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Doctor's duty of disclosure and the Singapore Court of Appeal decision in Hii Chii Kok: Montgomery transformed

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Doctor's Duty of Disclosure and the Singapore Court of Appeal Decision in Hii Chii Kok: Montgomery Transformed

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The subject of a doctor's duty of care to his patient, especially as regards the giving of advice, is a controversial one. In recent times, the courts and the medical professions in several jurisdictions have given their varying responses. In the Hii Chii Kok case, the Singapore Court of Appeal was faced with the difficult challenge of whether to and, if so, how to change the law. The judgment is as complex as it is important.

INTRODUCTION

The standard of the duty of care which a doctor owes to his patient is a controversial matter, and differing approaches are taken in different jurisdictions. The earlier approach, which favoured doctors, was that the *Bolam* test[1] – that a doctor is not negligent if he can show that his practice accorded with a substantial and respectable body of medical opinion in his field – applied to all three aspects of a doctor's work, namely, diagnosis, advice and treatment. Singapore had, prior to the recent decision in *Hii Chii Kok v Ooi Peng Jin London Lucien*,[2] adopted this position.

Over the years, several jurisdictions have moved away from this position either fully[3] (ie as regards all the three aspects) or partially.[4] Very recently, the UK Supreme Court, in the watershed decision of *Montgomery v Lanarkshire Health Board*,[5] radically changed the English law as regards a doctor's duty of disclosure and held that a doctor owes his patient a duty to disclose all material risks of a proposed treatment and of alternative treatments. The recent appeal to the Singapore Court of Appeal (SCA) in *Hii Chii Kok* was therefore a timely opportunity to consider if Singapore should do likewise.

FACTS AND HC DECISION

Hii Chii Kok is basically a case of an operation that turned out to be unnecessary. Hii, the patient, a prominent businessman with a law degree, underwent a Gallium positron emission tomography scan[6] at the Singapore General Hospital. The Gallium scan detected lesions in the head and body of the pancreas of the patient, and these lesions were either cancerous (NETs)[7] or noncancerous.

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[1] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, subsequently modified in *Bolitho v City and Hackney Health Authority* [1998] AC 232.

[2] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017), on appeal from the High Court's decision [2016] SGHC 21. The judges were Sundaresh Menon CJ, Chao Hick Tin JA, Judith Prakash JA, Tay Yong Kwang JA and Steven Chong JA.

[3] See, eg the Malaysian case of *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593.

[4] See, eg *Rogers v Whittaker* [1992] 3 Med LR 331, where the High Court of Australia decided that a doctor has a duty to warn a patient of any material risks of a proposed treatment. However, subsequent legislative reforms in Australia have retained the usage of the *Bolam* test for diagnosis and treatment: see, for example *Civil Liability Act 2002* (NSW) s 50, which essentially provides that a professional is not negligent if he acted in a manner widely accepted by peer professional opinion.

[5] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. According to Lord Kerr and Lord Reed ([87]), who delivered the judgment of the court: "The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

[6] This was combined with a CT (computed tomographic) scan.

[7] The term NET stands for neuroendocrine tumour.

The patient consulted doctors from the second respondent, the National Cancer Centre of Singapore (NCCS), who referred him to Dr Ooi, the first respondent. Dr Ooi's view was that the lesions were probably but not definitely cancerous. He recommended a surgical procedure called the Whipple procedure, which involved removing parts of the digestive tract and reconnecting the remaining parts. The patient also received advice from the Tumour Board, a multidisciplinary team within the NCCS. The Board was of the view that the lesion in the body of the pancreas was probably cancerous but was less certain about the lesion in the head of the pancreas.

Dr Ooi advised the patient as to the uncertainty of whether the lesions were cancerous and the pros and cons of the Whipple procedure. He also informed him of the option of removing the lesion at the body of the pancreas and leaving the other alone, as well as the option of holding off the operation for six months.[8]

The patient eventually opted for the Whipple procedure, after which it was discovered that the lesions were not cancerous. The patient suffered significant postoperative complications, which required many further surgeries. He then sued Dr Ooi and NCCS for being negligent in recommending the Whipple procedure, for failing to give him adequate information and for inadequate postoperative care. The High Court essentially applied the *Bolam* test and dismissed the action on all three counts. As regard the duty to advise, the learned judge found that *Montgomery* was also satisfied. The patient appealed.

Issues before the Singapore Court of Appeal

The main issues before the court were:[9]

(a) What test(s) apply to a doctor's standard of care?
(b) Did the respondents fall below the requisite standard of care in diagnosing the patient?
(c) Did the respondents fall below the requisite standard of care in furnishing advice and information to the patient?
(d) Did Dr Ooi fall below the requisite standard of care in relation to postoperative care?

The Singapore Court of Appeal Judgment

The SCA issued a lengthy and comprehensive judgment. As regards the law relating to a doctor's duty of care, the judgment can be divided as follows: an excursus of the existing law, the arguments for and against change and the new legal framework.

Existing Law

In his survey of the existing law, the Chief Justice examined and explained the *Bolam* test and the subsequent *Bolitho* addendum and noted how the Court of Appeal in *Gunapathy*[10] endorsed the *Bolam–Bolitho* test as well as the House of Lord's majority position in *Sidaway*.[11] The learned judge also made reference to leading cases such as *Canterbury v Spence*[12] and *Rogers v Whitaker*[13] as well as to several commentators. He also considered the question of whether the *Bolam* test applied to other professionals.

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[8] As well as the risk, in the latter option, of the lesions spreading if indeed they were cancerous. The option of doing an endoscopic ultrasound with a biopsy was also mentioned (see *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [23]).

[9] Two additional issues were whether NCCS owed the patient a non-delegable duty and whether there was causation. Since the SCA found that there was no breach, these two issues did not arise: see *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [222].

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

[11] *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC 871.

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

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

The Chief Justice then summarised the existing law as follows:[14]

- The standard of care of a professional is that of an ordinary and reasonably skilled professional.
- The specific test[15] in determining that standard is the *Bolam* test read with the *Bolitho* addendum.
- The *Bolitho* addendum is a two-stage inquiry of whether the experts had directed their minds to the risks and benefits, and whether their opinion was defensible.
- The *Bolam* test together with the *Bolitho* addendum applies to all aspects of the doctor's duty.
- The *Bolitho* addendum should be applied cautiously.

Impetus for and Options of Change

The Chief Justice then addressed the issue of legal change and outlined three options: full abolition of the *Bolam–Bolitho* test, retention of the test and the application of the test to some but not all of the aspects of a doctor's scope of work. After considering the pros and cons of each option, the third alternative was chosen – to retain the *Bolam* test for diagnosis and treatment but to apply a modified *Montgomery* test with respect to advice and disclosure.

There are several key reasons for the change. The first is the appreciation of the material difference in the dynamics of the doctor–patient relationship in each of the different phases of diagnosis, advice and treatment[16] and the recognition of the patient's right to make the decision on treatment. The Chief Justice explained:[17]

> The critical point to note is that in this aspect of the interaction [ie treatment and its risks] … it is the patient who is in charge because it is the patient who must make the choices and decisions … these are decisions that are ultimately the patient's to make.

The second is the shift in law in several common law jurisdictions towards patient autonomy, the most recent and perhaps notable of which is that of the United Kingdom in *Montgomery*. The third is the recognition by the medical profession itself of the prime importance of patient autonomy and the change in societal attitudes. The Chief Justice noted, for instance, that in Singapore the 2016 Ethical Code and Ethical Guidelines (2016 ECEG) of the Singapore Medical Council (SMC) "explicitly makes respect for autonomy an imperative".[18]

The New Legal Framework

After considering the arguments for and against change, the SCA decided that it was "necessary and justified"[19] for Singapore to depart from the *Bolam* test in relation to a doctor's duty to advise and proceeded to cite, approvingly, the following passage from *Montgomery*:[20]

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[14] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [76].

[15] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [104];The Chief Justice noted later in his judgment ([104]) that the *Bolam* test "is a proxy or a heuristic" for the test of a reasonably skilled professional. There is no doubt the *Bolam* test is a heuristic (ie aid to learning) but whether it is a proxy is more debatable. In the writer's view, the *Bolam* test is an exception and is really required when there are two or more acceptable ways to deal with a medical problem or where the doctor is engaged in pioneering or innovative work.

[16] See especially *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [92]–[93] and [97].

[17] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [97]. Note also the learned judge's later statements "it ultimately remains the patient's decision to make": [113] and "given the incontrovertible fact that it is ultimately the patient who must decide": [117].

[18] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [118]; see also: Singapore Medical Council, *Ethical Code and Ethical Guidelines* (Singapore Medical Council, 2016) (2016 ECEG) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Ethical%20Code%20and%20Ethical%20Guidelines%20-%20(13Sep16).pdf>.

[19] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [126].

[20] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [128].

> The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, 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.

However, the court made a few "significant alterations"[21] to the *Montgomery* test and introduced the following three-stage inquiry for determining if a doctor had complied with his duty of disclosure:

- Was there material information which the doctor did not disclose to the patient?
- Was the doctor aware of the information and, if not, was he negligent in not having the information?
- Was the doctor reasonably justified in not disclosing the information?

The court elaborated on each of these.

Stage 1 – Material Information

According to Menon CJ:[22]

> the information which doctors ought to disclose is (a) information that would be relevant and material to a reasonable patient situated in the particular patient's position, or (b) information that a doctors knows is important to the particular patient.

The inquiry at this stage is undertaken essentially from the patient's perspective as patient autonomy "demands nothing less".[23] Such disclosure would enable the patient to make an informed decision. What amounts to material information is "largely a matter of common sense".[24]

As regards risks, materiality depends on likelihood and severity.[25] A likely risk must be disclosed even if the outcome is slight injury; conversely, a slight risk of serious injury, such as paralysis or death, must be disclosed. However, the Chief Justice added:[26]

> it is conceivable for even a very severe consequence to not require disclosure if its chances of occurring are so low that the possibility is not worth thinking about.

and drew the analogy of death being a remote but real possibility each time one travels by automobile.

He also remarked that there is no breach of the duty of disclosure if a doctor fails to highlight risks that are obvious and risks that are "so plainly unlikely".[27]

As regards treatment options, only reasonable[28] alternatives (and their pros and cons) need to be disclosed. A doctor does not have to disclose "fringe" alternatives or "alternative medicine" practices.[29] The option of nontreatment should also be disclosed if the reasonable patient would consider it to be material.

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[21] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [131].

[22] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [132].

[23] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [132].

[24] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [139]; See also [141] and [143].

[25] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [140].

[26] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [141].

[27] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [141].

[28] Obviously, inappropriate options need not be disclosed: *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [142].

[29] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [142].

Materiality is assessed from the patient's perspective and there are objective as well as subjective aspects to materiality.[30] First, materiality inquires into what a reasonable person in the patient's position would consider material. Materiality also covers situations where although the information would be immaterial to a reasonable person in the patient's position,[31] the doctor knew or had reason to believe that it is nonetheless important to the particular patient "for his own (idiosyncratic) reasons".[32]

The doctor is required to provide information to enable the patient to make an informed decision, and the broad types of information are:[33]

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; and
e) the alternatives to the proposed medical treatment, and the advantages and risks of those alternatives.

Presumably, the costs of treatments could also be considered material, especially in this era of spiralling medical costs.[34]

Stage 2 – Possession of Information

At the second stage, the question is did the doctor have the required information? The Chief Justice remarked:[35]

> If the doctor was not aware of the information, it would make little sense to ask whether he should have given it to the patient; *one cannot give what one does not have*.

The suggestion appears to be that, in general, a doctor does not breach his duty of disclosure if he was not in possession of the information in the first place.[36] He then qualified:[37]

> This does not, of course, mean that a doctor can never be liable for negligence in this scenario. Rather, such issues should be dealt with as *instances of (potentially) negligent diagnosis or treatment, not (potentially) negligent advice.*

In other words, if the doctor did not have the information because of his diagnosis and/or treatment, he may be liable on that account but not on account of non-disclosure. The determination of whether the doctor was negligent in his diagnosis or treatment, the Chief Justice clarified, continues to be governed by the *Bolam–Bolitho* test. As Menon CJ subsequently reiterated:

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[30] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [144]; C6.1 of the 2016 ECEG provides a good example of information that is material to the particular patient – "while the risks of complications of surgery to a hand may be of a very low level, if the patient were a concert pianist, any loss of function of the hand, even if otherwise considered minor, would be catastrophic to that patient." See: 2016 ECEG, n 18, [C6.1].

[31] Such as where the information is important to the patient "for his own (sometimes idiosyncratic) reasons": *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [145].

[32] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [145].

[33] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [138], citing from *Dickson v Pinder* [2010] ABQB 269.

[34] "The costs of tests should also be disclosed, especially if the tests are expensive or you are aware that the patients view such information as important." Singapore Medical Council, *Handbook on Medical Ethics* (Singapore Medical Council, 2016) (2016 HME) B2 para (b) <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/2016%20SMC%20Handbook%20on%20Medical%20Ethics%20-%20(13Sep16).pdf>.

[35] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [133] (emphasis added).

[36] In contrast, the UK approach seems to assume that a doctor who does not have the material information is in breach of his duty but the point is debatable and there are as yet no decided cases on this issue. In the writer's view, *Montgomery* expects a doctor to have such material information that a reasonably competent and skilled doctor would have.

[37] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [133] (emphasis added).

> the question then should be whether he ought to have ordered the tests, or apprised himself of the medical knowledge, which would have given him the information – a question best considered under the rubrics of diagnosis or treatment and not advice.

The inquiry at the second stage thus appears to be heavily doctor-centric.

Stage 3 – Justification for Withholding Information

At the third stage, the court considers if the doctor was justified in withholding (or not disclosing) the information. The inquiry is physician-centric[38] though the burden is on the doctor to justify the non-disclosure.[39] However, in making the assessment, the court uses the general test of the reasonably competent and skilled professional[40] (or the "ordinary and reasonable doctor"[41]) and not the *Bolam* test. The former is preferred over the latter "to give recognition to the fact, previously overlooked, that the patient has a *prima facie* right to the information reasonably required to enable him to make a decision".[42]

It is important to note that the SCA prefaced its analysis of the three justifications[43] of waiver, emergency (or necessity) and therapeutic privilege with the caveat that the doctor's possible justifications should not be restricted to[44] or limited to the three specific situations.

The first justification – waiver – is consistent with the concept of patient autonomy; the patient is entitled to exercise his autonomy by deciding that he does not wish to hear further information about the proposed treatment or its alternatives. However, the Chief Justice cautioned:

> Given the seriousness of such a decision, waivers should ordinarily be express, or extremely clear if it is to be inferred. Moreover, the doctor should satisfy himself that, in deciding to waive his right to hear further information, the patient *properly appreciates the seriousness of his decision*. [emphasis added]

The emergency exception, his Honour noted, falls within the necessity exception and is a narrow ground of defence. In this inquiry, the doctor's perspective is important and the *Bolam* test is applied.[45]

The third exception – therapeutic privilege – was dealt with in some detail by his Honour. The privilege applies where the doctor reasonably believes that the very act of giving particular information would cause the patient "serious physical or mental harm".[46] Elaborating upon this, the Chief Justice explained:

> this should extend to cases where although patients have mental capacity, their *decision-making capabilities are impaired to an appreciable degree*.

These cases, he continued, include patients with anxiety disorders[47] and geriatric patients who may easily be frightened out of beneficial treatments which are relatively safe, and whose "state of mind,

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[38] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [148].

[39] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [149].

[40] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [134].

[41] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [135].

[42] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [135].

[43] Spelled out in David Andrew Ipp, "Australian Treasury", *Review of the Law of Negligence: Final Report* (2002) (the Ipp report) [3.61].

[44] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [149]; To quote the Chief Justice ([149]): "We do not think it would be helpful or appropriate to restrict the sorts of situations in which such non-disclosure might be justified." He reiterated at [149]: "We emphasise that these are not exhaustive … but [are] examples."

[45] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [151].

[46] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [152] (emphasis added).

[47] "to whom the mere knowledge of a risk may, without more, cause harm": *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [152].

intellectual abilities or education" makes it impossible or extremely difficult to explain the "true reality" to them.[48]

However, this privilege only applies in "such exceptional circumstances". The Chief Justice cautioned:

> 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 contrary to the patient's best interests. [emphasis original]

In keeping with this philosophy or policy, the inquiry as to whether therapeutic privilege applies "is an objective one and not one to be assessed using the *Bolam* test".[49] A doctor would not be excused for his non-disclosure on the ground of therapeutic privilege just because he can find a few peers who would also have invoked the privilege.

Rather, the focus of the inquiry is on whether the court is satisfied that the patient was suffering from such an affliction that he in fact was likely to be harmed by being apprised by the relevant information.[50] Alternatively, the exception applies where:[51]

> the patient, *though not strictly lacking mental capacity*, nonetheless suffered from such an impairment of his decision-making abilities that the doctor would be entitled to withhold the information having regard to –
>
> (a) the benefit of the treatment to the patient;
> (b) the relatively low level of 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 patient.

In other words, this alternative scenario of therapeutic privilege is where the patient is likely to reject a beneficial low risk treatment because he does not understand it.

Communication of Information

In introducing a duty of disclosure, the court does not have "unrealistic" expectations, bearing in mind that the doctor's duty is to take reasonable care.[52] As the Chief Justice reminded, the doctor is not required to ensure that the patient fully understands the information; rather, he is required to take reasonable care to ensure such understanding.[53]

But the doctor should provide "a quality of information that is commensurate with the ability of the patient to understand the information",[54] and "in terms and at a pace that allows the patient to assimilate it, thereby enabling him to make informed decisions".[55]

The Chief Justice also noted[56] the tendency and pitfall of hindsight bias as well as outcome bias and emphasised the importance of evaluating the doctor's conduct with reference only to facts known at the time of the material event.

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[48] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [152].

[49] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [153].

[50] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [153].

[51] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [153] (emphasis added).

[52] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [154].

[53] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [154], see also: Ipp report, n 43 and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

[54] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [155].

[55] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [156] and 2016 ECEG, n 18, [C5].

[56] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [157]–[159]. The court should also be alert to situations of "forgetful patients": *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [162].

Actual Result

The patient had appealed in respect of diagnosis, advice and postoperative care. The Court of Appeal found that the respondents did not breach their standard of care in relation to all the three aspects. As regards diagnosis, the court found that the respondents were not negligent in using the Gallium scan to diagnose the possible presence of pancreatic cell tumours as this practice was supported by a responsible and logical body of medical opinion.[57] The court also found[58] on the facts and the medical evidence that the postoperative care was not negligently carried out. On both these issues, the *Bolam* test was used.

Regarding non-disclosure, the appellant raised 14 points, which the court categorised as follows:

- Information regarding the Gallium test, such as the number of times it had been used and its diagnostic value;
- Risk that the patient may not have PNETs; and
- Alternative of removing the lesion in the body of the pancreas only, instead of removing both the lesions at the head and the body of the pancreas.

Regarding the first category, the court remarked that the doctor is not under a duty to provide the patient with "an encyclopaedic range"[59] of information but only such as are sufficient to enable him to make an informed decision. The court found that the respondents had conducted themselves responsibly by "ensuring that the gist of the relevant information was conveyed to the patient without an unnecessary and overwhelming amount of detail accompanying it".[60]

Regarding the second and third categories, the court was satisfied that the respondents had amply advised the appellant.

The court found that there had not been any omission to disclose material information. It also noted that the manner of communication was unimpeachable; the information was "concise, guided and to the point".[61]

The Chief Justice also remarked[62] that on the facts of the case, it mattered not whether the modified *Montgomery* test or the *Bolam* test applied.

Since there was no non-disclosure, there was no need for the court to consider justifications for non-disclosure.

Reflection and Comment

Like *Montgomery*, *Hii Chii Kok* is a landmark decision on a doctor's duty of disclosure. Overall, the new legal position as regards a doctor's duty of care is broadly similar in Singapore and in the United Kingdom – the *Bolam* test continues to apply to a doctor's duty in diagnosis and treatment but it does not apply to a doctor's duty of disclosure; in both jurisdictions, a doctor has a duty to disclose material risks and other material information to a patient. This duty of disclosure has both objective and subjective aspects: a doctor must disclose what is material to a reasonable person in the particular patient's position as well as what the doctor knows or ought reasonably to know is material to the particular patient.

Having said that, it must quickly be pointed out that the Singapore position on disclosure is far from being identical to the UK position. The exact differences are not easy to discern, and it is debatable whether they are necessary or desirable.

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[57] See *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [164]–[183].

[58] See *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [204]–[221].

[59] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [186].

[60] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [187]; The court noted that, ironically, had the respondents given all the information that the appellant had asserted as material, they might have opened themselves to an allegation that they had "failed to curate and present to the Patient, in an understandable fashion".

[61] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [202].

[62] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [203].

Differences

The main[63] differences are:

(a) In Singapore, there is a distinct three-stage inquiry whenever a doctor's duty of disclosure is in issue.
(b) Singapore retains the *Bolam* test as regards a doctor's duty of disclosure for two purposes:
    - deciding, at Stage 2, whether a doctor who did not have material information because he used a different mode of testing is liable for negligence; and
    - deciding, at Stage 3, whether the doctor is justified in not disclosing on the ground of emergency;
(c) The SCA takes a generous view of justifications for non-disclosure in general and a liberal interpretation of therapeutic privilege in particular.
(d) On the whole, there is hesitancy in embracing patient autonomy.

Requiring a Three-stage Inquiry

What should one make of the three-stage inquiry which the SCA has introduced? At one level, the inquiry is simply the practical application of the law to the scenario and the three stages are really about standard of care, breach and defences.

But there is more to it. Stage 2 asks two questions: did the doctor have the information, and was he negligent in not having it. The SCA's stance on the first question is somewhat disconcerting – "one cannot give what he does not have … [though] [t]his does not … mean that a doctor can never be liable." Further, the court suggested that in such a scenario, the issue is not disclosure (or advice) but diagnosis or treatment, and for which the *Bolam* test applied.

Two observations may be made here. First, such an approach looks like a backdoor readmission of the *Bolam* test and which tends to nullify the objective of moving to patient autonomy.

Second, does not the duty of disclosure encompass the duty to advise the patient of the risks of the proposed testing method as well as other testing options that are available? It should be pointed out that both the 2016 ECEG and the Handbook on Medical Ethics (2016 HME) embrace the standard and the expectation that a doctor has a duty in respect of both these matters. The following provisions are explicit:[64]

> You must ensure that patients are made aware of the purpose of tests … as well as alternatives available to them. 2016 ECEG, C6(3)

> You should be judicious in your choice of tests. In addition, you should … (f) Inform patients … about alternatives to tesing modalities … and (g) advise patients on … implications of undergoing the tests. 2016 HME, B2.1

Alongside this, one should bear in mind Menon CJ's averment that the types of information which would be considered material are "largely a matter of common sense" and that:[65]

> It would be unwise and perhaps impossible for us to set out in a pre-emptive manner just what the limits of such information should be, but in general, information that reasonable people would regard as immaterial or irrelevant, would be safe to omit.

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[63] The SCA speaks of information which is "relevant and material". Beyond reinforcing the idea of materiality, "relevant" is probably a redundant appendage.

[64] 2016 HME, n 34, [B1.3.1] (on availability of options), [B3(3)] (on medical records of discussions of investigations and treatment options), [C6.1] (which is similar to 2016 ECEG, n 18, [C6(3) and C6.2] (on the exchange of information as regards treatment and test options).

[65] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [139].

In this regard, the following words of the Chief Justice are instructive:[66]

> This is not to say that all diagnostic processes will take place without the prior involvement of the patient under the more active rubric of advice. That may be the case where the diagnostic method is routine, non-invasive and risk-free … ; however where a diagnostic procedure is unusual, invasive or risky … the advice facet will have to be engaged.

The learned judge appears to state two conversely related propositions: a doctor does not have the duty of disclosure as regards routine, non-invasive and risk-free diagnostic methods,[67] but he has a duty as regards unusual, invasive or risky ones.

He added that "the possibility of and reasons for a differential diagnosis, if any, will also generally be regarded as material."[68]

Certainly, if one applies the general duty of disclosure, one would conclude that a reasonable patient would regard the possibility of a different testing, which may lead to a different diagnosis, as material.

It therefore appears that the (new) duty of disclosure does include the duty to disclose the risks of the proposed testing option as well as information relating to alternative testing options. In that case, even if the doctor was not negligent in diagnosis, he may be negligent as regards his duty of disclosure.

Partial Retention of *Bolam* Test

The use of the *Bolam* test to vindicate the doctor who did not have the material information because he adopted a different testing or diagnostic option has been discussed. According to the SCA, the *Bolam* test is again to be applied when deciding if the emergency or necessity exception availed. In contrast, the applicability of the therapeutic exception is determined by neither the *Bolam* test nor, it would seem, the general test but rather by the court's own ascertainment of its applicability.[69]

A Generous View of Justifications

The SCA is favourable towards doctors in the subject of justification of non-disclosure in three ways:

- Its declaration that there may be situations of justification beyond the established categories of waiver, emergency and therapeutic privilege;
- The use of the *Bolam* test when considering the emergency exception (as just discussed above); and
- An expansive interpretation of therapeutic privilege.

On the third point, as discussed earlier, in the SCA's interpretation, therapeutic privilege also covers a situation where the patient, owing to a lack of understanding, might reject treatment which is beneficial and which carries a low risk. Such a viewpoint stands in contrast to the more calibrated and balanced approach which emerges from a holistic reading of provisions from the 2016 ECEG and 2016 HME, including:

- Patients are entitled to have accurate and sufficient information to be able to make their own decisions: C5, 2016 ECEG;
- You must accept patients' decision … even if you disagree with them, but you must ensure that patients have sufficient information to understand the consequences of their decisions: C5(2), 2016 ECEG;
- You have to ultimately respect your patients' choice of accepting or rejecting advice/treatment: C5.1, 2016 HME;

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[66] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [96].

[67] It is observed that the 2016 ECEG, n 18, [(C6(1))] and the 2016 HME, n 34, [(C6, 3rd para)] endorse the practice, so far as minor, routine or simple tests and procedures are concerned, doctors can just depend on "implied consent" (2016 ECEG, n 18) or "acquiescence" (2016 HME, n 34). It seems there is a lower standard of care as regards tests as compared to treatments.

[68] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [143].

[69] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [153].

- You must respect patients' right to refuse consent for tests, treatment or procedures, except when it is evident that their judgment is impaired or their mental capacity so diminished that they cannot make choices about their own care: C6(13), 2016 ECEG;
- You are obliged to respect the choices of competent patients who refuse consent for investigations and treatment even if such refusal will be harmful or life-threatening to themselves, or could even lead to death: C6.3, 2016 HME; and
- You should give patients time … to recover their ability to give competent consent … such as when fear, panic or emotional stress have temporarily interfered with your patient's judgment: C6.3, 2016 HME.

It must be remembered that the objective of requiring material disclosure is to enable informed decision. But informed decision is not synonymous with good decision. Here, reference may be made to s 3(4) of the *Mental Capacity Act*,[70] which provides that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision."

Similarly, a commentary from the SMC's Casebook explains:

> A bad decision is different from an uninformed decision. … Under the law, patients have the right to make "unwise" decisions, for reasons that are rational or irrational, or for no reason at all.[71]

The writer humbly suggests that if indeed a patient has the right to make bad or unwise decisions, then the therapeutic privilege exception should not be framed or crafted as broadly as has been done by the Court of Appeal.[72]

In this regard, it should be noted that apart from treatment with disclosure (and informed decision) and treatment without disclosure, there is a third path:

> If despite your best explanations patients persist in demanding[73] treatment that you strongly disagree with, you may find yourself unable to continue providing care. In such a situation, you may terminate your relationship with the patients and offer to refer them to other doctors: C3(5), 2016 ECEG.

In similar vein, 2016 HME states:[74]

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

Thus, in the writer's view, what has been said by the SCA regarding the therapeutic privilege should be read together with these elaborations, namely that a patient is entitled to make an informed but unwise or bad decision and that sometimes the doctor should decide not to proceed with the treatment.

IMPLICATIONS AND CHALLENGES

The SCA decision in *Hii Chii Kok* is very important for a variety of reasons. The positive ones are:

(a) The case provides comprehensive analysis of the pre-existing law as regards a doctor's duty of care to his patient, including the *Bolam* test and the *Bolitho* addendum and will henceforth be the main reference point on the subject.
(b) It provides detailed discussion of developments in medical ethics and practice, societal characteristics and expectations, and the resultant changes in law in some jurisdictions.

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[70] *Mental Capacity Act* (Singapore, Cap 177A, 2010 rev ed). It is observed that under the Act, a mentally impaired person, his condition notwithstanding, has the right to make his own decision. It would be ironic, as my research assistant pointed out in our discussion, if a mentally able person has a lesser right.

[71] www.bioethicscasebook.sg/case/ww/ *Making "bad" decisions: Commentary by Michael C Dunn.* Similarly, in *The Case of Mr Lim*, the same commentator states: "First, it is the patients' wants rather than their needs that are driving the medical encounter".

[72] But the point made by Kumaralingam, Medical Negligence and Patient Autonomy (2015) 27 SAcLJ 666 at para 51, is noted – that the ideals of patient autonomy do not match practice and that a significant number of doctors in Singapore do not believe that the patient is able to make rational decisions. Suffice it to say that the matter remains a controversial one.

[73] Or declining treatment which the doctor believes is in the patient's best interest: 2016 ECEG, n 18, [C3(4)].

[74] 2016 HME, n 34, [C6.3].

(c) In it, the SCA gave careful consideration as to the path that Singapore should take – full abolition of *Bolam* test, no change and partial abolition of *Bolam* test – and the pros and cons of each option.
(d) It declares the importance of patient autonomy and informed decision and explicitly recognises that in the composite bundle of a doctor's scope of duties namely of diagnosis, advice and treatment, there is a distinct phase or aspect: decision-making as to the treatment. Put another way, after the doctor has diagnosed and advised the patient and before proceeding with the treatment, there is this important and distinct phase or aspect – the decision, or choice – and which is primarily the domain of the patient.
(e) It introduces the new legal requirement that a doctor has a duty to disclose to his patient all material risks and all other material information. Alongside this, it affirms that as regards diagnosis and treatment, the *Bolam* test continues to apply.

The less positive ones are:

(a) The new three-stage inquiry framework is rather complicated and one struggles to fully understand the doctrinal and/or practical reasons for some of the nice distinctions and refinements. Different tests are employed for different parts of the framework, and there are no less than three applicable tests – the general test of the reasonably competent doctor), the *Bolam* test and ascertainment by the court, (using, it seems, common sense) which may apply. One wonders if it is not tidier and more desirable to apply a single test (perhaps ascertainment by the court[75]) for all aspects of the three-stage inquiry. This is especially since the Chief Justice noted that "the three aspects cannot always be rigidly demarcated."[76]
(b) In terms of policy shift and philosophical change, patient autonomy and informed decision are explicitly declared as the new paradigm and expectation. Yet in the manifestation and execution of this change, the hesitancy is palpable and one perceives a desire to retain much of what is purported to be put aside. Beneficence still occupies a major role in the new legal dynamics.
(c) This hesitancy is most evident in the following aspects of the new three-stage inquiry framework:
    (i) Stage 2 appears to suggest that the fact that the doctor did not have the material information in question prima facie provides a defence;
    (ii) Stage 2 also provides that if the reason for the doctor not having the information is that he employed diagnostic testing which is vindicated by the *Bolam* test, he also has a defence. Yet, this appears to contradict the duty of disclosure, which presumably includes disclosure as to testing options;
    (iii) Stage 3 subjects the availability of the emergency justification to the *Bolam* test; and
    (iv) Stage 3 takes an overly generous view of the ambit of therapeutic privilege and also suggests that there are situations of justifications for non-disclosure beyond waiver, emergency and therapeutic privilege; and

In effect, SCA followed Montgomery as regards to duty of disclosure and the threshold of materiality but departed by introducing a three-stage inquiry for which different tests are applicable for different aspects.

(d) In Singapore, the SMC's new expectations of informed decision and patient autonomy are clearly spelt out in the ECEG[77] and the HME. It is somewhat puzzling that the SCA, while declaring the importance of these related notions, chose to implement them through the three-stage test which

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[75] In *Rogers v Whittaker* [1992] 3 Med LR 331, Gaudron J stated at [4] of her judgment, "However, even in cases of that kind, the nature of particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense."

[76] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [90].

[77] It should be noted that the guidelines are "not … merely aspirational": *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [118].

strongly reasserts the importance of beneficence. But, to be fair, the Chief Justice had cautioned (without much elaboration or explanation):[78]

> It is therefore incumbent on us to reconsider the advice aspect of the relationship through the lens of patient autonomy *as well as* the principle of beneficence and ensure that *both* principles are upheld. There must be a balance of both principles … neither should dominate the other.

Concluding Remarks

On the subject of a doctor's duty of disclosure, the ground indeed has shifted, but the change is not as seismic or as extensive as the onlooker might have hoped. The patient has the right to be informed and the right to decide, but the physician is quite easily justified for his non-disclosure.

The new three-stage framework is not a simple one. Yet, the complications and imperfections belie the inherent challenges of the dynamic doctor–patient scenario and suggest that decision-making in the realm of medical treatment should be neither fully patient-centric nor fully physician-centric. For one thing, there may be other stakeholders, such as family members, whose views should count as well. Indeed, the realities of the dynamic scenario of medical treatment suggest that decision-making should really be a collaborative process.[79]

Hii Chii Kok has brought the law to a new and higher plain from which further refinements can be made in order to achieve a better equilibrium. For Singapore, it is clear that in this new paradigm of material disclosure and patient autonomy, beneficence still plays a critical role.

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[78] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38 (12 May 2017) [120].

[79] Readers are referred to the insightful article: Michael A Rubin, "The Collaborative Autonomy Model of Medical Decision-making" (2014) 20 *Neurocrit Care* 311–318 and the collaborative autonomy model set out in Table 1 of the article. The article also presents interesting empirical evidence as to the weight of patient autonomy in decision-making.