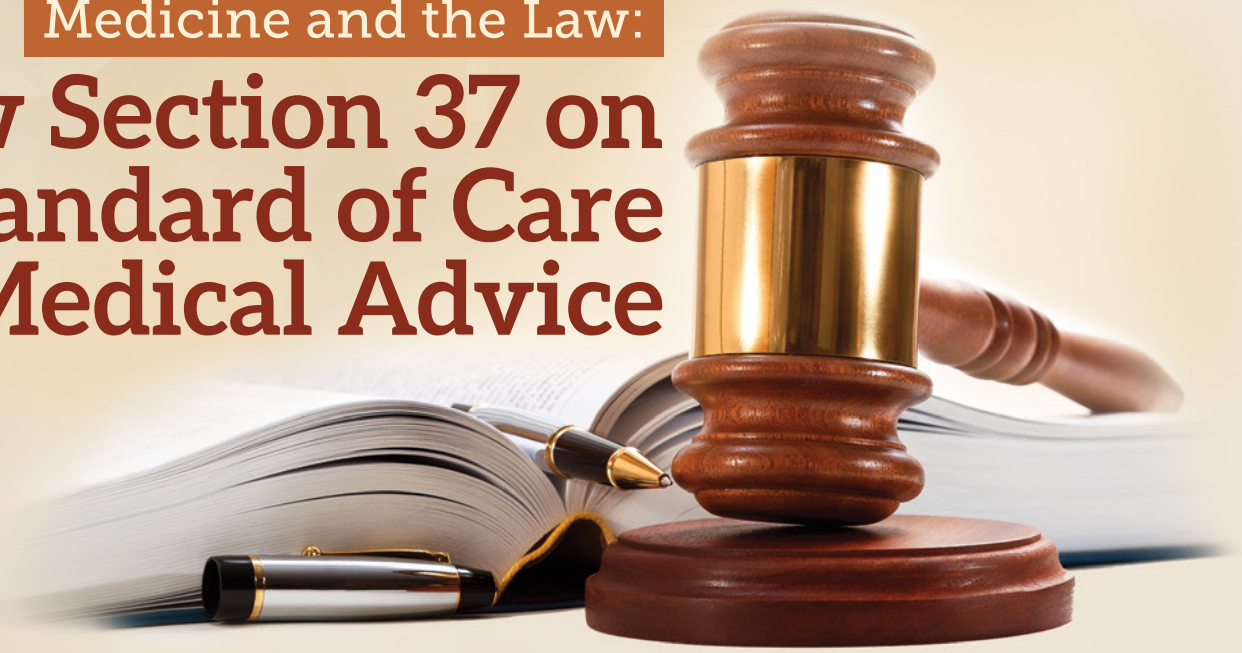
Medicine and the Law:

New Section 37 on Standard of Care for Medical Advice



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On 6 October 2020, the Singapore Parliament passed the Civil Law (Amendment) Bill (No. 33 of 2020)[1] which will come into effect imminently. The Bill introduced a new Section 37 in the Civil Law Act (CLA) to legislate the standard of care that healthcare professionals have to meet in giving *medical advice* to their patients, which has hitherto been based on common law (ie, judge-made law as decided in court cases). The Bill does not deal with, and does not affect the existing common law on the standard of care for *diagnosis* and *treatment* carried out. We will provide a brief background of the law pre-Section 37, followed by a commentary on the new Section 37, drawing substantially from its legislative intention as discussed in Parliament.

The Bolam-Bolitho test

A key aspect of medical advice is informed consent, which generally refers to the process by which a healthcare provider advises a patient on the risks, complications, benefits and alternatives of a medical procedure or intervention. The patient must be competent to make a voluntary decision as to whether to undergo the procedure or intervention.[2]

By way of background, Singapore Courts have been following and applying the *Bolam-Bolitho* (BB) test in respect of standard of care for medical diagnosis, advice and treatment. The 2002 Court of Appeal case of *Khoo James v Gunapathy*[3] endorsed this two-part test.

Under the *Bolam* part of the test, a doctor is not liable in negligence if he can demonstrate that there is a respectable and responsible body of medical opinion that accepts his practice as proper.[4]

The *Bolitho* addendum essentially provides that the medical opinion adduced must satisfy the threshold test of logic.

The first subtle sign that the Singapore Courts may eventually depart from the BB test for medical advice was around 2012. Then-Judge of Appeal Justice Chao Hick Tin, in his extra-curial speech on informed consent delivered at the 5th Chao Tze Cheng Memorial Lecture on 6 October 2012, made the following prophetic remarks:

"If I were to be asked to give a one liner advice, my answer will be this: Putting yourself in the shoes of the patient, what would you have liked to know from the doctor? You are unlikely to fall foul of professional and legal norms if this is your motto."[5]

The modified Montgomery test

Five years later, in 2017, a five-member Court of Appeal held in the landmark case of *Hii Chii Kok v Ooi Peng Jin London Lucien*[6] that while the applicable standard of care for diagnosis and treatment continues to be the BB test,[6] as laid down in *Gunapathy*,[7] a new legal test was minted for determining whether a doctor was negligent in advising the patient. This came to be known as the modified Montgomery (MM) test.

The Court's shift towards a more "patient-centric" approach follows from developments in the UK in the case of *Montgomery v Lanarkshire Health Board*.[8] In *Montgomery*, it was held that when seeking consent to treatment, the question of whether the information given to a patient is adequate is judged from the perspective of a reasonable person in the patient's position. Doctors have a duty to take reasonable care to ensure that patients are aware of "material risks". The test of materiality 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.[8]

Under our local MM test, a doctor's duty to advise requires that he/she disclose to a patient information that is relevant and material when giving them medical advice. The Court assesses what is relevant and material information from the perspective of the patient. The MM test was borne out of the observation that the BB test did not sufficiently give effect to the principle of patient autonomy and was regarded as too "doctor-centric".

A doctor would fall below this standard of care if he possessed information that is important or reasonably relevant and material to the patient, and failed to inform the

patient without any justification. The justifications for non-disclosure include waiver by the patient, emergency treatment and therapeutic privilege.

Whether a risk has to be disclosed depends on the severity of the potential injury and its likelihood.[9] In particular, a patient should have the freedom to make an informed choice about their medical treatment, consistent with the ethical tenet of patient autonomy.

According to the MM test, the doctor only has to tell the patient about reasonable alternatives, but the sufficiency of the advice and information will not depend solely on the views of other respectable doctors. Furthermore, a doctor must disclose information that he knows or ought reasonably to know would be important to that particular patient.[9]

Medical professionals are therefore expected to involve their patients to a greater extent when advising possible therapies or discussing treatment plans. Care should also be taken to record the patient's particular concerns, and what medical advice and information had been imparted to the patient as a result.

However, a key concern with the MM test is that it would result in "defensive medicine", whereby doctors dump excessive amounts of information onto patients in order to avoid negligence claims or complaints.[9] Doctors are fearful of needing to "read their patient's mind" to predict concerns that were not divulged by the patient at the clinic in order not to be considered negligent.[10] This is notwithstanding that the Court of Appeal made clear in *Hii Chii Kok*[9] that the doctor's duty to advise is not satisfied by conducting an "information dump" which tends to cause the patient to be more confused and less able to make a proper decision.

Another oft-cited criticism is that the MM test itself does not include the element of a reality check, save that it suggests that expert opinion could be taken into account when appropriate. The test of materiality is solely from the patient's perspective and does not take into account what is actually being practised on the ground. In medical practice, the three aspects of diagnosis, advice and treatment can sometimes overlap, making it hard to clearly apply the test.

Workgroup recommendations

Two years after *Hii Chi Kok* was decided came the highly publicised Singapore Medical Council (SMC) case of *SMC v Dr Lim Lian Arn*[11] in 2019. In brief, SMC prosecuted Dr Lim for failing to advise a patient of the possible risks and complications associated with a hydrocortisone and lignocaine injection. The Disciplinary Tribunal accepted Dr Lim's plea of guilt and imposed the maximum fine of $100,000 as sought by his counsel, while SMC sought a five-month suspension term. On appeal by the SMC, following strong reactions from the medical community, the Court of Three Judges set aside Dr Lim's conviction.

While Dr Lim's case does not engage the interpretation of the MM test, it catalysed further discussions on the MM test during the town halls conducted by the Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process, which was formed by the Ministry of Health in March 2019 to look into these areas after Dr Lim's case was reported.[12]

> *"The value of Section 37 lies in its spirit of bringing peer professional opinion back as a gatekeeper while giving effect to patient autonomy in the realm of medical advice."*

The general feedback was that "Many doctors grew uncertain as to what might be required of them when they saw a patient, advised a patient, took informed consent as well as have serious concerns as to whether the rigour of the SMC system was sufficient to see through the case to get a clear, consistent, and certain outcome."[12]

The Workgroup in particular found that many doctors perceived the MM test as bringing in an element of variability and hence uncertainty as to what each patient might want to know, since what is relevant and material is said to be assessed from the patient's perspective.

After extensive consultation with stakeholders of the healthcare sector, the Workgroup made three recommendations in relation to informed consent:[13]

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 Ethical Code and Ethical Guidelines 2016 edition (ECEG) 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 overall intention is not for the guidelines to be prescriptive, but to serve as a source of reference or as a baseline. In summary, these recommendations aim to restore the doctor-patient relationship, promote patients' interests and reverse the trend of defensive medical practice.

Rationale for Section 37

Section 37 is essentially the statutory embodiment of the Workgroup's first recommendation, combining aspects of the BB and MM tests.

Section 37 is intended to set a clear standard for healthcare professionals' duty in giving medical advice to their patients, to enhance decision-making and outcomes for the patient, rebuild trust between doctors and patients, and prevent defensive practices.

At one level, Section 37 aims to remove the dichotomy that one has to be either patient-centric or doctor-centric, rendering the patient and doctor constantly pitted against one another in a zero-sum game. A legal test which coheres with a patient and his/her doctor jointly managing his/her medical outcome is felt to be the better way forward.[12]

At another level, it seeks to balance preserving the principle of patient autonomy and upholding the principle of self-regulation in the medical profession, by providing that regard should be had to what peer healthcare professionals say as to the appropriate standard of care in giving a patient information. The Courts will continue to have oversight, by ensuring that the views of peer healthcare professionals pass muster when it comes to logic and reasonableness.

In concept, Section 37 is not a fundamental shift in direction. The underlying principles would be familiar to doctors and lawyers alike, and they are ones which are currently established in law.

What Section 37 does not change

Section 37 does not alter the burden of proof in a medical negligence claim. The claimant patient continues to bear the burden of proving his/her case on the civil standard of balance of probabilities.

Section 37 also does not change the test for medical diagnosis and treatment, which continues to be the BB test.

Unpacking the new Section 37

The following section draws substantially from Section 37's legislative intention as discussed in Parliament, and as reported in the Ministry of Health's news highlights.

Scope of Section 37

Section 37 applies not only in respect of medical advice given to patients, but also medical advice given to a person who is responsible for making a decision about undergoing a treatment or following a particular piece of medical advice on behalf of someone else, that someone else being a patient who is legally disabled.

A legally disabled person is someone who does not have the mental competence to make a decision for himself or herself. For example, a parent would be responsible for making a decision on behalf of his infant child.

Standard of care for medical advice

The Section 37 test provides that a healthcare professional will meet the standard of care in giving medical advice to a patient where two conditions are satisfied.[12]

Firstly, he acts in a manner which is accepted by the medical opinion of a respectable body of such healthcare professionals as reasonable professional practice in the circumstances (peer professional opinion).

Second, this peer professional opinion has to be logical, in that it has compared and weighed the risks and benefits of the conduct in question and arrived at a defensible conclusion that is internally consistent and does not ignore known medical facts and formulation.

These two conditions essentially incorporate the same legal principles that were used to assess healthcare professionals' conduct using the BB test.

Three Limbs of peer professional opinion

There are three limbs under which the peer professional opinion must assess the information given by healthcare professionals:[12]

In the First Limb, the healthcare professional must give his patient information that a "typical" patient would reasonably require to make an informed decision about whether to undergo treatment or follow a particular piece of medical advice. This provides for what a doctor might do to a typical patient that is judged by what his or her peers would regard.

In the Second Limb, the healthcare professional must give his patient information that he knows or reasonably should know is material to that "specific" patient, for the purposes of making the same informed decision as in the First Limb. It requires the professional to also think about what might be material information to this patient.

Material information

Material information may relate to specific concerns or queries that the patient expressly communicates in relation to undergoing the treatment or the medical advice, such as an expressed question, query or some discussion raised by the patient and if the doctors are asked specific questions, that becomes something he has to explain.

Material information may also relate to specific concerns or queries which the patient does not expressly communicate, but which ought to be apparent from the medical records of the patient which the healthcare professional has reasonable access to, and also ought to reasonably review.

In relation to information that ought to be apparent from medical records, this is not intended to impose an obligation on healthcare professionals to review and go back into reviewing substantial volumes of medical records, or voluminous medical history on the National Electronic Health Record in order to try and work out or ferret out concerns or queries that the patient might have.

The litmus test is that of reasonableness, both in terms of what the healthcare professional has reasonable access to, and also whether in the circumstance of the case, the discussion with the patient or the context in which the patient is seeing the doctor creates a scenario where the doctor ought reasonably to review these past records. What is reasonable is a matter to be assessed in the context of each case, and it is not possible to define upfront at the start all the categories in a closed fashion of information that will be regarded as reasonable or not reasonable.

A factor that would go into the assessment of what is reasonable is the age of the medical records in question. In general, the older the medical records are, the less likely it would be that it would be reasonable to expect the healthcare professional to review them. But if something is flagged out in the old medical record which suggests a need to make a train of enquiry, it would make it harder for the healthcare professional to say that it is not something that he ought not to look at in context of this treatment.

Other relevant factors to the assessment would include what transpired during the discussion that the patient has had with the doctor, and how the query or concern was characterised in the previous medical records. If something is mentioned only in passing, and does not feature prominently across the spectrum of the medical records, then it is less likely that it is something that ought to be apparent to the doctor.

Reasonable justification for not providing information

The Third Limb asks whether there is reasonable justification on the part of the healthcare professional in situations where information was not given. For example, there may be reasonable justification for not providing information in a situation of emergency. Or where a patient has waived his right to information, by telling the healthcare professional that he does not want to be given information. Whether there is a waiver is a matter of fact, sometimes of mixed fact and law, and the peer professional opinion can assist in the forensic analysis and weighing up of whether it is such a waiver by the Judge or tribunal.

On the other hand, a healthcare professional cannot simply refuse to provide information to his patient, merely because he thinks that providing a particular piece of medical advice or undergoing a treatment is in the best interests of his patient. In other words, the doctor cannot make up his/her mind for the patient and then decide based on that, an outcome and/or what he/she will and will not tell the patient. That would not be reasonable justification.

One would note that the three Limbs of peer professional opinion bear characteristics of the MM Test with some modifications.

Differing professional opinions

If there are different peer or professional opinions held by other respected healthcare professionals, then each of these opinions can still be used, provided it satisfies the test of logic. Section 37 recognises that there may be a diversity of views among healthcare professionals, all of which are in principle equally valid for consideration. But for each of them to be logical, they have to cohere with the standards and pass the test of logic and reasonableness (ie, the *Bolitho* addendum of the BB test).

Conclusion

The value of Section 37 lies in its spirit of bringing peer professional opinion back as a gatekeeper while giving effect to patient autonomy in the realm of medical advice. It is a timely legislative intervention in an area fraught with uncertainties for the medical fraternity. The entrenchment of peer professional opinion as a guidepost should go some way in allaying the concerns of doctors regarding what should be discussed or omitted when communicating with patients in taking informed consent.

How Section 37 will pan out for team management scenarios and its interface with the SMC ECEG for SMC disciplinary cases are matters pending further guidelines from the relevant authorities. It remains to be seen whether Section 37 will achieve all the objectives of legislation. In this regard, the Government's commitment to periodically review how this provision is working is assuring. This will help ensure that Section 37 is truly palatable for the medical profession and the public. ◆

References

1. Singapore Parliament. Civil Law (Amendment) Bill (Bill no. 33/2020). Available at: https://bit.ly/2U8X5aD.

2. Shah P, Thornton I, Turrin D, Hipskind JE. Informed Consent. In: StatPearls [Internet]. Available at: https://bit.ly/2UbqBwC. Accessed [10 Oct 2020].

3. Khoo James & Anor v Gunapathy d/o Muniandy [2002] 2 SLR 414.

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

5. Chao HT. 5th Chao Tze Cheng Memorial Lecture – Recent Developments in Informed Consent. Ann Acad Med Singap 2012; 41(11):540-8.

6. Hii Chii Kok v Ooi Peng Jin London and another [2017] SGCA 38.

7. Khoo James and another v Gunapathy d/o Muniandy and another appeal [2002] 1 SLR(R) 1024.

8. Montgomery v Lanarkshire Health Board [2015] UKSC 11.

9. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38.

10. Khoo EKH. Engage patients? Yes, but don't expect doctors to mind-read. The Straits Times [Internet]. 27 May 2017. Available at: https://bit.ly/3pfogiA.

11. Singapore Medical Council v Lim Lian Arn [2019] 5 SLR 739.

12. Ministry of Health. Opening Speech for Second Reading of the Civil Law (Amendment) Bill and Medical Registration (Amendment Bill) by Dr Edwin Tong, Second Minister for Law, on 6 October 2020. Available at: https://bit.ly/2VsgpQN.

13. Ministry of Health. Report on recommendations by Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process. Available at: https://bit.ly/3elTucO.

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