# Claiming wrongful diagnosis under the Mental Health Ordinance: The impossibility of building a reasonably arguable case

Urania Chiu* and Daisy Cheung**

*In the recent CFI decision Bhatti Bhupinder Singh v Hospital Authority, the judge refused to grant leave under section 69 of the Mental Health Ordinance (MHO) to the claimant for his wrongful diagnosis and wrongful detention claims against the Hospital Authority. This article considers this decision in detail, arguing that the judge's reasoning was highly flawed due to its lack of consideration of a crucial factual context of the case, as well as its lack of scrutiny of the decisions made by the various medical professionals involved, in particular in relation to whether the criteria specified by each relevant section of the MHO was satisfied. The resulting approach demonstrates an unacceptable level of deference towards the judgment of medical professionals, to the extent that it is difficult to see how a reasonably arguable case could ever be mounted under section 69 of the MHO – a problematic outcome given the implications of section 69 on the important right to access to courts. Given that compulsory admission and treatment is a highly draconian regime involving deprivation of liberty and the administration of powerful, mind-altering drugs, the court cannot simply be a rubber stamp and must exercise its supervisory role in a much more meaningful manner.*

## 1. Introduction

*Bhatti Bhupinder Singh v Hospital Authority*[1] began when Singh started hearing a persistent tapping noise from the unit above his home. When his complaints (and the tapping noise) were still unheard by his upstairs neighbours and the estate management two years later, his frustration culminated in two incidents at the management office, where he threw a stapler onto the floor and a letter at a management staff respectively. The latter of these incidents resulted in the police being summoned and Singh being escorted to the Accident and Emergency Department of Tuen Mun Hospital (TMH) on 12 October 2015.[2]

At TMH, Singh was assessed by a psychiatric nurse, who recommended consideration by a psychiatrist of whether he should receive inpatient treatment to prevent him from harming others, given the report about his "active display of violence" and provisional diagnosis of psychosis.[3] The next day, an application under section 31 of the Mental Health Ordinance (Cap. 136) (MHO) was made for Singh by a public officer in the Social Welfare Department based on his suspected psychotic symptoms, as evidenced by his reports of the "non-existence [sic] noise",[4] and supported by a registered medical practitioner's certificate that Singh "demonstrated uncontrollable violent behaviour with potential to cause bodily harm to others when he felt that he had not been fairly treated".[5]

Singh was then admitted to Castle Peak Hospital (CPH) for observation for seven days. During this time, information was obtained from Singh's family, who

* Graduate research student, Faculty of Law and Ethox Centre, University of Oxford.
** Faculty of Law and Centre for Medical Ethics and Law, University of Hong Kong.
[1] [2020] HKCFI 530 (hereinafter *Singh v HA*).
[2] *Ibid.*, [11]-[15].
[3] *Ibid.*, [18].
[4] *Ibid.*, [21].
[5] *Ibid.*, [22].

confirmed the existence of noises from the unit upstairs.[6] After that, his detention was further extended for 21 days under section 32 of the MHO with a diagnosis of delusional disorder.[7] He was eventually discharged on 6 November 2015, with a principal psychiatric diagnosis of paranoid personality disorder and follow-up appointments made.[8]

In October 2018, Singh commenced a case against the Hospital Authority (HA) for, *inter alia*, TMH's wrongful diagnosis of his mental state which led to his compulsory detention.[9] The proceedings were stayed in the District Court, as, under section 69 of the MHO, legal proceedings cannot be brought against anyone carrying out their duties under the MHO unless leave has been given. The current judgment concerns the application for such leave in the Court of First Instance (CFI).

Section 69(2) of the MHO stipulates that "leave shall not be given unless the Court is satisfied that there is substantial ground for the contention that the person, against whom it is sought to bring the proceedings, has acted in bad faith or without reasonable care". It should be noted that the threshold of "substantial ground" has since been read down in a remedial interpretation in the case of *陳碩謙 對 醫院管理局 (Chan Shek Him v Hospital Authority)* to a threshold of "reasonably arguable ground".[10] This standard was chosen by reference to the standard adopted by the Court of Final Appeal in granting leave for judicial review in *Po Fun Chan v Winnie*

[6] *Ibid.*, [25], [34].
[7] *Ibid.*, [24].
[8] *Ibid.*, [25]-[26].
[9] *Ibid.*, [3].
[10] *陳碩謙 對 醫院管理局 (Chan Shek Him v Hospital Authority)* [2014] CHKEC 980, [64] (hereinafter *Chan Shek Him*).

*Cheung*, where it was further elaborated that a reasonably arguable case is one which "enjoys realistic prospects of success".[11]

Deputy Judge Simon Leung, after considering the circumstances of Singh's detention and discharge and a further psychiatric report submitted by Singh, dismissed the application as he was not satisfied that "the applicant manages to establish that he has reasonably arguable grounds for saying that the nurse or any of the doctors … had acted in bad faith or without reasonable care in carrying out the matters in connection with his detention".[12]

We disagree with the Judge's decision to refuse leave. In the following sections, we argue that, not only should leave have been granted in this case, the Judge's reasoning throughout the judgment is also highly flawed. More importantly, it reflects a larger concern in the current Hong Kong mental health regime, namely that judicial scrutiny of the different compulsory powers wielded by medical professionals is inadequate or simply non-existent in many cases.

## 2. The threshold of "reasonably arguable grounds" under section 69

We begin by considering the approach that the Judge has taken in answering the question under section 69(2) of the MHO: whether there are reasonably arguable grounds, ie, realistic prospects of success, for contending that the nurse and doctors in this case had acted in bad faith or without reasonable care.

[11] *Po Fun Chan v Winnie Cheung* (2007) 10 HKCFAR 676, [15]. It is interesting to note that s 141 of the UK Mental Health Act 1959, upon which s 69 of the MHO was modelled, has since been replaced by s 139 Mental Health Act 1983. The wording of "substantial ground" is completely removed from s 139 and UK courts have chosen a very low threshold for granting leave of "whether the case deserves further investigation by the court", which the Court in *Chan Shek Him* explicitly decided not to follow: see *Seal v Chief Constable of South Wales* [2007] 1 WLR 1910 and *Chan Shek Him* (n 10 above). A fuller discussion about the propriety of the standard chosen by Hong Kong courts is beyond the scope of this paper.

[12] *Singh v HA* (n 1 above), [47].

We will, as the Judge did in the judgment, focus on the "reasonable care" limb of section 69(2), which presents a lower threshold than the "bad faith" limb. The current test for whether a medical professional has acted without reasonable care or, in other words, acted negligently, is set out in the *Bolam* case: "[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 … a man is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view."[13] Applying this standard, the Judge went through the different points of decision-making leading up to and during Singh's detention. It is our contention that the Judge failed to scrutinise the medical professionals' reasoning for these decisions and has effectively set an impossibly high threshold for a section 69 application.

*(a) The diagnoses and grounds for compulsory detention*

We begin by looking at the psychiatric diagnoses that supported Singh's admission to CPH and subsequent detention for almost a month. In the 17 paragraphs describing the circumstances leading up to and of Singh's detention, three main diagnoses are mentioned: the presumptive diagnosis of psychosis upon his first admission,[14] the "impression" of delusional disorder which led two doctors to recommend an extension of his detention,[15] and the principal psychiatric diagnosis of paranoid personality disorder eventually recorded on his discharge summary.[16]

[13] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[14] *Singh v HA* (n 1 above), [22].
[15] *Ibid.*, [24].
[16] *Ibid.*, [25].

It should first be noted that Singh's initial admission into hospital relied substantially upon others' report of his "active display of violence",[17] an observation of him being "agitated" when presented at TMH,[18] and, most importantly, "conflicting versions of the noises that [he] complained about".[19] Even though we are not qualified to say that this diagnosis of Singh at the time was erroneous, it is certainly dubious that merely having his perceptions doubted by someone else – and that someone else being his estate management, who had been engaged in a longstanding conflict with him over such noises – could be a sufficient basis for not only the finding that he had auditory hallucinations, but also the provisional diagnosis of clinical psychosis.[20]

More importantly, the mere presence of a mental disorder does not automatically warrant detention under section 31(1) of the MHO. The mental disorder must also be of a nature or degree which warrants such detention *and* there must be reason to detain the individual in the interests of his own health or safety or with a view to the protection of other persons. These criteria are not mentioned anywhere in the judgment. The primary rationale of detaining Singh, as stated by the nurse and doctors in the case, was ostensibly to "prevent the potential risk of the applicant harming the others".[21] Although the judgment is littered with references to Singh's "uncontrollable violent behaviour"[22] and seeming irritation and distress, the only verifiable instances of "violent" display on record are Singh's throwing of a stapler onto the ground on 9 or 10 October and throwing of the letter at the management

[17] *Ibid.*, [18].
[18] *Ibid.*, [16].
[19] *Ibid.*, [29].
[20] *See* David B. Arciniegas, "Psychosis" (2015) 21 *Continuum* 715 for further information on the diagnosis of psychosis.
[21] *Ibid.*, [18].
[22] *Ibid.*, [22].

staff on 12 October –[23] the first of these does not involve a physical act against people and the second would not have conceivably caused any actual harm to the staff involved. The construction of Singh's reactions and actions as pathological to fit the psychiatric diagnosis will be discussed further in Section 2(b) below. What is important to note for now is that there are serious questions to be raised about both arms of the justification for detaining Singh in the first place and it is concerning that the Judge made no reference to the requirements of section 31 at all when examining the nurse and doctors' reasoning in having Singh admitted to the hospital. It must be remembered that to compulsorily admit a person into psychiatric care is to subject them to a highly draconian regime involving the deprivation of their liberty and the administration of powerful, mind-altering drugs.[24] Looking at the scant evidence in this case, it is hard to see how Singh's so-called "violent" behaviour warrants drastic consequences of this kind.

In addition, the MHO does not provide for a *carte blanche* for medical professionals to keep patients under detention indefinitely once they have been admitted in the first place. Each instance of compulsory detention imposes a severe limitation on patients' fundamental rights and liberties and must be justified by reference to the conditions set out under the relevant section. The Judge, therefore, had the responsibility to ask the question of whether the medical professionals took reasonable care in applying for an extension of Singh's detention under section 32 as well. Section 32(1) requires two registered medical practitioners to be of the opinion that it is *necessary* for the patient under observation to be detained for a

[23] *Ibid.*, [13]-[14].

[24] The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment aptly described neuroleptics, or antipsychotics, as "mind-altering drugs" in its report on the protection of persons with disabilities from torture: "Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment" (28 July 2008) UN Doc A/63/175, para 40.

further period 'for the purpose of observation, investigation, and treatment'. Again, it is unclear from the judgment whether the Judge subjected the two doctors' reasoning to the test at all, as the doctors were only said to be "impressed" that Singh suffered from delusional disorder[25] and it is mentioned that although sometime during the first seven days of Singh's detention his family confirmed the existence of the noises, the diagnosis was presumably based on "the condition of [Singh] in coping with the subject of the alleged nuisance". [26] Aside from these vague observations, the Judge did not go into the reasonableness or logicality of the doctors' conclusion that it was necessary to extend Singh's detention in any detail, which is extremely troubling.

*(b) The relevance of context and biases in the psychiatric diagnostic process*

Singh's main argument for his case was that, as the nuisance he had been complaining of and which supposedly arose out of his psychosis / delusions did in fact exist, the diagnosis of his having delusional or paranoid personality disorder must have been wrong and the consequent detention wrongful. However, throughout the judgment, the Judge constantly downplayed the significance of the actual existence of the noise and the medical professionals' awareness of that fact, merely referring to the discharge summary which recorded that the doctors were focusing on Singh's "coping with the subject" in their assessment and that his condition did supposedly improve with the treatment.[27]

We submit that the Judge's approach was much misguided. The fact that the noise in question did exist not only cast great doubt on the correctness of the original diagnosis of delusional disorder, it also provided a crucial context in which Singh's

[25] *Singh v HA* (n 1 above), [24].
[26] *Ibid.*, [25], [34].
[27] *Ibid.*, [34].

displays of frustration and agitation should have been seen. Being disturbed by a persistent noise in one's home, "often during late night and the small hours of the day" and which causes one and one's family continued sleep deprivation over a lengthy period of time,[28] and having one's complaints to all of the different organisations and institutions he tried treated with indifference for two years would make the most mild-mannered of us extremely upset and angry, if not outright furious. One might even say that throwing things on the premises of those perceived as responsible for this state of affairs is within the "normal" range of human responses in this situation, even if it may not be the most advisable one. It is not without irony that the doctor who provided the initial certificate for Singh's initial admission opined that he "demonstrated uncontrollable violent behaviour … *when he felt that he had not been fairly treated*".[29] Conversely, Singh's signs of frustration and agitation upon his presentation at the hospital were only deemed pathological when seen as part and parcel of a diagnosis of psychosis – when the medical professionals realised that the auditory "hallucinations" were not a result of psychosis, then, is it really likely that those very same signs of distress on their own could ground a diagnosis of delusional disorder and later paranoid personality disorder? Of course, we cannot be certain without knowing the evidence on which these various changes to the diagnosis were made, which again the Judge did not make clear in his judgment.

The perceived "improvement" in Singh's condition, similarly, should not have been seen as an indicator of his supposed illness or the effectiveness of psychiatric treatment. If someone – mentally ill or not – were removed from a longstanding

[28] *Ibid.*, [11]. The extent of the disturbance was even such that Singh's mother had to leave to India.
[29] *Ibid.*, [22] (emphasis added).

situation of conflict and put on a course of psychiatric medication for an extended period of time, their "condition" would of course likely "improve" in the sense that they would seem less troubled by the conflict in question. There are also other reasons why a discharge summary would record an improvement in condition, such as the patient wanting to appear better so they would be discharged and the doctor's retrospective justification of the diagnosis, the possibilities of which the Judge failed to consider. Singh's case, therefore, seems like a classic case of "damned if you do, damned if you don't" in a psychiatric environment. Once detained in, or even presented at, the hospital with a label of being *potentially* mentally ill, whatever one does might easily be interpreted as a confirmation of that potential diagnosis. Had Singh not shown any "signs of improvement" but rather grown even more emotionally distressed during the course of his detention – which we now know would have been understandable given his deep-seated frustration from having his legitimate complaints ignored for years and the knowledge that his detention was grounded in non-existent hallucinations – he might have been detained further for his "worsening" mental state. In any event, it is wrong to justify a decision to detain someone under the MHO based on the perceived outcome of such detention. The question here is whether the doctors *exercised reasonable care* in their decision-making, not whether their decisions have turned out to be right or wrong, precisely because it is understood in medical law that whether a course of treatment appears to have a positive or negative outcome could be a fluke or accident and doctors should only be held liable when they have not exercised reasonable care. The fact that Singh's condition was recorded to have improved, then, cannot be used to show

the reasonableness of the initial decision to compulsorily detain and subject him to treatment.

The medical certificate by Dr Cheung produced by Singh as expert evidence further brings to light the dubiousness of the nurse and doctors' original diagnoses. Having examined Singh's mental condition in November 2017 and January 2018, Dr Cheung stated that, besides the noises that had been confirmed to be objectively real, "no other paranoid delusions or psychotic features could be established" and also that "the hallucinations of the applicant observed by the nurse and doctors at the material times were putative, in view of the conflicting versions [of events presented]". [30] Regrettably, the Judge rejected this report wholly for "lack[ing] relevance".[31] While it is true that a psychiatric evaluation today cannot be used to judge an individual's state of mind from more than two years ago, it may be relevant to an examination of whether a diagnosis had been entirely justified then. The fact that Singh showed absolutely no trace of any mental disorder two years after the discharge, despite not having received any psychiatric treatment since, for example, calls into question the validity of the diagnoses he received at TMH and CPH – delusional disorder and paranoid personality disorder are seen as disorders that are persistent in nature, the symptoms of which do not generally disappear without any clinical treatment or management.[32] In addition, Dr Cheung's expert opinion raises the possibility that the medical professionals involved in the extension of Singh's detention may have been affected by their pre-existing knowledge of the initial

[30] *Ibid.*, [40].
[31] *Ibid.*, [42].
[32] The ICD-10 classification of personality disorders describes these conditions as comprising of 'deeply ingrained and enduring behaviour patterns': World Health Organization, *ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*, p 156, available at https://www.who.int/classifications/icd/en/bluebook.pdf (visited 26 Aug 2020).

diagnosis of psychosis (even though its basis had been proven false) in their assessment of his outward behaviour.

Without questioning the professionalism and good faith of professionals working in psychiatry in Hong Kong in general, judges in these cases should be mindful of the inherent danger in psychiatric diagnostic procedures, which rely heavily on professionals' interpretation of an individual's outward behaviour and where confirmation bias – an all-too-common human error – may easily come into play.[33] This danger extends to other biases in psychiatry pertaining to gender, race, and social class as well, given the long and complex history of interactions between the medical, sociocultural, and legal definitions of mental illness which means that certain perceived traits have become more closely associated with certain disorders than others.[34] Such biases are especially concerning in assessments such as those under the MHO compulsory regime, where an individual's risk of harm to others is also under consideration – "risk", "aggression", and "dangerousness" being concepts which are, again, very much culturally and racially loaded in both psychiatry and everyday life.[35] Therefore, when faced with cases where the psychiatric diagnosis and finding of risk rely solely on conflicting reports and brief periods of observation without more (for example, a previous history of mental illness or corroborating information from people who know the individual well), judges must be especially vigilant in subjecting each assessment prior to and during the compulsory detention

[33] Jeffrey Poland and Paula J. Caplan provides a framework for exploring the different types of bias that often come into play in psychiatric diagnoses: "The Deep Structure of Bias in Psychiatric Diagnosis" in Paula J. Caplan and Lisa Cosgrove (eds), *Bias in Psychiatric Diagnosis* (Lanham: Jason Aronson, 2004) Ch 2.

[34] For example, Jill A. Cermele et al's analysis of the DSM-IV casebook shows that the case studies contribute to a gendered and racialised conceptualisation of mental illness, reflecting "whiteness" and socially sanctioned descriptions of women and men as normative points of reference: "Defining Normal: Constructions of Race and Gender in the DSM-IV Casebook" (2001) 11 *Feminism & Psychology* 229.

[35] For example, research in both the United States and United Kingdom has found that black patients are more likely than white patients to be attributed traits of being violent, suspicious, and dangerous by clinicians, even with similar case histories and information: Suman Fernando, *Mental Health, Race and Culture* (Basingstoke: Palgrave, 2nd edn, 2002), p 119-120.

to close scrutiny, including the possibility of any racial or cultural biases at play, keeping in mind the drastic deprivation of liberty and rights that would result for the patient.

*(c) Conclusions on the judge's approach*

As demonstrated above, the judge essentially failed to scrutinise any of the decision-making concerning Singh's detention. In relation to the nurse who initially received Singh at TMH and recommended further psychiatric assessment, he wrote: "the assessment was not merely the nurse's personal preference between two conflicting versions of events … That was her exercise of *professional judgment*, which she has trained to do."[36] He also addressed Singh's claim that the management office misinformed the nurse and doctors of the facts: "If that was indeed the case, it would be difficult to see how the nurse and the doctors should be to blame for being so allegedly misled at the material times."[37] Of the doctor who signed the certificate for Singh's admission under section 31, which was based on a presumptive diagnosis of psychosis and Singh's supposed potential risk of harm, the Judge wrote: "that was *professional judgment* on the basis of the information available to the doctor and his observation then and there."[38]

As a result, all that seems to be required by the Judge for a medical professional's action to be deemed "reasonable" is for it to be a within the "professional" remit of the personnel, despite the glaring weaknesses reflected in each step of the detention process we have highlighted above. What then, can ever meet the threshold of "acting without reasonable care", if a court will not go into the reasonableness of any decision taken in a professional capacity at all? The very

[36] *Singh v HA* (n 1 above), [31] (emphasis added).
[37] *Ibid.*, [30].
[38] *Ibid.*, [32] (emphasis added).

purpose of having a special test for clinical negligence is so that courts will not be "impos[ing] liability on hospitals and doctors for everything that happens to go wrong".[39] The line for what counts as a "reasonable", even if wrong, decision then surely needs to be drawn somewhere *within* that remit of "professional judgment". This very principle is set out in *Bolitho*: "if … it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that body of opinion is not reasonable or responsible."[40] Unfortunately, this crucial addition to *Bolam* is completely absent from this case.

It is trite to say that frontline medical staff in public hospitals work under enormous time pressure. This pressure is all the heavier when it comes to cases where someone is suspected to present a risk of physical harm to others. However, the powers medical professionals have under the MHO in compulsorily admitting and treating patients have extensive and far-reaching effects on their fundamental rights and liberties and must therefore be wielded carefully. Given the questionable nature of the grounds for Singh's initial diagnosis and detention, it is at least reasonably arguable that reasonable care had not been exercised here. Indeed, it is far from obvious that the decision to use section 31 to compulsorily admit Singh at this point was necessary, when there was no clear evidence that his auditory "hallucinations" were hallucinations and, even if they were, the "violent" behaviour exhibited by him did not show a level of risk nearly high enough to necessitate him being locked away for the protection of others. The case for lack of reasonable care in relation to the continued detention of Singh after the noises were verified is equally if not more compelling – the diagnoses of delusional disorder / paranoid personality disorder

[39] *Roe v Minister of Health and Another* [1954] 2 QB 66 (Denning LJ), as cited in *Bolam* (n 13 above).
[40] *Bolitho v City and Hackney Health Authority* [1997] UKHL 46 (Lord Browne-Wilkinson).

were highly suspect in light of the apparent lack of other supporting evidence, which the Judge should have questioned in detail, and the possibility of confirmation bias on the part of medical professionals.

Moreover, it should be kept in mind that the question this judgment should be answering is whether there are *reasonably arguable grounds* for arguing that the medical professionals in the case did not exercise reasonable care, which, presumably, is different from and has a lower threshold than the question to be answered at the full hearing, of whether the professionals did or did not exercise reasonable care. As both Hong Kong and UK courts have emphasised, the requirement to apply for leave before commencing an action against professionals acting in pursuant of the MHO or the equivalent English legislation is intended to protect these professionals from frivolous or vexatious claims, given that the diagnosis of mental illness, which relies largely on professionals' evaluation of symptoms, is prone to generating controversy.[41] At the same time, it is recognised that this requirement touches on the fundamental right to access to courts and "[b]lanket provisions, which catch a great many cases in which the restriction is not justified in order to catch the few where it may be, require particularly careful scrutiny".[42] As Baroness Hale, before she was appointed to the bench, wrote in relation to section 139 of the Mental Health Act 1983: "patients are in a peculiarly powerless position which merits, if any, extra safeguards rather than the removal of those available to everyone else".[43]

[41] *Chan Shek Him* (n 10 above) [53], [57].
[42] *Seal v Chief Constable of South Wales Police* [2007] 1 WLR 1910, [59] (Baroness Hale), also cited in *Chan Shek Him* (n 10 above).
[43] Brenda Hoggett, *Mental Health Law* (London: Sweet & Maxwell, 4th edn, 1996), p 250.

It is therefore a shame that the Judge had not subject the present case to any, let alone close, scrutiny at all. Singh has been treated most unjustly at every stage of this unfortunate case – by his management, who refused to hear his complaints; by the medical professionals, who refused to hear his side of the story; and now by the CFI, which refused him the right to have his grievances heard fully in the District Court. It can hardly be said that justice has been done by section 69, which is supposed to protect medical professionals from, not *all* claims, but only unfounded ones – and we submit that this claim, made by a man driven to a state of intense frustration by incessant noises over the years and labelled as mentally ill simply because he expressed his anger over it, is one which is founded on reasonably arguable grounds and merits full consideration by a court.

**3. Concluding remarks**

Our analysis has shown that the judgment in *Bhatti Bhupinder Singh v Hospital Authority* is highly unsatisfactory, in that the Judge has failed to challenge the weak grounds for compulsory detention provided by the medical professionals, disregarded a crucial factual context in the case, and adopted, on the whole, an impossibly high standard that the applicant had to meet in order to be granted leave to have his case heard in full in the District Court.

This is, unfortunately, not the first time judges in Hong Kong have decided to hem in the power of judicial scrutiny under the MHO. Deputy Judge Leung's total refusal to question medical professional judgment is reminiscent of Hartmann J's opinion in *The Hospital Authority v A District Judge*, a case about the District Judge's

role in countersigning applications for long-term detention under section 36 of the MHO, where he stated: "The judge or magistrate is, of course, much more than a rubber stamp. But that does not mean that he is entitled to question the medical validity of opinions expressed if those opinions comply, on their face, with the relevant section of the Ordinance."[44] In the original case concerned, *Re Patient O*, Judge Li did precisely what Deputy Judge Leung did not do in this case – question the reasons behind doctors' opinion that the patient required detention under the section.[45] If judges can do no more than examine the formal compliance of doctors' certificates with the MHO, what exactly sets them apart from rubber stamps? One may also argue that it is, in fact, impossible to assess an application form's compliance with the MHO without examining closely the doctors' opinion, because the MHO is concerned not with purely "medical" diagnoses or opinions, but ones that have legal definitions and serious legal consequences.[46] Judges in these cases must remember that compulsory detention and treatment are extremely violating and are often traumatic experiences for patients, who are stripped of their dignity and the ability to have any semblance of control over their lives, in terms of both the liberty to come and go as they please and the autonomy to make decisions about their own care and treatment. As with any questions concerning fundamental rights and liberties, proportionality is the principle to be always kept in mind: any public safety concerns in light of "violent behaviour" must take into account the grave physical, psychological, and social costs borne by the individuals concerned.

[44] *The Hospital Authority v A District Judge* [2001] HKEC 1657, [27].
[45] *Re Patient O* [2001] HKEC 509.
[46] *See also* Daisy Cheung, "The compulsory psychiatric regime in Hong Kong: Constitutional and ethical perspectives" (2017) 50 *International Journal of Law and Psychiatry* 24.

The refusal of the judiciary to seriously scrutinise and critique medical opinions has severe consequences for individuals subject to the compulsory mental health regime, who are in a very vulnerable position in relation to the professionals in charge of them. Persons perceived as having a mental illness are usually those who are already marginalised and stigmatised in society, and for various reasons are often disbelieved by professionals in the clinical setting as well.[47] When such persons believe that they have been treated wrongfully or negligently, the courts are the only avenue they have to have their cases reviewed to ensure the deprivation of their rights and liberties has been justified. If the judiciary is no more than a rubber stamp, they will be left with absolutely no safeguards against the possibility of abuse. The case of Singh, built completely upon auditory hallucinations that were later proven false, is the prime case to be put forward for a claim of wrongful diagnosis. If this case is unable to meet the threshold of "reasonably arguable grounds", we contend that section 69 as it currently stands leans too much in favour of protecting medical professionals from claims of negligence in their implementation of the MHO, to the point it is essentially impossible for a case to ever be granted leave under this section. The consequences of this are grave: the court's refusal to grant leave means that the individual involved will not even have the *opportunity to have their case heard fully in court*. With no alternative avenues to address wrongful treatment, this is a devastating outcome.

[47] The power disparities between patients and psychiatrists are analysed in Michael McCubbin and David Cohen, "Extremely Unbalanced: Interest Divergence and Power Diversities Between Clients and Psychiatry" (1996) 19 *International Journal of Law and Psychiatry* 1.