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Recalibrating a doctor's duty to advise

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Section 37 of the Civil Law Act

The past two decades have witnessed significant developments in the area of a doctor's duty to advise his patient. Whilst observers are still digesting the full implications of the Hii Chii Kok modifications to the Montgomery test, the legal position has been altered yet again, this time by the statutory addition of s 37 of the Civil Law Act. This article examines the changes and their implications.

Introduction

Judicial Formulations of a Doctor's Duty to Advise

The question of what a doctor is required to disclose to the patient is a difficult and evolving one and is part of the backdrop of a doctor's composite duty of diagnosing, advising and treating his (or her) patient. Traditionally, the stance is that medical science is a very complicated subject and a doctor, in his paternalistic way, will do what, in his view, is in the best interests of the patient. Judges, not being medically trained, should be slow to scrutinize the decisions and actions of a doctor. A doctor lives up to the standard of care if he passes the *Bolam*[1] test – whether his practice accorded with a 'substantial and respectable' body of opinion in his field.

However, over time, it was thought that, along with the advancement of society, patients have become more knowledgeable and are keen to play a larger role in the decision as to treatment. In the UK, the House of Lords in *Sidaway v Bethlehem Royal Hospital*[2] made the qualification that the *Bolam* protection would not avail if there was a "substantial risk of grave adverse consequences" such that disclosure was "so obviously necessary to an informed choice" that "no reasonably prudent" doctor would fail to disclose it.

A few years later, the House of Lords in *Bolitho v City & Hackney Health Authority* laid down the important qualification that the application of the *Bolam* test is subject to an additional requirement (hereafter, the *Bolitho* addendum) – the Court has to be satisfied that the accepted practice had a "logical basis", in that the experts had "directed their minds" to the comparative risks and benefits and reached a "defensible" conclusion. (Two points to note here. One, the addendum has some slight resemblance to the *Sidaway* qualification but is really quite different. Two, the *Bolitho* addendum qualifies not just advice but diagnosis and treatment as well.)

Finally, in 2015, in the watershed decision of *Montgomery v Lanarkshire Health Board*,[3] the UKSC radically changed the law and held that a doctor owes his patient a duty to disclose all material risks of a propose treatment and of alternative treatments, and elaborated upon this paradigm.

The Hii Chii Kok Decision

Two years later, the Singapore Court of Appeal had the opportunity to revisit this issue in *Hii Chii Kok v Ooi Peng Jin London, Lucien* (hereafter, ***HCK***).[4] Singapore's apex court decided that it was time to move towards patient autonomy and informed decision. Chief Justice Menon cited with approval the following passage from *Montgomery*:[5]

> The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether… a reasonable person in the patient's position would likely attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The Court, however, modified[6] *Montgomery* and introduced a three-stage inquiry of:

- whether there was material information which was not disclosed,
- whether the doctor was aware of the information and, if not, was he negligent in not having the information, and
- was the doctor reasonably justified in not disclosing.

Of the modifications, the more notable ones are that the *Bolam* test applies at stage two when ascertaining whether the doctor is negligent for not having the information because he used a different mode of testing and also in stage three in deciding whether the emergency exception excuses the doctor.

The Disciplinary Tribunal Excesses

Even before the *HCK* decision, the Singapore Medical Council had, in 2016, introduced new ethical standards in the form of the Ethical Code and Ethical Guidelines (**ECEG**) and the Handbook of Medical Ethics (**HME**), raising the bar on ethical expectations.

As the medical profession was anxiously grappling with the applications and implications of the new legal standards and ethical standards, the SMC Disciplinary Tribunal (**DT**) case of Lim Lian Arn[7] came to the fore. In that case, to the astonishment of doctors, the DT imposed the maximum fine (of $100,000) on Dr Lim for a relatively simple procedure with minor negative side effects. The uproar intensified months later in the DT case of Soo Shuenn Chiang,[8] this time on breach of confidentiality. The medical profession was in disarray on two counts – uncertainty over the new standards of disclosure and distrust in the medical disciplinary process.

The Workgroup Consultations and Recommendations

To deal with the exigencies of the situation, the Ministry of Health (**MOH**), on 13 March 2019 appointed a Workgroup to review the taking of informed consent and the SMC disciplinary process. The Workgroup conducted over 30 consultation sessions, involving more than 1,000 doctors from diverse backgrounds. While these consultations were taking place, the DT decisions of Dr Lim and Dr Soo were overturned by the High Court in July and October respectively,[9] adding to the intensity of the furore.

In November 2019, the Workgroup presented its 100-page Report[10] on the two related urgent matters. As regards informed consent, the Workgroup made three recommendations:

1. Provide a clear legal standard for medical professionals' duty to advise which is one that is patient-centric but ultimately based on the opinion of a responsible body of doctors.

2. Revise the SMC's ECEG provisions on informed consent down to basic irreducible principles, with helpful illustrations to guide doctors on how these principles apply.
3. Develop nationally agreed specialty-specific guidelines to deal with standard commonplace procedures in each specialty.

The government accepted these recommendations and introduced section 37 of the Civil Law Act to bring to pass recommendation one.

The New Legal Position

The Impetus for Section 37

In the Opening Speech for the Second Reading of the Civil Law (Amendment) Bill) (and the Medical Registration (Amendment) Bill), Minister Edwin Tong explained the rationale for the need for change, highlighting some of the concerns expressed in the Workgroup Report.

As a start, he pointed out that the practice of medicine revolves around the patient-doctor relationship for which trust is an important element. The patient needs to trust that the doctor will do what is best for the patient; and to the doctor, the interests of the patient must be paramount. At the same time, the doctor needs to trust the system that regulates the medical profession.[11]
The introduction of the new legal standard by *HCK* (and the ethical standard by ECEG) had ushered in a period of great uncertainty as to what a doctor needs to disclose to his patient in each specific case. As mentioned earlier, this anxiety was exacerbated by the harsh outcomes in the DT decisions of Lim Lian Arn and of Soo Chuenn Chiang and led to a breakdown in the trust in the disciplinary process.

Instead of facilitating informed decision, the uncertainty and anxiety resulted in defensive practices on the part of doctors, the foremost of which was information dumping. As the Minister explained:

> Patients are not necessarily better informed. On the contrary… they are now increasingly inundated with information and are none the wiser.

Other negative consequences included lengthy consultation times, reluctance to guide patients' decision-making, sending patients for more tests (to avert the suggestion that some other test should have been suggested or done), refusal to treat and instead referring the patient to another doctor,[12] rising insurance and medical costs, undue stress on doctors and, overall, an erosion in of trust in the doctor-patient relationship.[13]

Hence the urgent need to set a clear standard for the giving of medical advice and to restore trust in the system.

The Section 37 Legal Regime

Section 37 says many things, the foremost of which are:

1. In providing medical advice, a doctor must give material information which he knows or ought reasonably to know is required for informed decision by the patient, and which addresses the patient's express and apparent concerns, unless there is reasonable justification not to give the information: section 37(2).
2. The manner in which the information is given must accord with peer professional opinion in that it is accepted as reasonable professional practice by a respectable body of medical opinion: section 37(1)(a).
3. The peer professional opinion must be logical – the respectable body must have directed its mind to the comparative risks and benefits and the opinion must be internally consistent must not contradict the extrinsic facts: section 37(5). The peer professional opinion may be relied upon even if there are differing opinions within the medical profession: section 37(4).
4. A patient's apparent concerns are those which a patient does not expressly communicate but which ought to be apparent to the doctor from the patient's records which the doctor has reasonable access to and ought reasonably to review: section 37(3).
5. The requisite information includes information which is important to the particular patient for his own reason, including an idiosyncratic reason: section 37(2)(a)(ii) expl.
6. Reasonable justification for not giving material information includes emergency (section 37(2)(b) ill. a) and waiver (section 37(2)(b) ill. b) but does not cover a situation where the doctor does not disclose because he is of the view disclosing the risks would dissuade the patient from undergoing a treatment which the doctor thinks is in the patient's best interests (section 37(2)(b) ill. c).
7. The material information can be given directly or indirectly[14] by the doctor: section 37(2)(a).
8. Section 37 applies to healthcare professionals, namely registered medical practitioners and registered dentists (section 37(6)) and the duty to a patient includes a duty to a person who is responsible for making a decision for the patient: section 37(6).
9. The common law on the subject continues to apply where it is not inconsistent with section 37: Explanatory Statement of the Amendment Act).

Comments

Section 37 and HCK

Section 37 partly confirms *HCK* and partly departs from it.

Proposition one confirms the stance in *HCK* (and *Montgomery*) that, as a general principle, a doctor owes a duty to his patient to inform him of material risks and benefits of the proposed treatment and (implicitly) of alternative treatments. It also confirms the *HCK* fault thresholds of actual knowledge and constructive knowledge ("ought reasonably to know").
Proposition two moves the yardstick of assessment of a doctor's disclosure back to the doctor-centric *Bolam* test. It should be noted that the statutory formulation of the test omits the term 'substantial' and appears to signal a relaxation as to the size of the body of the peer professional opinion.
Proposition three is a faithful encapsulation of the *Bolitho* addendum. It is likely that the statutory formulations of the *Bolam* test and the *Bolitho* addendum, though specifically addressing advice, will be referred to by courts even in cases on diagnosis and treatment.
Proposition four, consistent with *HCK*, requires the doctor to pay heed to the patient's concerns and elaborates on what are apparent concerns, expecting the doctor to do what is reasonable in the circumstances.
Proposition five echoes the words of Menon CJ in *HCK*, that the material information includes that which is important to the particular patient "for his own (idiosyncratic) reasons".[15]
Proposition six adopts the *HCK* stance of "reasonable justification" as regards exceptions to a doctor's duty to advise and it appears that the *HCK* view that the justifications are not restricted to emergency, waiver and therapeutic privilege continues.[16]

Proposition seven, as it relates to the indirect giving of advice or information, accords with reasonableness and pragmatism.

Proposition eight specifically extends the duty of advice legal framework to dentists as well.

So, how has section 37 changed or modified the *HCK* legal regime?
Well, section 37 affirms the aspiration of moving towards patient autonomy and informed decision but does so in a more cautious fashion. Rather than leaving it to the courts to scrutinize a doctor's discharge of his duty, as is the position under *Montgomery*, section 37 adopts a more balanced approach. It reinstates the doctor-centric *Bolam* test but at the same time counter-balances this with the *Bolitho* addendum of logic, allowing the courts some oversight as to the peer professional opinion.
And, in applying the new legal regime to a case at hand, the *HCK* three-stage enquiry may be employed. However, it is now clear that the *Bolam-Bolitho* (joint) test will apply to all aspects of the duty to advise.[17]

Continuing HCK Propositions

The Explanatory Statement to the Bill makes it clear that the common law, to the extent that it is not inconsistent with section 37, will continue to apply.

On this count, following *HCK*, the broad types of information which should be disclosed in order to facilitate informed decision are:[18]

- the doctor's diagnosis of the patient's condition;
- the prognosis of that condition with and without medical treatment;
- the nature of the proposed treatment;
- the risks of the proposed treatment; and
- the alternatives to the proposed treatment and the advantages and the risks of those alternatives.

and the assessment of materiality takes into account factors such as:

- magnitude of risk;
- nature of risk;
- effect upon the life of the patient;
- importance to the patient of the benefits sought to be achieved by the patient;
- alternative treatments and their risks to that patient; and
- characteristics of the patient.

Likewise, the legal expectation is still that the information which the doctor provides should be comprehensible and should facilitate understanding.[19] The words of Menon CJ bear repeating here:

> … a doctor is not under a duty to provide his patient with an encyclopaedic range of information in relation to anything and everything which the patient might wish to know. Instead, a doctor's duty to advise only covers that which would enable the patient in question to make an informed decision.[20]

Rather, the doctor discharges his duty by conveying to the patient the "gist" of the relevant information, "without an unnecessary and overwhelming amount of detail accompanying it".[21] Bombarding or inundating[22] the patient with technical information or routinely requiring signature on a consent form would not fulfil the duty.

Also, in ascertaining if a doctor had been negligent in his duty in a particular case, it is important to guard against hindsight and outcome bias, as Menon CJ counselled in *HCK*; courts should apply the test with reference to the facts that were known at the time of giving the advice and not at the time when the harm to which the risk pertains has eventuated.[23]

But there are aspects, on which section 37 is silent, and it is uncertain what the new legal position is on these issues.

First, section 37 does not mention whether the costs of the alternative treatments should be disclosed. The HME, in contrast, says specifically: "The costs of tests should also be disclosed, especially if the tests are expensive or you are aware that the patients view such information as important."[24]

Second, the section does not elaborate upon patient autonomy and informed decision. Specifically, it does not point out that informed decision is not synonymous with good decision. In this regard, one should note section 3(4) of the Mental Capacity Act, which provides that 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision'.

The ECEG and HME are more specific and state, for example, that:

> You must accept patients' decision… even if you disagree with them, but you must ensure that patients have sufficient information to understand the consequences of their decision: C5(2) ECEG;
>
> You are obliged to respect the choices of competent patients who refuse consent for investigations and treatment even if such refusal will be harmful or life-threatening to themselves, or could even lead to death: C6.3 HME.

Third, section 37 does not specifically address the possibility of the doctor declining to treat. The ECEG, in contrast, states at para C3(4):

> If despite your best explanations patients persist in demanding treatment that you strongly disagree with, you may find yourself unable to continue providing care.

More poignantly, HME at para C6.3 states:

> For patients who refuse information relating to consent taking, you should… seriously consider whether it is appropriate to provide the treatment at all.

Both these injunctions are faithful applications of the objective of facilitating informed decision.

Finally, the ascertainment of material information, it is often said, is largely a matter of common sense. It is noted, that in this connection, Menon CJ remarked in *HCK* that "it is conceivable for even a very severe consequence to not require disclosure if its chances are so low that the possibility is *not worth thinking about*" (italics added).[25] Likewise, he thought it was not necessary to disclose risks which are obvious to a reasonable person in the patient's position. Both these propositions can be controversial as they may exclude material risks which may be commonly known or obvious but which the patient may not be aware of. The status of these propositions is unclear in the section 37 framework.

Upcoming Developments

As recommended by the Workgroup, the new legal regime is to be bolstered by two other developments – the revision of the ECEG[26] provisions on informed consent by paring them down to "basic irreducible principles", and the crafting of nationally agreed guidelines on informed consent, as applied to specialties and situations.

As regards the first development, Annex F of the Workgroup Report gives a draft ECEG on informed consent. It remains to be seen what the final form will take and whether the provisions on other disclosure issues covered by the current ECEG and HME will be revised.

The second anticipated development is of equal importance. Whilst the section 37 framework and its constituent principles are reasonably clear, it remains a real challenge for the individual doctor who strive to give advice in a reasonable and professional manner to a whole spectrum of patients in respect of a myriad medical conditions on the testing/treatment options and the attendant risks and benefits.

Achieving the Objectives of the Change in Law

The key objective of the new section 37, in the words of the Workgroup and of the Minister, is to set a "clear standard" as to a doctor's duty in giving advice. The hope is that the provision of this clear standard would go some way in alleviating the existing problems of uncertainty and anxiety amongst doctors over the requisite disclosure, the prevalent inundation of information and other defensive medicine practices, and the resultant perplexity on the part of patients.

For sure, section 37 sets a new standard and one which is more accommodative towards doctors. The resurrection of *Bolam* would no doubt assuage the fears of doctors to some degree. But is the new test a clearer one and would it conduce to patient understanding and informed decision? This question is not easily answered, and for several reasons.

First, although the section 37 principle of material disclosure is similar to *HCK* and is reasonably clear, the scrutiny of its application to a specific scenario is governed by the delicately-balanced *Bolam-Bolitho* test. The difficulty is in predicting when a court would conclude that the peer professional opinion crumbles in the crucible of logic.

Second, in addition to the general principle and the sub-principles of disclosure, guidelines are much needed to assist doctors as they seek to comply with their legal obligation in specific situations. So, a major piece of the composite framework remains to be crafted. At the same time, it needs to be reiterated that the guidelines, when they are eventually issued, are just "a source of reference" or a "baseline" and that the non-adherence to them does not necessarily mean there is misconduct just as adherence is not conclusive that the doctor is not negligent.[27]

Third, the conduct and the manner of due diligence on the part of the doctor is influenced by both legal standards and ethical standards. It remains to be seen how the ethical standards will be revised. Here, it should be pointed out that, the natural order is that the ethical standard is higher than legal standard and one puzzles over the apparent intention to bring the ethical standard down to the legal standard.

Relatedly, the amendments to the Medical Registration Act will bring about a new disciplinary process and system, which will take time to be worked out. As that occurs, the complementarity between the legal regime and the disciplinary regime will evolve.

Finally, the attainment of patient's understanding and informed consent depends as much on the patient as it does on the doctor. There is wide variation in both the ability to understand and the appetite to participate in decision-making and in administering the new composite framework, a great deal of flexibility, discernment and pragmatism is required.

Concluding Remarks

Patient autonomy and informed decision are worthy aspirational goals for an advanced society such as Singapore. But the implementation of change is never an easy thing. Flexibility and wisdom are required for a variety of reasons, including:

- the width, depth, complexity and mystery of medical science, and the compendious range of medical conditions and their treatment options and their accompanying risks and benefits;
- the spectrum of patients, in terms of the ability to understand diagnosis and prognosis and the desire to participate in the treatment decision;
- the extent to which the doctor's temperament, experience and other attributes lend themselves to a constructive communication of information and the facilitation of informed decision; and
- other peculiarities, constraints and sensitivities of the situation at hand.

Further, it is not a dichotomous choice of doctor decides or patient decides; instead, it is a quest of finding the optimal balance of joint or collaborative decision-making,[28] with the proportion varying according to the circumstances of the case. And the assessment of whether, in a given case, the doctor had given the appropriate advice must be sensitive to the needs of the situation. While it is right to recognise the complexities of medical science and to defer to peer professional opinion, there is a need to provide some check on this privilege. To this end, the following words of Menon CJ in *HCK* are a good reminder:[29]

It is therefore incumbent on us to reconsider the advice aspect of the relationship through the lens of patient autonomy *as well as* the principle of beneficence and ensure

that *both* principles are upheld. There must be a balance of both principles…; neither should dominate the other. (italics original)

Section 37 of the CLA recalibrates the legal requirements of a doctor's duty to advise his patient, partly endorsing and partly changing the HCK legal position. While still expecting the doctor to give material information in order to facilitate informed decision, the yardstick is that he should do so in a manner which is reasonable and professional. If a doctor acts in a way which is acceptable to his peers and which passes the judicial filter of logic, he has discharged his duty.

But the application of general principle to the myriad practical situations can be a very challenging matter and, to this end, the anticipated nationally agreed guidelines, along with the appropriate changes to the disciplinary process, will play a critical role in the ambitious but worthy objective of lifting society to the higher plane of informed decision in medical treatment.

For sure, the aspiration of informed decision is a laudable but very challenging one.

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