision. No one else, however close by reason of kinship or friendship, is legally entitled to make that decision for the patient. Where a patient is incapable of giving or withholding such consent, a third party may apply to the court under the Mental Disorders and Treatment Act (Cap 178, 1985 Rev Ed) for a Committee of Person to be appointed for the purpose of acting in place of the patient and to give or withhold consent as the case may be. When this is done, the doctors may proceed as if the consent or lack thereof came from the patient herself. In cases in which the medical condition is critical, such as the present case; or for various reasons like the absence of anyone who may want or can be made

a Committee of Person, which is also the case here, the court will have to exercise its inherent jurisdiction in such manner as it thinks right and proper to hear an application such as the present one before me. It would be noted that Proviso 19 of the First Schedule of the Supreme Court of Judicature Act (Cap 322, 1999 Rev Ed) gives the court the power to "order medical examination of a person who is a party to any proceedings where the physical or mental condition of the person is relevant to any matter in question in the proceedings". But that is a specific provision that does not relate to the giving of consent to medical treatment. Mr Chong drew my attention to s 61 of the Mental Disorders and Treatment Act and submitted that the court retained some residual power from that source. Section 61 provides that:

> Nothing contained in Part II shall be taken to interfere with the power of the court over any person found to be mentally disordered under Part I.

However, in order to exercise any power under s 61 it must first be determined that the person concerned was "mentally disordered under Part I". That means that the requirements and procedure under this Act must first be complied with if this application was to be heard on that basis. I do not think that s 61 was of assistance in this case.

5 Mr Chong submitted the alternative proposition that the court has powers under O 15 r 16 of the Rules of Court (Cap 322, R 5, 2004 Rev Ed), as well as under its inherent jurisdiction to hear an application of this nature, that is, an application to declare the act of the doctors in the present circumstances to be lawful. For convenience I shall set out O 15 r 16 as follows:

> No action or other proceeding shall be open to objection on the ground that a mere declaratory judgment or order is sought thereby, and the Court may make binding declarations of right whether or not any consequential relief is or could be claimed.

Lord Brandon dealt with both grounds in *In re F* [1990] 2 AC 1 ("*F*"). He was of the opinion that it would not be right to describe the jurisdiction as being under the UK RSC Ord 15 r 16 (which is identical to our rule). He held at 63, that the jurisdiction "is part of the inherent jurisdiction of the High Court, and the rule does no more than say that there is no procedural objection to an action being brought for a declaration whether any other kind of relief is asked for or available or not". I agree with that opinion. As Lord Brandon also observed at 55, "The common law would be seriously defective if it failed to provide a solution to the problem created by such inability to consent." Lord Goff expressed an almost identical sentiment at 72 where he stated:

> Mr Munby, for the Official Solicitor, advanced the extreme argument that, in the absence of a parens patriae or statutory jurisdiction, no such treatment or care of the kind I have described can lawfully be given to a mentally disordered person who is unable to consent to it. This is indeed a startling proposition, which must also exclude treatment or care to persons rendered unconscious or unable to speak by accident or illness. For centuries, treatment and care must have been given to such persons, without any suggestion that it was unlawful to do so. I find it very difficult to believe that the common law is so deficient as to be incapable of providing for so obvious a need. Even so, it is necessary to examine the point as a matter of principle.

6 Courts do not perform an oracular or purely academic function of merely declaring a particular conduct lawful or unlawful in the absence of a real dispute. The function of rendering such advice lies with the lawyers. That is to say, that a court would usually only consider an application for a declaration where there is an issue between litigants. There are exceptions. In the present instance, given the patient's previous indications and the lack of support from her family, this application was a reasonable one. Although there was no physical entity appearing as an opposing litigant, there were

some indications that the surgery might result in litigation. The patient might sue the doctors and the hospital for a surgery carried out without her consent. Whether she would succeed is not the point – I was not here dealing with the issue as to whether the doctors would be liable for any prior omission or act. Since doctors are usually the only people qualified to act positively in serious or critical cases when a person's life is threatened by illness or injury, a doctor concerned would be entitled to rely on the defence of necessity in the event of his being sued. But that would not be sufficient comfort to the doctor. He might, understandably, prefer not to act at all for fear of being sued. But I was not here dealing with a doctor's positive obligations in the case of an emergency. The situation was a less direct one. In this case, given that there were some indications from the patient herself that would conflict with the proposed operation, was it prudent for the doctors to place the matter for an independent evaluation of their opinion regarding the patient's best interests? I was of the view that it was, and that the court could hear the application. However, I should say in passing, that where a situation was neither grave nor urgent, reasonable effort must be made to have the application heard on an *inter partes* basis rather than an *ex parte* one. I think it is also fair to say that the present case before me was of much greater urgency than that in *F* where there was sufficient time for counsel to be instructed by the Official Solicitor as *amicus curiae*.

7 The questions arising here had also arisen in *F*. In that case, the House of Lords had to consider whether the High Court was correct in assuming jurisdiction to hear an application for a declaration of a similar order as the one presently before me. In *F*, however, the medical treatment required in question was of a different nature than the one before me. *F* concerned the question of the sterilisation of a woman who was mentally incapable of giving consent. Hence, it was not a case that had the same urgency as the one before me, nor was it a life-threatening situation. In that case, the House of Lords approved the declaration granted by the High Court. Although the Court of Appeal below also approved the application, the court was doubtful that the application by way of a declaration was an appropriate or satisfactory procedure. Dispelling the doubts of the Court of Appeal, Lord Brandon held at 64:

> With respect to all three members of the Court of Appeal, I do not consider that these objections are well founded. The first objection, that a declaration changes nothing would be valid if the substantive law were that a proposed operation could not lawfully be performed without the prior approval of the court. As I indicated earlier, however, that is not, in my view the substantive law, nor did the Court of Appeal, as I understand the judgments, hold that it was. The substantive law is that a proposed operation is lawful if it is in the best interests of the patient, and unlawful if it is not. What is required from the court, therefore, is not an order giving approval to the operation, so as to make lawful that which would otherwise be unlawful. What is required from the court is rather an order which establishes by judicial process (the "third opinion" so aptly referred to by Lord Donaldson of Lymington M.R.) whether the proposed operation is in the best interests of the patient and therefore lawful, or not in the patient's best interests and therefore unlawful.
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> The second objection, that the application for a declaration might be unopposed and it is not the ordinary practice to grant declarations by consent or where there is no contrary claim, would only be valid in the absence of appropriate rules of procedure governing an application of the kind under discussion. The same objection could be raised against the procedure by way of application for approval of the proposed operation favoured by the Court of Appeal, in the absence of rules of procedure such as those propounded by Lord Donaldson of Lymington M.R. and agreed to by Neill and Butler-Sloss L.JJ. I, accept, of course, that no such rules of procedure have so far been made. But even without them, there would have to be a summons for directions, preferably before a judge, and he could be relied on to ensure that the application was not unopposed, and that all necessary evidence, both for and against the proposed operation, were adduced before

the court at the hearing.

The third objection, that the public interest requires that the court should give express approval to a proposed operation and that a declaration does not have that effect, appears to be largely semantic. By that I mean that, whichever the two forms of procedure, if both were available, were to be used, the nature of the inquiry which would have to be made by the court, and of the reasoned decision which it would be obliged to give after carrying out that inquiry, would be substantially the same.

The fourth objection, that a declaration granted at first instance may have limited efficacy in any subsequent litigation was not the subject matter of any argument before your Lordships. My provisional view is that, whatever procedure were to be used, only the parties to the proceedings and their privies would be bound by, or could rely on, the decision made. In practice, however, I think that that would be enough.

8 I am in full agreement with Lord Brandon's reasoning set out in the above passage. Specific life-and-death situations vary in their character and complexity. In some cases, there would just be enough time to come to the courts for a ruling. In other situations the doctors would have to decide for themselves, as they were entitled to do, as Lord Brandon observed in his judgment in *F*. They might decide not to treat, or simply not decide. In either case, the patient is likely to lose her life. In some jurisdictions such as those in the US, the court would apply the "substituted judgment" test. That is to say, it would seek evidential proof as to what that patient herself would do had she been conscious for a brief moment to be appraised of her condition and to give or withhold her consent as required. In situations of that kind, the courts (in America) would seek the views of the patient's family and friends to enable it to form a view that it thinks best coincides with what the patient herself would have done. See, for example, *Re Quinlan* 70 NJ 10 (1975). That approach led eventually to the development of the "advance medical directive", sometimes called by the odd name of "living will". I should point out that the nature, scope and procedure of the Advance Medical Directive in Singapore differs in some substantial ways from that in the American notion. But that is not an issue of direct relevance in the present case, save to note that the applicability of the American-type advance directive remains an open matter. Suffice it to say in the present case that if that is the approach that we should follow, then the statements made by Mdm LP to her doctors to "save her legs at all costs", and that she would "rather die than lose her legs" to her son might become important evidence for me to consider whether she would have given or withheld her consent to the proposed amputation of her legs. In the present case, L informed me that the doctors had advised him that his mother would die without the operation, but she might also die in the course of the operation. He said that consequently, he was in a dilemma as to whether he would like them to proceed with the operation on his mother. It has to be noted for completeness that it was recorded in the hospital notes produced by Elizabeth Loh, the hospital's nursing manager, that at one point, L had requested the doctors to "switch off the respirator". There was no medical evidence that this was a question that needed to be addressed. There was no evidence before me that Mdm LP was already brain-dead.

9 The courts in England take a slightly different approach. While greater emphasis is placed on patient autonomy in America than in the UK, consent is still of paramount importance in the latter jurisdiction. Hence, if there is clear evidence of consent or refusal to consent to any medical treatment, doctors will have to respect the patient's decision. When it comes to a situation where the patient is incapable of giving her consent, or where such consent (or lack of it) was not made reasonably clear, the doctors would have to treat the patient according to what they think is in the best interests of the patient. The best interests of the patient may not be the best interests of her spouse or parents or children. And likewise, what the patient might think is in her own best interests

may not be similarly shared by the doctors. The decision as to what is in a patient's best interests from the point of view of the doctors is strictly a medical one, and one that is expected to be professionally formed. Hence, while a patient herself might think that it would be in her best interests not to have any treatment that might incur heavy financial costs to her family, but the doctors have to concentrate on the medical aspects of treatment. So, although the opinions and sentiments of the patient's family ought to be sought, they are not binding (for indeed, as I have mentioned, they can sometimes be at odds) on either the doctors or the court.

10 Where doctors do not have a clear and express consent of their patient, their only course is to act in the best interests of the patient. I think that it would not be unreasonable in this case for the doctors to regard the proposed amputation, which was the only hope of saving the patient's life, to be in Mdm LP's best interests. In coming to this conclusion, I am not evaluating the matter of whether it would be in the best interests of this patient to remain in her comatose state indefinitely. That question has not yet arisen, and it was not unreasonable for the doctors to consider the main and more critical situation first. The sense of urgency in some situations, including medical ones, may not arise instantaneously or rapidly leaving little time for reflection, but develop gradually, with time for other options to be explored before they become critical and give rise to an emergency. I accept that this was such a case. Having reached the point of such urgency, and having no better option remaining, the matter should be delayed no further.

11 I am of the view that the evidence indicated that the statements made by Mdm LP before she lapsed into a coma regarding her preference to death over losing her legs, were probably made without the benefit of medical advice of impending death. I could not say, on the evidence before me, that Mdm LP had clearly and expressly refused her consent to the surgical operation now intended by the doctors, knowing that it was the only treatment to save her from impending death. Further, I was satisfied that the proposed surgical operation would be in her best interests. I therefore granted an order in terms of the application.