A NEW LEGAL FRAMEWORK FOR THE PROVISION OF MEDICAL ADVICE
A case study of Hii Chii Kok v Ooi Peng Jin London Lucien & Anor [2017] SGCA 38

In the *Hii Chii Kok* case, the Singapore Court of Appeal considered if the *Bolam-Bolitho ("Bolam")* test should continue to apply when deciding if a doctor has been negligent for failing to provide appropriate advice to a patient. In this landmark decision, the Court decided to depart from *Bolam* when determining the standard of care in medical negligence cases involving advice, in favour of the more patient-centric approach espoused by the UK Supreme Court decision of *Montgomery* v *Lanarkshire ("Montgomery")*, but with key modifications.

The Approach Before

Why is this decision significant? For so long, the *Bolam* test had come to represent that a doctor could not be found negligent as long as he/she adhered to a responsible body of practice, even if there was another body of practice that might disagree with what the doctor did. This meant that the standard of care was essentially determined by medical practice and through peer review, rather than with due regard to patients' expectations.

Critics have been arguing that such an approach is out-dated and should be abandoned, particularly in cases where the allegations of negligence relate to advice and informed consent, because the advice a patient receives should logically be determined by reference to what the patient wants to know, rather than what doctors routinely disclose as a matter of medical practice. The contention is that continuing to apply *Bolam* to advice and informed consent cases completely undermines the importance of respecting patient autonomy. Indeed, countries such as the US, Canada, Australia and Malaysia have moved on from *Bolam* when determining the standard of care in informed consent cases, and in March 2015 so did the United Kingdom in the form of the *Montgomery* decision.

The New Approach

In *Hii Chii Kok,* the Court held that the *Bolam* test should continue to apply in the context of diagnosis and treatment, but that a more patient-centric test was needed when assessing the information and advice doctors provide to their patients. This is in keeping with changing patient expectations which have evolved, with the ordinary Singaporean today being better educated and having greater access to knowledge and information. The Court acknowledged that when a doctor is advising a patient, "*the patient is not a passive recipient of care, but an active interlocutor in whom ultimately rests the power to decide what course to pursue.*"

Describing this test as "the modified *Montgomery* test", it entails the following three-stage inquiry:

1. First, is the information that the patient alleges was negligently withheld from him:
    a. information which would be relevant and material from the perspective of a reasonable patient in that particular patient's position, or
    b. information which the doctor *knew or should have known* would have been considered relevant and material by the particular patient for reasons specific to this patient?

Broadly, material information would include:

a. the doctor's diagnosis of the patient's condition;
b. the prognosis of that condition with and without medical treatment;
c. the nature of the proposed medical treatment;
d. the risks associated with the proposed medical treatment;
e. the reasonable alternatives to the proposed medical treatment, and the advantages and risks of those alternatives; and
f. the consequences of foregoing treatment.

The personal circumstances of the patient including his unique needs and specific concerns must be considered, and the discussion should aim to address these factors in a manner that the patient can understand. The Court emphasized that providing proper advice does not mean bombarding a patient with voluminous information without providing any proper guidance and context.

2. Second, assuming the patient is able to establish that material information was withheld, was the doctor in possession of this information at the time? If the doctor was not, was he/she negligent in not obtaining this information?

3. Third, assuming the patient is able to establish that material information in the doctor's possession was withheld, was the doctor reasonably justified in withholding the information? This third stage of the inquiry essentially gives the doctor the opportunity to provide a reasonable excuse or justification for withholding the information from his/her patient. The burden is on the doctor to provide the justification, but the Court agreed to adopt a physician-centric approach at this stage by allowing doctors to rely on expert evidence on certain aspects of medical practice and professional judgment to justify the non-disclosure.

   The Court will then assess all the circumstances and determine if the doctor's conduct was justified. In this regard, the Court provided three *non-exhaustive* examples where non-disclosure might be justified:

   a. Waiver - where the patient has clearly exercised his autonomy by deciding that he does not wish to receive further information about the proposed treatment or its alternatives.
   b. Emergency situations – where the duty is suspended because there is a threat of death or serious harm to the patient, who lacks decision making capacity and there is no appropriate substitute decision maker. This falls within the principle of necessity.
   c. Therapeutic privilege – where the doctor reasonably believes that the very act of giving particular information would result in serious physical or mental harm to the patient. The Court agreed that doctors should have a measure of latitude and this should extend to cases where although patients have mental capacity, their decision-making capabilities are impaired to an appreciable degree. Examples mentioned by the Court -- patients with anxiety disorders and some geriatric patients. However the Court agreed with *Montgomery* that the therapeutic privilege exception should not be abused by enabling a doctor to prevent a patient who is capable of making a choice from doing so merely because the doctor considers that choice to be against his/her best interests.

Hindsight and Outcome Bias

The Court of Appeal also stressed the importance of guarding against hindsight and outcome bias which cuts across all aspects of medical care. Hindsight basis occurs where having known the outcome, an expert may have an inflated sense of his/her ability to foresee it. Similarly, outcome bias can occur where knowledge of the eventual outcome impacts an evaluation of the quality of the decision.

The Court therefore stressed that the relevant tests should be applied with reference only to the facts that were known at the time that the material event occurred. For diagnosis, what is relevant is the information that was available at the time of the diagnosis. For the provision of advice, assessing what information a reasonable person in the patient's position would consider material must be with reference to the time at which the relevant decision was made, and not at a later time.

Key Takeaways

The doctor-patient relationship is a collaborative process where doctors are expected to actively communicate and engage with their patients in a manner that the patient is able to understand. Taking the time to understand a patient's specific circumstances and needs is important. Knowledge of the patient's background, occupation, lifestyle choices, and whether the patient has any specific concerns, will help the doctor provide appropriate and sound advice which will allow the patient to meaningfully exercise his/her autonomy. At the same time, the Court noted that:

"The doctor has no open-ended duty to proactively elicit information from the patient, and will not be at risk of being found liable owing to idiosyncratic concerns of the patient unless this was made known to the doctor or the doctor has reason to believe it to be so. In the usual case, the standard of care should only extend to materiality on this ground where the patient has in fact asked particular questions *or otherwise expressed* particular concerns *that are relevant to the omitted information."*

It is the quality of the information and advice conveyed that matters, not the quantity. A doctor's role is to provide the patient with the necessary information to empower and enable to patient to arrive at an informed decision on treatment. Ultimately, the course of treatment to be adopted is the patient's decision to make. A doctor cannot and should not impose his preferred course of treatment on the patient.

Nevertheless, doctors can take comfort in the Court's statement that *"in implementing the test, it should be recalled that as the duty of the doctor is a duty to take* reasonable *care, he is not expected to meet "unrealistic standards of behaviour"*.

With the provision of advice coming under close scrutiny, conscientious note-taking and robust documentation is more important than ever. Often, the strongest defence against allegations of non-disclosure of material information is for the doctor to properly document the information imparted to the patient, and to keep appropriate records of such discussions.

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23 May 2017