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Examining the New Standard of Care for Medical Advice and Patients with Mental Health Conditions

Gary Kok Yew Chan*

In 2017, the Singapore Court of Appeal in Hii Chii Kok v Oii Peng Jin London Lucien (Hii Chii Kok) favoured a patient-centric approach towards issues of providing medical advice. Section 37 of the Singapore Civil Law Act, which took effect on 1 July 2022, stipulates that the standard of care in giving medical advice to patients is based on peer professional opinion. This article will analyse, with reference to other common law jurisdictions, how the new statutory provision applies to patients with mental disorders under the Singapore Mental Capacity Act 2008. It will provide an interpretation of s 37 of the Civil Law Act taking into consideration the likely challenges encountered and issues raised by patients including those with mental health conditions, the value of protecting patient autonomy, their participation in decision-making, the quality of the doctor-patient communication and the scope of therapeutic privilege.

I. INTRODUCTION

The lack of, or inadequacy, of the medical advice given by doctors to patients is one of the common allegations in medical negligence. Where the doctor negligently failed to provide medical advice to the patient, the patient is entitled to claim for personal injury that is attributable to the negligent advice.

Without the requisite medical advice given to patients, they would not be able to make informed decisions about their own health, which is a crucial aspect of patient autonomy and liberties.[1] This might be challenging in situations where the patients' cognitive capacity to understand and/or retain the information provided by doctors has been significantly impaired. Apart from cognitive problems, certain patients may experience attendant emotional disturbances that can affect their ability to receive and process the information and advice from the doctors. Further, the patient may possess a reduced capacity to weigh the risks and benefits, or to communicate their desires and preferences to the doctor. Persons with mental disorders associated with social stigmatisation[2] may be especially vulnerable. For particular groups of patients with diagnosed psychiatric conditions such as schizophrenia or depression[3] there might be a need to take note of suicide risks and how medical consultations and advice can address and alleviate the risks. Hence, there is a need to consider the application of the legal standard of care in negligence in respect of medical advice to patients with mental disorders or other mental health conditions and to recognise their autonomy and rights to participate in decisions concerning their health as far as possible.[4]

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[1] J Coggon and J Miola, "Autonomy, Liberty and Medical Decision-making" (2011) 70 *Cambridge Law Journal* 523; E Cave, "Selecting Treatment Options and Choosing between Them: Delineating Patient and Professional Autonomy in Shared Decision-making" (2020) 28 *Health Care Analysis* 424. See also *Chester v Afshar* [2005] 1 AC 134; [2004] UKHL 41; and *Chappel v Hart* (1998) 195 CLR 232; [1998] HCA 55.

[2] S Talukdar, "Ensuring Risk Awareness of Vulnerable Patients in the Post-Montgomery Era: Treading a Fine Line" (2020) 28 *Health Care Analysis* 283.

[3] JY Thong et al, "Suicide in Psychiatric Patients: Case Control Study in Singapore" (2008) 42 *Australian and New Zealand Journal of Psychiatry* 509, 519.

[4] See, eg, the United Nations Convention on the Rights of Persons with Disabilities which aims to ensure that persons with disabilities can participate in society on an equal basis. Singapore ratified the Convention in 2013: see Report of Singapore,

The assessment of medical advice, which may involve disclosing information of potential side effects of antipsychotic medication and the efficacy of psychotherapies,[5] would depend to a considerable extent on the doctor's prevailing knowledge of the patient's symptoms and the treatment options. In addition to physical examinations, one important aspect that should not be overlooked is the patient's subjective lived experiences as communicated to the psychiatrist.[6] A patient may be diagnosed with a mental disorder based on clinical standards and guidelines such as the International Classification of Diseases[7] and the Diagnostic and Statistical Manual of Mental Disorders[8] as well as assessments by psychiatric experts. Other patients may experience mental health challenges such as symptoms of anxiety or depression that fall short of a clinically diagnosed mental disorder.[9] Treatment options may include medication, psychotherapies and other supportive therapies, dietary supplements or a combination of treatments.

The common law approach to medical advice to patients generally has transitioned from one premised on medical paternalism that the "doctor knows best" to a more patient-centric approach incorporating the patient's perspective and role in matters involving their personal health. In the past, the *Bolam v Friern Hospital Management Committee* (*Bolam*) test[10] prioritised the views of a responsible body of medical opinion on acceptable practices, and the *Bolitho v City and Hackney Health Authority* (*Bolitho*) addendum[11] placed a restriction on the medical opinion by requiring that it satisfy the court as to its logic. *Bolam* itself was concerned with a mentally ill patient, and the doctor's failure to warn of risks of bone fracture associated with the use of electro-convulsive therapy without the administration of a relaxant drug. Medical paternalism in the *Bolam* test remained the guiding principle in Singapore through to the new millennium.

In 2002, the Singapore Court of Appeal decision in *Khoo James v Gunapathy d/o Muniandy* (*Khoo James*)[12] applied the *Bolam* and *Bolitho* tests to deny the patient's claim against the neurosurgeon for negligent advice on the risks of neurosurgery to remove a brain tumour. Yong CJ famously issued the caution in *Khoo James* that "judges and lawyers should not play at being doctors".[13] Though Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* (*Sidaway*) [14] had advocated the reasonable, prudent patient test, it was not until the United Kingdom (UK) decision in *Montgomery v Lanarkshire Health Board* (*Montgomery*)[15] that the *Bolam-Bolitho* standard was finally jettisoned with respect to medical advice. Prior to *Montgomery*, a number of common law

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"Initial Report Submitted by Singapore under Article 35 of the Convention, Due in 2015: Convention on the Rights of Persons with Disabilities" (UN Human Rights Office of the High Commissioner, CRPD/C/SGP/1, 2018). On Singapore's communitarian approach to the Convention, see H Chua, "The Voluntary Sterilisation Act: Best Interests, Caregivers and Disability Rights" (2022) *Medical Law Review* 1, 6.

[5] M Yousif, "Montgomery v Lanarkshire Health Board: Implications of the Supreme Court Ruling for Psychiatry" (2016) 22 *Clinical Risk* 30, 31.

[6] WC Torrey and RE Drake, "Practicing Shared Decision Making in the Outpatient Psychiatric Care of Adults with Severe Mental Illnesses: Redesigning Care for the Future" (2010) 46 *Community Mental Health Journal* 433, 436.

[7] See World Health Organization, *International Classification of Diseases 11th Revision* <https://www.who.int/standards/classifications/classification-of-diseases>.

[8] American Psychiatric Association, *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* <https://psychiatry.org/psychiatrists/practice/dsm>.

[9] The issue as to whether these patients possess decision-making capacity in respect of their health matters or otherwise will be discussed below: see Part III.

[10] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[11] *Bolitho v City and Hackney Health Authority* [1998] AC 232.

[12] *Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024.

[13] *Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024, [3].

[14] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871; [1985] 2 WLR 480.

[15] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768; [2015] UKSC 11.

jurisdictions including Australia,[16] Canada,[17] Malaysia[18] and the United States[19] had already endorsed a patient-centric approach.

In lieu of *Bolam-Bolitho*, the *Montgomery* decision was premised on the materiality of information, that is "whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to 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 UK Supreme Court held that the doctor was negligent in failing to disclose to Mrs Montgomery, who was diabetic, the material risks of shoulder dystocia arising from a vaginal delivery, which led to her baby being born with severe disabilities. This decision was made notwithstanding expert evidence that the doctor's omission to disclose was accepted as proper by a responsible body of medical opinion. There was thus a perceptible shift in underlying values from medical paternalism to a patient-centred approach, though the latter was balanced against the concept of the reasonable person in the patient's position.[20]

Shortly thereafter, the Singapore Court of Appeal in *Hii Chii Kok v Oii Peng Jin London Lucien*[21] (*HCK*) applied *Montgomery* with some modifications and rejected the *Bolam-Bolitho* tests for medical advice. The Court of Appeal emphasised the active role of patients in matters concerning personal decision-making regarding their health. While *Montgomery* focused on disclosures of risks, *HCK* covered all relevant and material information. It proffered a three-step inquiry as follows: (1) whether the patient can identify the relevant and material information; (2) whether the information was in the possession of the doctor; and (3) whether the doctor was justified in withholding that information. On the facts, the respondents (a doctor and the National Cancer Centre of Singapore) were held not to be negligent because they had advised the patient about the risks regarding the patient's lesions in the pancreas and the available alternative treatment.

With regard to the materiality of information in the first inquiry, a patient-centric approach should be adopted. The court inquires whether the information would be relevant and material to a reasonable patient situated in the particular patient's position, or whether the doctor knew the information to be important to the particular patient.[22] Whether the information relating to the diagnosis and treatment options (eg, information about the risks and alternative treatments) under the second inquiry is in the possession of the doctor is a factual issue. If there is an allegation of negligent diagnosis or treatment, that would be assessed based on the *Bolam-Bolitho* tests. As for the third inquiry, the doctor would be justified in withholding relevant and material information in his or her possession if the doctor can show that exceptional circumstances (eg a waiver by the patient, an emergency situation or therapeutic privilege) exist. The presence of exceptional circumstances (waiver and therapeutic privilege) will be assessed from the doctor's perspective while the assessment of the emergency exception would be based on the *Bolam-Bolitho* tests.

The principles espoused in *HCK* have been met with resistance from the Singapore medical profession. Doctors have become uncertain as to how they should fulfil their duty to advise patients pursuant to the *HCK* principles and expressed concern that defensive practices may increase medical costs to be borne by patients.[23] A workgroup consisting of medical doctors, lawyers and laypersons with expertise[24] made

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[16] *Rogers v Whitaker* (1992) 175 CLR 479.

[17] *Reibl v Hughes* (1980) 114 DLR (3d) 1.

[18] *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593.

[19] *Canterbury v Spence*, 464 F 2d 772 (1972).

[20] J Herring et al, "Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-making in Person-centred Care" (2017) 25 *Medical Law Review* 582.

[21] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492.

[22] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [132].

[23] Report on Recommendations, *Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process* (28 November 2019) [41].

[24] Comprising of a CEO of a health care company and an academic.

recommendations in a report in November 2019[25] advocating a new statutory approach based on the *Bolam* and *Bolitho* tests. Following that, the Singapore Parliament passed the *Civil Law (Amendment) Act 2020* (Singapore)[26] regarding the standard of care expected of medical practitioners when giving medical advice to patients.[27] The statutory amendment overrides, to a large extent, the common law approach in *HCK* although, as will be argued below, certain elements of the judge-made principles may continue to have an impact on the interpretation of the new law.

The interpretation of this statutory amendment should take into account the likely challenges encountered and issues raised by patients including those with mental health conditions. This article will begin with an analysis in Part II of the new legislative framework in Singapore regarding doctors providing medical advice to patients. In Part III, the focus will turn to the preliminary question of whether s 37 of the *Civil Law Act* applies to patients with mental disorders under the *Mental Capacity Act 2008* (Singapore) (*MCA*).[28] The main sections will analyse and interpret s 37 with reference to patients with mental health conditions who are nonetheless mentally capable of making decisions on their health. The important issues of protecting patient autonomy, ensuring participation in decision-making and the quality of the doctor-patient communication will be discussed in Part IV. This is followed by Part V on the scope of therapeutic privilege that doctors may invoke to justify withholding certain information from patients. Part VI concludes with some suggestions on the interpretation of the new statutory provisions on giving medical advice to patients which are inspired, ironically, by common law precedents.

II. THE NEW LEGISLATIVE FRAMEWORK IN SINGAPORE: SECTION 37 OF THE CIVIL LAW ACT

In 2020, provisions were added to the *Civil Law Act*, creating new questions about the interpretation of and implications arising from s 37 in respect of medical advice to patients. During the second reading of the parliamentary Bill,[29] the Second Minister for Law stated the Bill aimed to "set a clear standard" on how health care professionals should provide advice. The Bill sought to strike a balance between patient autonomy and self-regulation by the medical profession, akin to the *Bolam* approach based on deference to medical opinion. The statutory framework in s 37(1) of the *Civil Law Act* encompasses two requirements for meeting the standard of care in relation to the provision of medical advice to a patient as follows:

(1) the manner in which the health care professional acts in the matter (at the time the medical advice is provided) is accepted by a respectable body of medical opinion (called in this section the peer professional opinion) as reasonable professional practice in the circumstances; and
(2) the peer professional opinion is logical.

The above provision follows the structure of the twin *Bolam* and *Bolitho* tests. Determining reasonableness of a doctor's practice by reference to peer professional opinion in s 37(1)(a) is consistent with the *Bolam* test (ie, practice accepted as proper by a "responsible body of medical opinion"), whereas the statutory requirement for logic in the peer professional opinion in s 37(1)(b) is based on *Bolitho* and subsequent refinements in *Khoo James*.[30] The logic test enquires whether the body of health care professionals holding the opinion has directed its mind to the comparative risks and benefits relating to the matter, and

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[25] Report on Recommendations, n 23.

[26] This law took effect from 1 July 2022: see the *Civil Law (Amendment) Act 2020 (Commencement) Notification 2022* (Singapore).

[27] Compare New York statute entitled "Limitation of medical, dental or podiatric malpractice action based on lack of informed consent": see *McKinney's Public Health Law* § 2805-d, *NY PUB HEALTH* § 2805-d. On regulation of informed consent based on professional standards, see JL Dolgin, "The Legal Development of the Informed Consent Doctrine: Past and Present" (2010) 19 *Cambridge Q Healthcare Ethics* 97, 101–102; *Civil Liability Act 2002* (NSW) s 5O(1); *South Western Sydney Local Health District v Gould* (2018) 97 NSWLR 513; [2018] NSWCA 69; and *Dobler v Halverson* [2007] NSWCA 335, [59]–[60].

[28] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed).

[29] Singapore Parliament Reports, *Civil Law (Amendment) Bill*, Sitting Date: 6 October 2020, Vol 95 (The Second Minister for Law, Edwin Tong Chun Fai).

[30] *Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024, [65]–[66], citing *Hucks v Cole* [1993] 4 Med LR 393.

whether the opinion is internally consistent and does not contradict proven extrinsic facts relevant to the matter.[31]

On the other hand, s 37(2) has introduced, with respect to the peer professional opinion, an informational content-related requirement. It states that the peer professional opinion must:

(1) require the health care professional to have given (or caused to be given) to the patient:
  (a) information that a person in the same circumstances as the patient (which circumstances the health care professional knows or ought reasonably to know) would reasonably require to make an informed decision about whether to undergo a treatment or follow a medical advice; and
  (b) information that the health care professional knows or ought reasonably to know … is material to the patient for the purpose of making an informed decision about whether to undergo the treatment or follow the medical advice; and

(2) support the non-provision of any information mentioned in para (a)(i) or (ii) to the patient only where there is reasonable justification for that.

In other words, the informational content under s 37(2)(a) covers information that a person in the patient's position would reasonably require as well as information which is material to the particular patient. In substance, under the new statutory framework, the approach to assessing medical advice is based on the requirement for informational content to be disclosed as assessed by medical peers with the courts acting as a check on the logic of the medical assessment. This is contrasted with the paternalistic approach based on *Bolam* and *Bolitho* under the earlier common law approach in *Khoo James* without any need to satisfy any informational content-related requirement.

With respect to s 37(2)(a)(i), what information the patient would reasonably require depends, according to *HCK*, on objective factors such as the severity of harm, likelihood of risks[32] and patient wellbeing.[33] A reasonable patient would normally desire to know about alternative treatments, possible complications of the proposed treatment and the prognosis. Importantly, the reasonable person is placed in the "same circumstances" as the patient, and these circumstances may include the mental health state of the patient (eg cognitive or emotional deficits which reduce his or her ability to reason). Judges have commented, albeit in different contexts, on the paradoxical concepts of the "reasonable unintelligent person"[34] or the "'normal' condition of unsound mind"[35] with respect to persons with mental disorders.

In relying on peer professional opinion to determine the legal standard of care, the statutory provision implicitly accepts that reasonableness as to the informational content required by the reasonable patient should be viewed through the lens of the professional peers. The court cannot disregard the opinion of the professional peers unless it is illogical. Thus, it is argued that the peer professional opinion, in assessing the requisite informational content to be communicated to the patient under s 37(2)(a)(i), need not consider the subjective decision-making incapacity of the particular patient with mental health conditions to, for example, understand or to weigh the information to reach a decision. This statutory provision is focused on the professional peer's opinion as to the informational content that the reasonable person in the circumstances of the patient would require rather than the actual patient's subjective viewpoint.

In addition to the information which a reasonable patient would require, s 37(2)(a)(ii) refers to information that the health care professional knows or ought to have known is "material" to the particular patient. This is explained as information that is "important" to the particular patient based on the patient's specific concerns or queries:

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[31] *Civil Law Act*, s 37(5).

[32] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [140].

[33] See also MC Dunn et al, "Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Treatment" (2018) 27 *Health Care Analysis* 110.

[34] *A v Hoare* [2008] 1 AC 844, [35]; [2008] UKHL 6.

[35] *Carrier v Bonham* [2002] 1 Qd R 474, [35]; [2001] QCA 234.

> (3) In subsection (2)(*a*)(ii), an assessment as to whether any information is material to the patient for the purpose of making an informed decision about whether to undergo a treatment or follow a medical advice must be based on any specific concern or query the patient has in relation to the treatment or medical advice –
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> (a) which the patient expressly communicates to the healthcare professional; or
> (b) which the patient does not expressly communicate to the healthcare professional but which ought to be apparent to the healthcare professional from the patient's medical records that the healthcare professional has reasonable access to and ought reasonably to review.

A patient with or without mental health conditions may have his or her own reasons (including "idiosyncratic" reasons)[36] to ask their doctor about certain information relating to treatment so as to enable the patient to make health and treatment-related decisions. For patients with mental health conditions, there may be instances where the patient's cognitive impairments prevent him or her from expressly communicating a specific query or concern under s 37(3)(a). This potentially results in a gap in the information disclosed to such a patient arising from an obstacle to doctor-patient communications.[37]

Notwithstanding, reliance may be placed on medical records to which the doctor has reasonable access concerning the patient. For example, medical records may indicate the particular patient's adverse reactions to certain medication or psychotherapy. The doctor should take into account such specific concerns of the patient when assessing what would be material information to disclose to the patient under s 37(3)(b), for example the effects of alternative medication.

To conclude this analysis of s 37, a few brief comments may be made about the appropriateness of the new statutory provision. First, the *Bolam-Bolitho* tests are applied only where there are genuine differences in medical opinions regarding the appropriate standard at common law.[38] However, s 37(1) applies the *Bolam-Bolitho* framework in the absence of genuine differences in medical opinion. Second, it is not abundantly clear from the parliamentary discussions that the perceived uncertainties and reactions of the medical profession arising from *HCK* cannot be addressed. Reference could have been made to the concept of reasonableness, the legal principles and factors which have been discussed in *HCK*. Third, the medical profession may not necessarily be better placed than the court to assess the materiality of the information from the patient's perspective or the reasonable justifications (eg therapeutic privilege) for withholding disclosure.

Notwithstanding these pertinent and significant issues, this article will not evaluate the merits of the statutory reforms per se. Instead, it will examine how s 37, as it stands, can be interpreted taking into consideration its applicability to patients with mental disorders under the *Mental Capacity Act*. This is followed by discussions of the concept of patient autonomy and how it applies in practice, patient participation in decision-making, the quality of doctor-patient communications and the exercise of therapeutic privilege to justify a doctor's decision to refrain from disclosing information to their patients.

III. THE NEW STATUTORY FRAMEWORK: PATIENTS WITH MENTAL DISORDERS UNDER THE MENTAL CAPACITY ACT

At common law, the validity of a patient's consent to (or refusal of) medical treatment depends on establishing his or her mental competence to make such a decision.[39] Prior to the *MCA*, in Singapore the Committee of Persons and Committee of Estate may be appointed to act on behalf of mentally incapacitated persons with respect to their personal affairs.[40] According to the *MCA*,[41] which came into force in 2010, a patient may now authorise a proxy under a Lasting Power of Attorney (LPA) to make

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[36] See Explanation to *Civil Law Act*, s 37(2)(a)(ii).

[37] See Part IV.C.

[38] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [63], [109]; *Armstrong, Carol Ann v Quest Laboratories Pte Ltd* [2020] 1 SLR 133, [53], [76].

[39] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95.

[40] See the *Mental Disorders and Treatment Act* (Singapore, cap 178, 1985 rev ed) s 9.

[41] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 11.

decisions regarding his or her personal welfare should the patient become mentally incapacitated. Such decisions include giving or refusing consent to the carrying out or continuation of a treatment. Excluded from this scope are matters pertaining to consent to sexual sterilisation, consent to treatment to terminate a pregnancy and the making of an advance medical directive.[42]

In line with the recognition of patient autonomy and empowerment, the *MCA* supports the presumption of mental capacity. Patients should not be treated as mentally incapable of making a decision merely because of their appearance or behaviour[43] or where the decision in question was "unwise".[44] Practical steps must be taken to aid the patient in making a decision.[45] This reflects a shift to more patient-centric decision-making where a person is supported to make a decision, rather than having the decision made on his or her behalf. Moreover, mental capacity is issue-specific in that a person may lack capacity to make a specific health-related decision but is otherwise capable of making other health-related decisions.[46] For example, Patient B might have a psychiatric diagnosis and be able to make day-to-day decisions but may need some assistance with medical decisions. That could include having the risks explained in language they understand by a health care professional.

The person asserting a patient's mental incapacity to make a specific decision has to prove it based on clinical and functional incapacity tests. Clinical incapacity, defined as the impairment of, or a disturbance of, the mind or brain,[47] must be assessed by medical experts. Such mental impairment may be temporary or permanent. On the other hand, functional incapacity – the inability to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making *or* communicating the decision[48] – remains the province of the judges.[49] The doctor should take account of the patients' residual or fluctuating[50] cognitive ability when taking consent from patients with diminished mental capacity according to the Singapore Medical Council, *Ethical Code and Ethical Guidelines* (SMC ECEG 2016).[51]

To what extent does s 37 of the *Civil Law Act* apply to patients with mental disorders? If the patient's clinically recognised mental disorder has led to functional incapacity to make a decision on his or her health matters as defined in the *MCA*, it is argued that the doctor is not obliged to disclose the information to the patient under s 37. This is because s 37(2) contemplates that the patient in question is capable of making an "informed decision" about whether to undergo a treatment or follow a medical advice. Hence, in a situation where say a neurologist determined Patient C lacked decision-making capacity, a doctor would not be required to discuss the risks of treatment directly with the patient. They would be required to discuss those risks with Patient C's legal proxy, as discussed below.

The above interpretation is corroborated by s 37(6) which refers to a patient under a "legal disability". As mentioned by the Second Minister for Law moving the parliamentary bill, "a legally disabled person is someone who does not have the mental competence to make a decision for himself or herself".[52] A reference to such a patient under s 37 would include "a person with the responsibility for making a

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[42] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 26.

[43] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 4(3).

[44] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 3.

[45] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 3.

[46] *A NHS Foundation Trust v X* [2014] EWCOP 35.

[47] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 4.

[48] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 5.

[49] *Re BKR* [2015] 4 SLR 81.

[50] For example, *UWF v UWH* [2021] 4 SLR 314 (individual's bipolar condition and psychosis in remission at time of decision-making).

[51] Singapore Medical Council, *Ethical Code and Ethical Guidelines* (2016 ed) s C6 para (19) (*SMC ECEG 2016*). It also states that "If patients can demonstrably understand, retain and use your information and explanations to make clear and consistent decisions and communicate them in a coherent manner, you must obtain consent from the patients themselves".

[52] See also *United Overseas Bank Ltd* v *Bebe bte Mohammad* [2005] 3 SLR(R) 501, [27] (person of unsound mind being under a "legal disability" within the meaning of *Land Titles Act* (Singapore, cap 157, 1994 rev ed) s 46(1), (2)).

decision for the patient having regard to medical advice". Where a patient with a mental disorder is considered as lacking mental capacity under the *MCA*, health-related decisions may be made by legal proxies, for example, persons who are conferred authority under a LPA (donees) to make decisions on behalf of the patient or court-appointed deputies. In these circumstances, the doctor would be obliged under s 37 to disclose the requisite information to the relevant legal proxies.

The doctor's standard of care in giving medical advice to a legal proxy under s 37 would probably be circumscribed by the legal proxy's scope of responsibility. An LPA may only extend to authorising the donee to make treatment decisions if the LPA states so expressly.[53] Furthermore, the *MCA* restricts the donee of an LPA from making decisions relating to the carrying out or continuation of life-sustaining treatment on the patient, or "any other treatment on P which a person providing health care reasonably believes is necessary to prevent a serious deterioration in P's condition".[54] In these instances, the doctor should not be expected under s 37 to disclose information relevant to such decisions to the donee.

Should the patient be mentally incapable of making his or her own health-related decisions and there are no appointed proxies, the doctor would be justified in acting based on the patient's "best interests" under the *MCA*.[55] However, before adopting the "best interests" approach, the statute highlights the need to inquire whether the patient might at some point in the future acquire mental capacity to make the decision,[56] and even if the patient is mentally incapable of doing so, to allow for and encourage the patient's participation in the act done on his or her behalf where reasonably practicable.[57] Hence, the "best interest" test is applied to persons who are mentally incapable to make a decision, in a way that accords respect to their autonomy and emphasises their residual rights if any to participate in decision-making.[58]

Determining the mental capacity of patients with mental disorders can be challenging. It can be particularly challenging in circumstances where the patient's mental states fluctuate. For example, patients diagnosed with bipolar disorders experience episodes of mania and periods of remission in between.[59] Patients with clinically recognised mental disorders may in some instances have sufficient functional capacity to make an informed decision.[60] For example, in a UK case, a patient, diagnosed with bipolar disorder, maintained her decision to terminate her pregnancy based on a number of rational grounds and was therefore assessed as functionally capable of making such a decision.[61] In such cases, s 37 will remain relevant to determine the legal standard of care in respect of medical advice provided. On the other hand, in a separate case, a woman diagnosed with paranoid schizophrenia was held not to possess mental capacity to consent or refuse treatment to ovarian cancer (including abdominal hysterectomy).[62] Her auditory hallucinations had led her to believe that there was no tumour due to false scans and "screen things". Further she perceived the hospital treating team and her parents as imposters controlled by "bad machines". As a result of her condition, the patient was unable to understand, use

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[53] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 13(6).

[54] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 13(8).

[55] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 3(5). See also *SMC ECEG 2016*, n 51, s C6 para (20) ("If patients have such diminished mental capacity that they cannot give consent, you must obtain consent from persons with the legal authority to make such medical decisions for them unless such persons are not contactable within reasonable time depending on the urgency of the situation. Otherwise, you must proceed according to your best judgment of the patients' best interests.").

[56] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 6(3).

[57] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 6(4).

[58] In certain jurisdictions, there has been a shift in decision-making that takes into account the patient's values and preferences. See, eg, *Medical Treatment Planning and Decisions Act 2016* (Vic) s 61(2). The medical treatment decision-maker has to consider the preferences that the patient, who does not have decision-making capacity, has expressed and the circumstances in which the preferences were expressed; and, in the absence of expressed preferences, to consider the values of the patient.

[59] T Gergel and GS Owen, "Fluctuating Capacity and Advance Decision-Making in Bipolar Affective Disorder – Self-binding Directives and Self-determination" (2015) 40 *International Journal of Law and Psychiatry* 92, 93.

[60] For example, *Re SB (A Patient; Capacity to Consent to Termination)* (2013) 133 BMLR 110; [2013] EWHC 1417 (COP).

[61] *Re SB (A Patient; Capacity to Consent to Termination)* (2013) 133 BMLR 110; [2013] EWHC 1417 (COP).

[62] *Cambridge University Hospitals NHS Foundation Trust v BF (by her Litigation Friend, the Official Solicitor)* [2016] EWCOP 26.

or weigh information relevant to the decision to consent to or refuse the medical treatment. Further, a patient diagnosed with catatonia and elective mutism may be unable to communicate his or her decision and be adjudged mentally incapable of making a particular decision even if he or she may possess the capacity to understand, retain,[63] use and weigh the information.

The applicability of the legal standard of care in giving medical advice to patients with mental disorders depends on the court's assessment of its role in protecting patient autonomy versus medical paternalism (where the medical profession is seen as needing to protect vulnerable patients).[64] With regard to the latter, the criteria to determine functional incapacity primarily reflect the importance of cognition and rationality (eg in using and weighing the information) when assessing mental capacity. One interesting question is whether, and to what extent, the *MCA* should accommodate factors such as: (1) the lack of insight (akin to a lack of awareness of one's illness); (2) delusional beliefs; and (3) pathological values in ascertaining mental capacity.[65]

The first issue is how to respond to a patient who lacks insight into his or her decision-making capacity. The lack of insight has been found relevant for ascertaining mental incapacity for decision-making of patients with psychosis and bipolar affective disorders using the MacArthur Competence Assessment Tool for Treatment.[66] Though the patient's lack of insight has been recognised as an indicium of mental incapacity in UK court decisions,[67] it is argued that such recognition should be limited to situations where a connection can be drawn to an explicit criterion for the assessment of mental incapacity under the *MCA* (such as the inability to understand or weigh information).[68] Moreover, the patient's non-conformity or non-compliance with medical views about the alleged mental disorder should not be automatically regarded as evidencing a lack of insight.[69]

Arguably, the lack of insight might be accommodated under the *MCA* framework in a limited sense. Information relevant to the decision includes "information about the reasonably foreseeable consequences of (a) deciding one way or another; or (b) failing to make the decision".[70] Thus, the patient's lack of insight concerning such reasonably foreseeable consequences would be pertinent to ascertaining the patient's understanding of information relevant to the decision whether to consent to or refuse the treatment.

A second issue involves patients who experience delusional beliefs. Delusional beliefs may also render a patient mentally incapable of making a health decision. According to an illustration in the Singapore *Code of Practice*[71] issued pursuant to the *MCA*, a person who was diagnosed with schizophrenia had suffered a physical injury. She held delusional beliefs that her family members were plotting to harm her. It was stated that such beliefs could impact her mental capacity to use and weigh relevant information to make a decision to treat the injury. In a UK decision, the court invalidated the advance directive of a patient with borderline personality disorder who engaged in self-harm due to her "misconception of

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[63] C Ryan, S Callaghan and C Peisah, "The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members" (2015) 49 *Australian & New Zealand Journal of Psychiatry* 324, 331.

[64] E Cave, "Protecting Patients from Their Bad Decisions: Rebalancing Rights, Relationships and Risk" (2017) 25 *Medical Law Review* 527.

[65] G Richardson, "Rights-based Legalism: Some Thoughts from the Research" in B McSherry and P Weller (eds), *Rethinking Rights-based Mental Health Laws* (Hart Publishing, 2010) 181, 189–195.

[66] G Owen et al, "Mental Capacity, Diagnosis, and Insight in Psychiatric Inpatients: A Cross Sectional Study" (2008) 39 *Psychological Medicine* 1389.

[67] *Trust A, Trust B v H (an adult patient) (represented by her Litigation Friend, the Official Solicitor)* [2006] EWHC 1230 (Fam), [23]; *Cambridge University Hospitals NHS Foundation Trust v BF (by her Litigation Friend, the Official Solicitor)* [2016] EWCOP 26, [56].

[68] P Case, "Dangerous Liaisons? Psychiatry and Law in the Court of Protection-expert Discourses of 'Insight' (and 'Compliance')" (2016) 24 *Medical Law Review* 360, 372–373.

[69] Case, n 68, 367.

[70] *Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) s 5(4).

[71] *Code of Practice, Mental Capacity Act 2008* (Singapore, cap 177A, 2020 rev ed) [4.6.3].

reality". This constituted evidence of a mental disorder which rendered her unable to use and weigh the relevant information in making her decision to refuse blood transfusion.[72]

A third issue relates to treating patients who hold "pathological values". For example, where a patient diagnosed with an eating disorder, coupled with depression, expresses a preference for thinness to life itself, it is arguably the holding of such pathological values as opposed to (lack of) cognitive impairment that underlies the decision-making.[73] The "pathological values" might, however, be linked to distortions of reality[74] that can indirectly affect the patient's understanding of the consequences of a decision (to maintain thinness at the expense of life). Thus, a patient with anorexia nervosa may be assessed as unable to evaluate the short and long-term consequences of her refusal of treatment,[75] or unable to weigh the information due to the inability to appreciate the associated risks including death.[76] In addition, courts have on occasions regarded the impaired ability to exercise self-control in patients with anorexia as relevant to determining cognitive incapacity to make decisions.[77]

In summary, the *MCA* prioritises patient autonomy in presuming that patients have capacity, and requiring those who dispute that (ie contend the patient lacks capacity) to prove it based on clinical and functional tests. Yet courts, in assessing the functional incapacity test are also mindful about safeguarding the interests of patients with mental disorders from the adverse effects of their health-related decisions. Whether the doctor would (or would not) be obliged to provide medical advice to the patient with mental disorders for the purpose of making an informed decision under s 37 depends crucially on the balance struck by the courts in assessing mental incapacity.

IV. PATIENT AUTONOMY, PARTICIPATION IN DECISION-MAKING AND THE QUALITY OF DOCTOR-PATIENT COMMUNICATION

As discussed in the preceding section, certain patients with mental disorders may nevertheless possess functional capacity, as defined in the *MCA*, albeit at a reduced level. Other patients with mental health conditions (eg, symptoms of depression) falling short of the criteria for clinically recognised mental disorders would not satisfy the clinical incapacity test. These patients would therefore be mentally capable of making informed decisions concerning their health. The main questions discussed below concern how the new statutory standard of care ought to be interpreted as it applies to doctors giving medical advice to patients so as to adequately protect patient autonomy, facilitate patient participation in decision-making and promote the quality of doctor-patient communication. The statutory interpretation will impact on the approach to be adopted by doctors when giving advice to patients including those with mental health conditions.

A. Patient Autonomy and the Disclosure of Informational Content

One may view the change in regulation as akin to a swinging pendulum. Under the *Bolam-Bolitho* and *Khoo James* tests, the law favoured deference to medical experts. Later, under the *HCK* test, the pendulum rapidly swung in the opposite direction, and favoured a patient-centric approach. Now, s 37 shifts the pendulum back to a point that lies somewhere between the two extremes. Under the new statutory approach, there is now greater emphasis on patient autonomy than in *Khoo James*. However, unlike in *HCK*, patient autonomy is to be assessed by the medical profession and subject to the requirement of logic under s 37(1).

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[72] *NHS Trust v T* [2004] EWHC 1279 (Fam), [61], [63].

[73] J Tan et al, "Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values" (2006) 13 *Philosophy, Psychiatry and Psychology* 267, 273–274.

[74] T Grisso and P Appelbaum, "Appreciating Anorexia: Decisional Capacity and the Role of Values" (2006) 13 *Philosophy, Psychiatry and Psychology* 293, 294–295.

[75] *Re C (A Minor)* [1997] 2 FLR 180.

[76] *A NHS Foundation Trust* v *X* [2014] EWCOP 35, [27]–[28].

[77] J Craigie and A Davis, "Problems of Control: Alcohol Dependence, Anorexia Nervosa, and the Flexible Interpretation of Mental Incapacity Tests" (2018) 27 *Medical Law Review* 215, 223–224.

The duty of the doctor to communicate material information to the patient, so as to enable the latter to make an informed decision on health matters, is central to patient autonomy. As the objective of information disclosure under s 37(2) is to allow the patient to make an "informed" decision, the statutory approach respects patient autonomy. The disclosure of information reasonably required by the patient and material to the particular patient should allow the patient the opportunity to make decisions reflecting either what the patient *should* desire (ideal desire autonomy)[78] or his or her values and preferences (best desire autonomy).[79] The phrase "informed decision" was used 10 times in *HCK* in the context of information disclosure by doctors (or the defendant doctor) to patients generally (or to the claimant specifically). In one instance, patient autonomy was mentioned as a basis to allow for the making of informed decisions.[80] In two other instances, the term "informed decision" was used in conjunction with the objective of ensuring the quality of communication and/or the patient's understanding of the information.[81] It should be noted that the common law principles continue to be applicable where they are not inconsistent with the statute according to the Explanatory Statement to the parliamentary bill.

Alongside patient autonomy is the notion of the doctor's professional autonomy in the selection of treatment options.[82] As a general rule, the doctor is not legally obliged to administer any or all treatment options requested by the patient.[83] In a situation where the patient ultimately makes a choice among the treatment options offered by the health care professional, there may be room in practice for combining patient autonomy with professional intervention (eg, the doctor questioning the patient's preferences) in a way that supports patient autonomy.[84] The doctor may also help the patient explore health-related values in the selection of treatment options.[85]

But does an "informed decision" necessarily require a decision that is aligned with the patient's preferences and values?[86] Section 37 does not explicitly refer to the role of the doctor in helping the patient to interpret his or her values and preferences or to explore the most appropriate patient's values in connection with the intervention options available. Furthermore, *HCK* did not mention the patient's preferences and values in connection with the making of an "informed decision". However, as we will discuss in the next section, it is nonetheless important to facilitate participation by the patient in the making of an informed decision.

B. Patient's Participation in Decision-Making

The patient-centric approach at common law was premised on patients assuming a more active role with regard to their own health. One legitimate question is the extent to which such a premise is borne out in practice especially for patients with mental health conditions. On the whole, the evidence appears to be mixed. Some patients with specific mental health conditions have preferred a more passive role,[87] and there are obstacles encountered in terms of the doctor-patient relationship and the patient's appreciation of the information disclosed. Yet there are studies indicating that some patients with mental health

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[78] Cave, n 64, 539.

[79] Coggon and Miola, n 1.

[80] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [132].

[81] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [155]–[156].

[82] Cave, n 1.

[83] *R (Burke) v General Medical Council* [2005] 3 WLR 1132, [31]; [2005] EWCA Civ 1003.

[84] A Cribb and VA Entwistle, "Shared Decision Making: Trade-offs between Narrower and Broader Conceptions" (2011) 14 *Health Expectations* 210.

[85] EJ Emmanuel and LL Emmanuel, "Four Models of the Physician–Patient Relationship" (1992) 267(16) *Journal of the American Medical Association* 2221.

[86] Compare *Medical Treatment Planning and Decisions Act 2016* (Vic) s 61(2) in respect of patients who do not possess decision-making capacity. The legislation prioritises a person's values and preferences.

[87] I Morán-Sánchez et al, "Shared Decision-making in Outpatients with Mental Disorders: Patients' Preferences and Associated Factors" (2019) 25 *Journal of Evaluation in Clinical Practice* 1200.

conditions have benefited from the participatory approach and/or shared decision-making (SDM)[88] though the impact is dependent on a number of mediating factors.[89]

In a controlled study,[90] patients diagnosed with bipolar and psychotic disorders were found to prefer a more passive role in the decision-making process compared to comparison participants without any psychiatric disorder. Lower BPRS (Brief Psychiatric Rating Score) global scores and history of compulsory admissions were significantly correlated with the preference of SDM.[91] The researchers argued that the implementation of SDM should be tailored to the individual patient's values, preferences and expectations about SDM.

There is evidence that SDM has led to improved patient engagement and outcomes in health care.[92] In particular, SDM has generated positive albeit small effects of treatment-related empowerment (which includes the subjective sense of involvement in treatment and autonomy) for patients with psychosis.[93] It has been found to be feasible for patients with schizophrenia accompanied by enhanced involvement and knowledge of treatment options.[94]

However, not all studies demonstrate the impact of SDM on patient outcomes.[95] Clinicians in mental health care have tended to adopt a more paternalistic approach partly due to concerns that certain patients (eg patients with schizophrenia) may lack insight about their mental health conditions. It is also important to examine how patients with mental health conditions understand or view the decision-making processes and models.[96] The feasibility of patient participation in decision-making may depend on various factors such as the specific psychiatric disorder, the severity of illness, and capacity for decision-making,[97] and the patient-provider relationship.[98] In this regard, SDM demands considerable investments in time and communication between patients and psychiatrists.[99] In view of the mixed evidence, there is no "one-size-fits-all" solution to the practices relating to patient participation in decision-making and SDM.

Section 37 of the *Civil Law Act* imposes a duty on the doctor to provide the requisite information to the patient without specifically mentioning the sharing of information by the patient so as to reach a *joint* decision between the doctor and the patient. Though the statutory provision does not explicitly preclude

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[88] WT Trusty et al, "Shared Decision-making in Mental and Behavioural Health Interventions" (2019) 25 *Journal of Evaluation in Clinical Practice* 1210; D Stovell et al, "Shared Treatment Decision-making and Empowerment-related Outcomes in Psychosis: Systematic Review and Meta-analysis" (2016) 209 *British Journal of Psychiatry* 23; and J Hamann et al, "Shared Decision Making for In-patients with Schizophrenia" (2006) 114 *Acta Psychiatrica Scandinavica* 265.

[89] J Eliacin et al, "Patients' Understanding of Shared Decision Making in a Mental Health Setting" (2015) 25 *Qualitative Health Research* 668.

[90] Morán-Sánchez et al, n 87. The study was conducted in two health centres in Southeastern Spain. One hundred and seven bipolar and psychiatric patients and 100 non-psychiatric comparison (NPC) participants with no psychotic disorders completed a questionnaire regarding their preferences in decision-making. The questions were based on the components of the SDM model: see CA Charles, A Gafni and T Whelan, "Shared Decision-making in the Medical Encounter: What Does It Mean? (or It Takes at Least Two to Tango)" (1997) 44(5) *Social Science & Medicine* 681. The statistical analysis revealed that NPCs were 24 times more likely to prefer options about their treatment compared with psychiatric patients ($P < 0.001$), and were twice as likely to prefer taking medical decisions on their own than psychiatric patients ($P = 0.010$).

[91] Other factors were age and education level which were positively correlated with the patient's preferences for participation in decision-making while the severity and chronicity of illness was negatively correlated with the desire to participate in decision-making.

[92] Trusty et al, n 88.

[93] Stovell et al, n 88.

[94] Hamann et al, n 88.

[95] K Lovell et al, "Embedding Shared Decision-making in the Care of Patients with Severe and Enduring Mental Health Problems: The EQUIP Pragmatic Cluster Randomised Trial" (2018) 13(8) *PLoS One* e0201533.

[96] EM Woltmann and R Whitley, "Shared Decision Making in Public Mental Health Care: Perspectives from Consumers Living with Severe Mental Illness" (2010) 34 *Psychiatric Rehabilitation Journal* 29.

[97] J Hamann, S Leucht and W Kissling, "Shared Decision Making in Psychiatry" (2003) 107 *Acta Psychiatrica Scandinavica* 403.

[98] Eliacin et al, n 89.

[99] Torrey and Drake, n 6.

joint decision-making by the doctor and the patient, it obliges the disclosure of requisite information by the doctor with a view to enabling the patient's informed decision. In short, there is no legal requirement for doctors to take steps to enable a joint decision to be made with the patient under the SDM approach.

On the other hand, the SMC ECEG 2016 refers to patients' participation in decision-making[100] including patients with diminished capacity.[101] In *HCK*,[102] the Court of Appeal referred to "the standard of care in relation to the doctor's duty to *advise* the patient and to provide the patient with the requisite information to enable him to *participate meaningfully in decisions affecting the medical treatment he will receive*". Here, a connection was further drawn between patient participation in *HCK* and patient autonomy in decision-making,[103] a concept that had been openly expressed in the Minister's second reading speech. Moreover, since the *MCA* favours participation in decision-making even for persons without mental capacity where reasonably practicable, patients who are capable of making an informed decision should, a fortiori, be given the opportunity to participate in decision-making about their health. Based on the above, the notion of patient participation in decision-making at common law is consistent with the statutory provision that emphasises the making of an "informed" decision by the patient.

C. Quality of Doctor-Patient Communication

It follows from the above discussion that the doctor's duty should extend beyond mere disclosure of informational content and encompass the patient's participation in decision-making. Indeed, the term "medical advice", which appears in s 37, would typically involve the giving of "recommendations" as to the appropriate course of action for the patient's health aside from providing relevant information on, for example, the risks involved and alternative treatments.[104] Moreover, s 37(1) refers to the "manner" in which the doctor acts. This should be broad enough to include the manner in which the information is communicated by the doctor to the patient and not merely its content.

In this regard, reference may be made to *HCK* where the court cautioned against doctors "indiscriminately bombarding the patient with information"[105] and highlighted the importance of the "quality of communication that is commensurate with the ability of the patient to understand the information".[106] In a similar vein, the High Court of Australia in *Rogers v Whitaker*[107] referred to the communication of information to the patient that is "reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information".

Communication is indeed a two-way street. The taking of reasonable steps by doctors to satisfy themselves that the patient comprehends the information is required at common law.[108] This is corroborated by the SMC ECEG 2016 which emphasises patient autonomy and their ability to make "informed choices".[109] Therefore, the guidelines state that the doctor "must ensure that patients understand the information [the doctor gives] for the purpose of consent. If there are language difficulties, [the doctor] must use interpreters".[110]

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[100] *SMC ECEG 2016*, n 51, s C6, para (6).

[101] *SMC ECEG 2016*, n 51, s C9, para (2).

[102] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [4] (emphasis added).

[103] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [4].

[104] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [97].

[105] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [143].

[106] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [155].

[107] *Rogers v Whitaker* (1992) 175 CLR 479, 490.

[108] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [156]; and *Al Hamwi v Johnston* [2005] All ER (D) 278, [69]; [2005] EWHC 206 (QB).

[109] *SMC ECEG 2016*, n 51, s C5 on "Patients' right to information and self-determination".

[110] *SMC ECEG 2016*, n 51, s C6, para (9).

It should not be taken for granted that information disclosed by the doctor will be understood or utilised by patients to enable them to make informed decisions.[111] The communication of information may be particularly challenging in cases where the patient suffers from impaired cognition. In this respect, the SMC ECEG 2016 requires, with respect to persons with diminished mental capacity, that the doctor "determine whether they have sufficient residual capacity to understand and retain information for the purpose of making informed decisions for themselves".

As outlined above, a patient's cognitive impairment may prevent him or her from expressly communicating a specific query or concern which results in a gap in the doctor's knowledge of information that may be material to the particular patient. The new legislative provision does not directly address this issue but refers to the underlying purpose of providing information that is material to the particular patient ie, to allow the patient to make "an informed decision about whether to undergo the treatment or follow the medical advice".[112] One plausible argument is that the peer professional opinion under s 37 should, in line with the implicit statutory objective of enabling an informed decision, take into account whether the doctor had considered the patient's inability to expressly communicate his or her specific queries or concerns and had taken steps to elicit the patient's queries or concerns through other appropriate means.

V. THE DOCTOR'S THERAPEUTIC PRIVILEGE

At common law, a doctor may invoke therapeutic privilege in order to withhold material information from the patient on the basis that disclosure of such information would likely be detrimental to the patient's health.[113] Under the statutory framework, the peer professional opinion must take account of whether the doctor may be reasonably justified to withhold disclosure of information to the patient.[114] The illustrations stated in s 37(2)(b) include examples where the patient has waived his or her right to receive information from the doctor[115] and situations of emergency where the patient was unconscious and there was no legal proxy to make decisions on behalf of the patient.[116] On the other hand, as indicated by one of the illustrative examples, the doctor's view of the patient's best interests not to inform the patient of risks cannot justify the withholding of such information.[117] There is no explicit illustration concerning therapeutic privilege in the statute though the Explanatory Statement to the Bill states that the illustrations are "non-exhaustive" as to the presence or absence of reasonable justification.

In *HCK*, however, the Singapore Court of Appeal recognised the relevance of therapeutic privilege as a justification for withholding disclosure of information. It is applicable to situations "where although the patients have mental capacity, their decision-making capabilities are impaired to an appreciable degree".[118] The Court gave examples of patients with anxiety disorders or certain geriatric patients. Hence, if the doctor knows that disclosure of information about the risks of a treatment would aggravate the health condition of a patient with anxiety disorder, the doctor may invoke therapeutic privilege in order to withhold the information. It is argued, based on the wording of the Explanatory Statement to the Bill to preserve common law principles that are not inconsistent with the statute, that therapeutic privilege would likely be applicable under s 37(2)(b). Furthermore, the SMC ECEG 2016 implicitly acknowledges the existence of such a privilege.[119]

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[111] E Jackson, "Challenging the Comparison in Montgomery between Patients and 'Consumers Exercising Choices'" (2021) 29 *Medical Law Review* 595.

[112] *Civil Law Act*, s 37(2)(a)(ii).

[113] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [152].

[114] *Civil Law Act*, s 37(2)(b).

[115] *Civil Law Act*, s 37(2)(b), Illustration (*b*).

[116] *Civil Law Act*, s 37(2)(b), Illustration (*a*).

[117] *Civil Law Act*, s 37(2)(b), Illustration (c).

[118] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [152].

[119] *SMC ECEG 2016*, n 51, s C5 reads: "(4) If family members request withholding of information from patients, you must not do so unless you assess that the patients will react in an extreme way which would cause them serious harm."

Therapeutic privilege served as an "exception" to patient autonomy in *HCK*.[120] It is "physician-centric"[121] rather than "patient-centric". The burden of justifying non-disclosure of information is on the doctor. In terms of the underlying rationales, the Court referred to therapeutic privilege as being premised on beneficence[122] that might override the patient's autonomy upon an assessment of the patient's situation.[123] It stipulated three conditions for a therapeutic privilege to withhold information from the patient whose decision-making abilities are impaired:[124]

> (a) the benefit of the treatment to the patient, (b) the relatively low risk presented and (c) the probability that even with suitable assistance the patient would likely refuse such treatment owing to some misapprehension of the information stemming from the impairment.

The above conditions are useful for determining whether the doctor should withhold information on treatment options. The abovementioned concept of beneficence does not, however, cover a situation where the doctor is merely providing to the patient information relating to an adverse diagnosis or prognosis without offering any specific treatment options.

As a supplement to the beneficence rationale, therapeutic privilege may be justified in *HCK* based on arguably the rationale of non-maleficence[125] where "the doctor reasonably believes that the very act of giving particular information would cause the patient serious physical or mental harm".[126] In the mental health context, this can arise when the disclosure of information will likely worsen the conditions of the patient with a mental disorder such as depression without necessarily involving treatment options.

This non-maleficence approach to therapeutic privilege has been utilised in other jurisdictions such as the United Kingdom, Australia and United States with reference to the patient's mental health conditions. Lord Scarman in *Sidaway* opined that the privilege is justified where the doctor "reasonably believed" that communication to the patient of the existence of the risk would be "detrimental to the health (including, of course, the mental health) of his patient".[127] Lords Kerr and Reed in *Montgomery* referred to the limited therapeutic "exception" to the duty to disclose material risks namely disclosures that are "seriously detrimental to the patient's health". *Dicta* from the majority opinion in *Rogers v Whitaker*[128] appeared to support the withholding of information of risks to the patient when the disclosure would "harm an unusually nervous, disturbed or volatile patient". In *Canterbury v Spence*,[129] the invoking of therapeutic privilege may be called for when "risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view". The court added that "patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient".[130]

Returning to the new statutory framework, how would therapeutic privilege operate as a reasonable justification for the doctor's withholding of information from the patient under s 37(2)(b)? Assume that the doctor has given evidence that he or she withheld information to the patient on the basis of therapeutic

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[120] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [153].

[121] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [148].

[122] This was defined as "a group of norms for providing benefits and balancing benefits against risks and costs" in Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (OUP, 5th ed, 2001) 12, cited in *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [114].

[123] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [149].

[124] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [153].

[125] It was described as "a norm of avoiding the causation of harm": see Beauchamp and Childress, n 122, 12 which was cited in *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [114].

[126] *Hii Chii Kok v Oii Peng Jin London Lucien* [2017] 2 SLR 492, [152].

[127] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871; [1985] 2 WLR 480, 494.

[128] *Rogers v Whitaker* (1992) 175 CLR 479, 490.

[129] *Canterbury v Spence*, 464 F 2d 772, 789 (1972).

[130] *Canterbury v Spence*, 464 F 2d 772, 789 (1972).

privilege.[131] The reasonableness of the justification based on therapeutic privilege would be assessed by professional peers[132] subject to the court's assessment that the professional opinion satisfies the test of logic. There is indirect support in case law for the statutory approach based on the assessment by medical peers,[133] and that expert testimony is generally required to assess the relevance of the therapeutic privilege invoked by the doctor.[134]

At common law, it is quite rare for therapeutic privilege to be invoked by the doctor to absolve him or her from liability for medical negligence.[135] In *Canterbury v Spence*, the case from which this doctrine of therapeutic privilege emanated, the court did not make any specific finding on therapeutic privilege. However, the defence succeeded in *Nishi v Hartwell*[136] on the basis that disclosure "might induce an adverse psychosomatic reaction in a patient highly apprehensive of his condition".

On the question of the appropriate scope of therapeutic privilege under s 37, the analysis of the next few cases in Australia and the United Kingdom would appear to support the three conditions in *HCK* under the beneficence rationale as well as the non-maleficence approach. In the Australian case of *Battersby v Tottman* (*Battersby*),[137] the patient was prescribed a drug for her mental illness (acute depression and suicidal tendencies). The doctor did not warn the patient of the risks of damage to the patient's eye from taking the drug. According to the majority judges, the doctor's withholding of information was justified on the ground of serious detriment that would result from the patient's refusal of treatment. The patient was "likely to react hysterically and irrationally" and to refuse treatment due to "distorted mental processes produced by her mental illness", and the refusal would likely have meant for the patient "indeterminate close confinement in a mental institution with a high risk of suicide".[138] Further, Jacob J in *Battersby* observed that there was "no alternative treatment that offered any prospect of success" if the patient were to refuse the treatment.[139] However, Zelling J in *Battersby* dissented, noting the serious risk of injury to the plaintiff's eyes that had materialised.[140] Upon balancing the seriousness of the risks of disclosing the information, and the likelihood of the injury, Zelling J took the view that disclosure of information of the serious risk to the eyes was warranted.[141]

Therapeutic privilege was also successfully invoked in the English Court of Appeal decision in *Pearce v United Bristol Healthcare NHS Trust*.[142] It should be highlighted that the court had applied the *Bolam-Bolitho* tests to determine the appropriate extent of medical advice to be given to the pregnant patient concerning the delivery of her baby which turned out to be stillborn. Lord Woolf MR accepted that the doctor in those circumstances may take account of "the state of the patient at the particular time, both from the physical point of view and an emotional point of view" subject to the presence of a "significant risk", which would have to be disclosed.[143] On the facts, the doctor was justified in withholding information of

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[131] See *Barcai v Betwee*, 98 Haw 470, 487; 50 P 3d 946, 963 (2002), where no therapeutic privilege was asserted since the doctor did not testify that his decision to withhold information was based on specific considerations with respect to the patient.

[132] See Lord Diplock in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871; [1985] 2 WLR 480, 500.

[133] See *dicta* in *O'Keeffe v Rosen* (Unreported, BC9800834, 13 March 1998) ("[w]hether … a surgeon should give such a warning to the patient, and what should be the terms of such a warning, are not so much matters of medical judgement, except perhaps in cases where the warning might cause detriment to the plaintiff, the so-called therapeutic privilege.").

[134] *Barcai v Betwee*, 98 Haw 470, 487, 50 P 3d 946, 961 (2002).

[135] See generally R Mulheron, "Has Montgomery Administered the Last Rites to Therapeutic Privilege? A Diagnosis and a Prognosis" (2017) 70 *Current Legal Problems* 149.

[136] *Nishi v Hartwell*, 52 Haw 188, 197; 473 P 2d 115 (SC) (1970), app denied: 52 Haw 296; 473 P 2d 116, 121 (1970).

[137] *Battersby v Tottman* (1985) 37 SASR 524.

[138] *Battersby v Tottman* (1985) 37 SASR 524, 527.

[139] *Battersby v Tottman* (1985) 37 SASR 524, 542.

[140] *Battersby v Tottman* (1985) 37 SASR 524, 534.

[141] *Battersby v Tottman* (1985) 37 SASR 524, 534.

[142] *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118; [1998] EWCA Civ 865.

[143] *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118, 125; [1998] EWCA Civ 865.

the very small risk of stillbirth given the patient's "distressed condition".[144] Hence, similar to Zelling J's approach in *Battersby*, the potential physical and mental detriment to the patient from disclosure of information had to be balanced against the serious risk of injury from the delivery.

Other cases have rejected the therapeutic exception on the facts. In *Tai v Saxon*,[145] the Supreme Court of Western Australia held that the doctor attending to a patient with depression and who took drugs for her anxiety, was obliged to disclose to the patient the risks of treatment (namely the perforation of the bowel and fistula developing) based on the test in *Rogers v Whitaker*.[146] The doctor's reason for withholding information to avoid making the patient more anxious was rejected as the proposed treatment was "nonessential, and where it is reasonably possible that the patient might exercise a choice to decline to undergo it". In contrast, where the treatment is essential for preservation of life and the patient's quality of life was poor, making it inevitable that the patient would agree to the proposed treatment, there would be no obligation to disclose the risks that would only exacerbate the patient's anxiety. It is argued that the above consideration on the nature of the treatment (whether it is essential or nonessential) may be incorporated under the first condition (ie, benefit of the treatment) in the determination of therapeutic privilege in *HCK*. If the treatment is essential for the preservation for life, the great benefits of the treatment may tilt the balance towards withholding the information on the basis of therapeutic privilege.

Notwithstanding the absence of an explicit provision for therapeutic privilege, the statutory provision on reasonable justifications for withholding disclosure of information to patients is sufficiently broad to encompass therapeutic privilege given that the common law doctrine is not inconsistent with the statute. On the reasonableness of the justification, this article has highlighted that the three conditions based on beneficence and the serious detriment to the patient that would likely result from disclosure of information (non-maleficence) as grounds for invoking therapeutic privilege in *HCK* are complemented by other guidelines and factors from foreign case precedents. Collectively, they can guide the courts in scrutinising the logic of the professional peer opinions as to the weighing of comparative risks and benefits relating to the scope of therapeutic privilege in a medical negligence lawsuit.

VI. CONCLUSION

The new statutory framework under s 37 represents another milestone in the continuing search for the appropriate legal approach to address the issue of medical advice given by doctors to patients. The legal and medical professions in Singapore have witnessed in *HCK* the judiciary's patient-centric approach to assessing the material information to be disclosed to patients. It remains to be seen how medical peers would examine the manner in which the health care professional acts under s 37.

The new statutory standard requires the courts to scrutinise the peer professional opinions so that they satisfy the informational content requirements in s 37(2) and the test of logic in s 37(5). This article has put forward the argument that, with respect to the doctor's disclosure of relevant and material information to patients, the courts should interpret the new statutory standard with a view to advancing certain values such as patient autonomy, facilitating patients' participation in decision-making, and ensuring the quality of the doctor-patient communication subject to therapeutic privilege.

Notwithstanding the statutory enactment, the principles in *HCK* which emphasise the abovementioned values are likely to remain influential in shaping the legal standard of care of doctors when giving medical advice to patients who are mentally capable of making decisions related to their health. Common law principles that are consistent with the language and policy underlying the statutory provision are preserved. Hence, aspects of *HCK* can and should usefully contribute to our understanding and interpretation of the new statutory developments.

Based on the preceding discussion, the Judiciary should adopt an enlightened approach to interpreting s 37 that is not only inspired by *HCK* but which has also benefited from the real challenges and issues arising

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[144] *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118, 125; [1998] EWCA Civ 865.

[145] *Tai v Saxon* (Unreported, No 23/95, Supreme Court of Western Australia, Pidgeon, Franklyn and Ipps JJ, 1996).

[146] *Rogers v Whitaker* (1992) 175 CLR 479.

from doctors' interactions with patients with mental health conditions. It is proposed that first, the peer professional opinion, in the assessment of the reasonableness of the informational content to be disclosed or withheld in s 37(2), should take account of (1) the quality of the doctor-patient communication and the understanding of the patient; and (2) the doctor's acts in facilitating the participation of the patient in decision-making. *HCK* on patient participation in decision-making and the quality of doctor-patient communication are not inconsistent with the statute given that s 37(2) specifically refers to the objective of the informational content, ie to enable the patient to make an "informed decision". Thus, if the peer professional opinion did not consider that the information given by the doctor to the patient would enable the patient to make an informed decision, the court would be justified under s 37 not to rely on that peer professional opinion.

Second, the court, in assessing whether the professional peer opinion is logical, should consider whether the peer professional opinion had taken account of the comparative risks and benefits of withholding information under therapeutic privilege. In this respect, the three conditions for exercising therapeutic privilege in *HCK* (benefits and risks of treatment and the likelihood of the patient refusing treatment due to the patient's impairment) as well as the likelihood of serious detriment to the patient from the receipt of information from the doctor balanced against the extent of injury from the treatment option, if any, would be important criteria.

In sum, the above proposals are underpinned by the policy underlying the new law to balance patient autonomy and self-regulation by the medical profession, supported by the statutory language and strive to uphold established and cherished values of patient autonomy, facilitating participation in decision-making and maintaining proper doctor-patient communications.