SURVIVAL MEDICINE: THE MODIFIED MONTGOMERY TEST

(Part 2)

This is the second instalment of a two-part reprint from the SMA Hobbit's blog. The first instalment was published in the January issue of SMA News *(https://goo.gl/pzTZr7).*

MM test: boundaries already creeping?

In para. 62 of the High Court Judgement issued by the Court of Three Judges in the Chia Foong Lin case on 27 June 2017, it was stated:

"When the available tests to exclude Kawasaki Disease (KD) are simple to undertake and when the consequences of no timely treatment of KD could be severe, it is not for a doctor to take chances with the well-being of a patient. If there was a need to take chances, that determination should be left for the patient (or his parents if the patient is an infant) to make on an informed basis. We struggle to understand why such exclusionary tests, which were not harmful to the Patient, were not undertaken, or why the parents of the Patient were not informed of their availability. It is here that Dr Chia badly faltered".[1]

It would appear here that having a patient-centric (or rather in this case, parent-centric) approach to advice given not only applies to treatment but has now also creeped into advice for investigation in order to make a diagnosis as well. Is the modified Montgomery (MM) test strictly limited to advice for treatment or does it impact advice for investigation as well? In the Judgement given by the five judges in May 2017 in *Hii vs Ooi*,[2] it was stated in para. 96: "where the diagnostic method is routine, non-invasive and risk-free (as in the case of the measuring of body temperature or blood pressure)", the MM test need not be applied.

So, if you read the two judgements, one could ask: "Does the MM test apply to the decision to order 'unharmful' blood tests or not? Is the reach of the MM test creeping further than originally intended? Was Dr Chia guilty of professional misconduct because she omitted ordering the test, or because she did not give advice to the parents so that the parents could make an informed decision whether to have the test? Or does the Bolitho-Bolam (BB) test continue to 'apply with great force in the diagnostic context' (para. 101)?" This Hobbit doesn't have the answer to these questions either.

To be on the safe side, this Hobbit will be applying the MM test to all information transfers from doctor to patient, whether the information is for treatment or just ordering an "unharmful" blood test. The patient will have to decide on an informed basis whether he/she wants an "unharmful" test or not. This change in practice has become an essential part of my survival medicine toolkit.

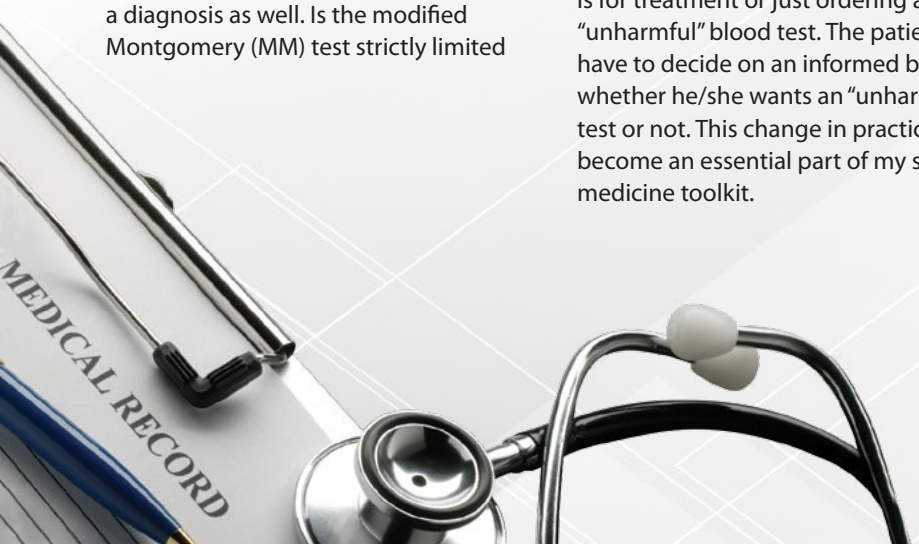
National Electronic Health Record (NEHR)

There is a lot of talk that participation in the NEHR will be made a requirement for clinic licensing (ie, participation in NEHR by hospitals, clinics and doctors will be made compulsory).

The doctor therefore will soon have access to years and years of patient information that may be relevant to the stipulation of the MM test that "other types of information that may be needed to enable patients to make an informed decision about their health" should be given to the patient.

Problems arise when a doctor misses out on information in the NEHR that was recorded a long time ago. Is the doctor truly responsible for taking into account the whole record of the patient from birth till present so as to tailor-make relevant advice for every patient, such that the patient can make "informed decisions"? Is this humanly possible given the constraints of time, resources and simple human frailty?

The MM test more or less says that the doctor is not responsible for not taking into account the information if the patient doesn't give the information to the doctor, and especially if the doctor has made some effort to elicit such information. But does this afford the doctor significant protection when almost all information is already in the NEHR and the NEHR is readily available to all doctors? Must the patient still



give the information when the physical consultation takes place? Would the doctor be held liable because of the extensive coverage of the NEHR? The prospect of being guilty of professional misconduct, because the doctor missed out a relevant morsel of information in the cavernous repository that is the NEHR, is real and possibly quite alarming.

Defensive medicine

The judges have opined that the MM test will not lead to defensive medicine. No one can really predict the future with 100% accuracy, but this Hobbit hopes that the judges are correct. As this Hobbit has said in a previous column, the Hobbit doesn't really know what defensive medicine is. The Hobbit has to practise "survival medicine" so as to NOT run afoul of Singapore Medical Council's (SMC) requirements and the law, and stay registered as a doctor.

Resources required

The first likely consequence of the MM test is that advice (and consent-taking) will take a much longer time than in the previous BB test era. A professional's time is a precious resource, be it for a doctor, accountant or lawyer. So, appropriate fees have to be charged to reflect the time and resources spent. With the extensive work that the MM test requires, this Hobbit wonders if consent-taking should be made a separate long consultation by itself and therefore is chargeable as a separate encounter between the doctor and the patient?

Since we are on the subject of resources, the private sector actually has it better. The private sector can readily adjust prices or turn away work so as to give each patient better attention and more time so that advice given can be compliant with the MM test.

The public sector will find this more difficult. They can neither turn away work nor readily titrate work volume using the price mechanism, since most of their work involves subsidised patients. The end result is that either waiting and appointment times have to lengthen or the system has to employ more doctors. In the distant past, the public sector was able to cut some corners, eg, use junior staff to perform tasks like advice and consent-taking. But this is no longer possible, because from another core ethical principle of justice, private and public sector patients must be accorded the same level of protection under the MM test.

Another consideration is that public sector doctors usually know their patients less well than those in the private sector. Many patients see different doctors over time, especially in the subsidised classes, and so the chances of missing out on relevant information about the patient is higher, while the MM test demands that the doctor gives advice in the context and from the perspective of the patient. You cannot give the right advice when you do not even notice the relevant information. Basically, the MM test requires less effort on the part of the doctor, when there is good continuity of care with the same doctor, which is hardly possible in the public sector due to training and service imperatives.

My way forward (which may not be yours…)

I do not profess to have the solution or "model answer" to complying fully with the MM test, but I shall share with you what I think will work for me, to the best of my limited abilities.

The MM test is divided into three parts. This hobbit suggests that advice-giving could also be divided into three parts:

1. Advice to the reasonable patient
2. Advice arising from information from past medical records
3. Advice arising from information actively obtained from current encounter

The first part deals with a doctor-centric model of the "reasonable patient". The reasonable patient is an artificial legal/ethical construct that does not exist physically. In the BB test era, as long as the doctor gives advice sufficient for "the reasonable patient", he is absolved of wrongdoing. Here, I think standard forms can be designed and used as a checklist to aid both the doctor and patient when the doctor gives advice, especially for common procedures such as a colonoscopy, transurethral resection of the prostate, removal of breast lump, etc.

The second part deals with information that can be gleaned from the patient's records, such as the NEHR. This is perhaps where Artificial Intelligence (AI) tools can be designed to automatically screen a patient's electronic record to highlight relevant and important information for both the patient and doctor. I think an AI tool will be far less error-prone than a doctor scrolling and reading a voluminous patient record quickly. But for now, we still have to just go through the past medical records manually and look for aspects that we think, from the patient's perspective, will affect our advice-giving – those aspects that happen to be more than what is required by the hypothetical reasonable patient.

In giving advice, both doctor and patient should sign off the standard forms, AI-highlighted information and the advice that is consequently given.

The third part involves the doctor actively eliciting information that is not expected of the reasonable patient or highlighted from the patient's electronic records and giving relevant advice from the information obtained in the second phase. The doctor can and should ask the patient: **"Is there any other information you want to tell me that I do not already know from your past medical records that you think may affect my advice to you from your perspective?"**

On top of this, an audio recording, with the patient's consent, of the entire three-part advice-giving process should be made. The patient's decision to give consent or not to an audio recording should be duly documented and acknowledged by the patient in writing (a simple signature in a simple form would suffice, I suppose).

If the patient refuses to even acknowledge in writing that he refused giving consent to making an audio recording, then the doctor can

always refuse to carry on with the doctor-patient relationship and stop the consultation in non-emergency situations. (The MM test only applies to non-emergency situations anyway.)

I am not advocating this approach to anyone, but it is my personal "best effort" response to complying with the MM test now – which is to make an audio recording. It is useful for both the patient and the doctor when a dispute arises.

Survival medicine in the new era

Let us now return to survival medicine, which is what this Hobbit is trying to achieve to ensure his professional survival. Recently, three unrelated events have collectively affected me greatly.

The first is the new 2016 Ethical Code and Ethical Guidelines (ECEG) and SMC Handbook on Medical Ethics (HME) which have been in force since 2017. The new ECEG is 65 pages long and the HME is 155 pages long. That's 220 pages in total and multiples in length of the last version. This weighs heavily on this Hobbit. It's tough reading through both documents and complying with them is even tougher. When the prosecution lawyers "throw the book" at you today as they draft their charge(s), you can bet there is a lot more book to throw at you – all 220 pages to be exact.

The second is the MM test. Some of the implications of the MM test have been described above. The MM test demands a lot more effort from doctors, because doctors now do not have to just give advice that is relevant to the reasonable patient, but information that pertains to the particular patient's circumstances and perspective that the doctor should have known.

The third is a little lesser known. It is a High Court judgement delivered on 25 July 2016 on the case of *Singapore Medical Council v Wong Him Choon*.

In para. 117 it is stated:

"As can be seen from *Lee Kim Kwong* and *Kwan Kah Yee*, we have on at least one previous occasion referred to and, on another, exercised our discretion to depart from precedents that do not reflect the prevailing circumstances and state of medical practice. In our judgment, public interest considerations weigh heavily in *imposing deterrent sentences on errant doctors* who are found guilty of professional misconduct. In this regard, we expressed at the hearing that we found the sentences imposed in the *Dr K* case, *Dr L* case and *Dr Amaldoss* case ("the Relevant Precedents") to be lenient. *We observed without reservation that these sentences should have in fact been longer*. We highlighted to the parties that this court has given fair notice of its intention to recalibrate sentences across professional misconduct cases, and would do so in the present case".[3]

In other words, in many cases, doctors can expect to face more severe punishments than in the past should they be guilty of professional misconduct, especially in cases where the public interest is involved.

Personal survival medicine

I do feel anxious about the current and future practicing environment. When I ask questions about certain aspects of the MM test to lawyers, many of the answers come back as: "We are not sure, this has not been tested in the Courts yet. We have to wait for the first case." There is uncertainty in both medical and legal work (the Honourable Chief Justice made this point as well in the Ransome Oration) and we have to accept that.

But still, it is hardly reassuring. I know doctors who would rather have a purulent abscess in their buttocks than be a test case for the SMC or Courts. An abscess you can drain and treat over a few days; a test case can last for months if not years.

So, again, my response is to practise survival medicine: be safe, rather than sorry. I am prepared to overcompensate a little out of prudence.

Is that defensive medicine? Like I said, I do not know what defensive medicine is. I just know I need to practise survival medicine. I need to survive. ◆

References

1. Chia Foong Lin v Singapore Medical Council [2017] SGHC 139.

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

3. Singapore Medical Council v Wong Him Choon [2016] SGHC 145.