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# A doctor's duty of disclosure: UKSC sets new paradigm in Montgomery v Lanarkshire Health Board

Kee Yang LOW
*Singapore Management University*, kylow@smu.edu.sg

In May 2015, *the Law Gazette* published an article on the *Montgomery* decision which looked at the law on consent with a focus on patient autonomy. In this article, we consider another ramification of the decision.

The duty of disclosure a doctor owes his patient has been a sticking point in English law. The House of Lords had decided in *Sidaway* that the *Bolam* test – a doctor is not negligent if his practice accords with that of a respectable body of experts in the field – applied as well to the doctor's duty to advise the patient. In the recent *Montgomery* decision, the UKSC revisited this important issue and radically changed the law.

# A Doctor's Duty of Disclosure: UKSC Sets New Paradigm in *Montgomery v Lanarkshire Health Board*

## Introduction

*Montgomery v Lanarkshire Health Board* ("*Montgomery*")[1] is about a baby being born with severe disabilities. Expectant mothers of small build and suffering from diabetes,[2] such as the plaintiff, run the risk of shoulder dystocia, that is – the situation of the baby's shoulders being unable to pass through the pelvis in a normal delivery.[3] In this case, the patient was not told of the risk of shoulder dystocia as, in the doctor's opinion, the possibility was very small. The doctor was not inclined to warn as most mothers, if told would opt for a ceasarean section and that would deprive them of the (desirable) opportunity of a natural delivery.

During delivery, shoulder dystocia occurred and after desperate manouvres, the baby was delivered. Unfortunately, because of occlusion (blockage) of the umbilical cord, the baby was deprived of oxygen and this resulted in cerebral palsy.

In the Court of Session, one[4] ground of claim was that the doctor failed to advise on the risk of shoulder dystocia and its attendant consequences, and on the alternative of caesarean delivery. On this ground, the Court accepted the medical evidence given on behalf of the Health Board that the omission was proper and, following the majority approach in *Sidaway v Bethlehem Royal Hospital* ("*Sidaway*"),[5] held that the defendant had not been negligent. The Judge also held that the plaintiff would not have elected for caesarean even if she had been advised; in other words, there was no causation. The decision was upheld by the Inner House on appeal.

The plaintiff further appealed to the Supreme Court and invited the Court to depart from *Sidaway* and also reverse the finding as regards causation. The Court of seven Judges obliged the plaintiff and unanimously allowed the appeal. The judgment was issued jointly by Lord Kerr and Lord Reed, while Lady Hale delivered a short concurring judgment.[6]

This case comment deals with the issue of duty of disclosure. Before that, a few words on causation. The Supreme Court was mindful that appellate Courts should exercise restraint in reversing findings of fact made at first instance. Nevertheless, the Court was certain that there had been a failure to consider relevant evidence. In the light of the evidence (in particular, the doctor's own admission that had she raised the risk of shoulder dystocia with the plaintiff, the latter would "no doubt" have elected to undergo a caesarean section), the Court was of the view that causation was established.[7]

On the main issue of duty of disclosure, the structure of the judgment was as follows:

1. The existing legal landscape;

2. Social and other developments and the need for a change in the law;

3. The new legal framework of disclosure; and

4. Arguments against changing the law.

## Existing Law on Duty of Disclosure

As readers well-versed in this area are aware, under English law, in ascertaining whether a defendant doctor had lived up to the standard of care expected of him (or her), English Courts apply the *Bolam*[8] test. According to this test, a doctor is not negligent if he can show that his practice accorded with a substantial and respectable body of opinion in his field; he will not be considered negligent "merely because there is a body of opinion who take a contrary view".[9]

In *Sidaway v Bethlehem Royal Hospital*,[10] where a patient became paralysed after a back operation, the House of Lords held that the *Bolam* test applied not only to a doctor's diagnosis and treatment of his patient but also his duty to advise or warn the patient. Hence, the doctor's omission to disclose the risks of the particular treatment (here, a 1-2 per cent risk of some degree of paralysis) was not negligent since the practice (of not disclosing, in such circumstances) was accepted as proper by a responsible body of neurosurgeons. Lords Kerr and Reed noted that the lower Courts in *Montgomery* had applied *Sidaway*.

However, they also noted that according to Lord Bridge in *Sidaway*, the *Bolam* protection would not avail if there was a "substantial risk of grave adverse consequences" such that disclosure of the particular risk was "so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it"[11] (hereafter referred to as the Bridge qualification).[12]

Their lordships then referred to the qualification made by the House of Lords in *Bolitho v City & Hackney Health Authority*[13] that the application of the *Bolam* test is subject to an additional requirement (hereafter, the *Bolitho* addendum) – the Court had to be satisfied that the accepted practice had a logical basis, in that the experts had directed their minds to the comparative risks and benefits and had reached a defensible conclusion on the matter. The Judges noted[14] that there was a "superficial" resemblance between the Bridge qualification and the *Bolitho* addendum.

They also noted Lord Scarman's dissenting view in *Sidaway* that a doctor is under a duty to inform the patient of the material risks inherent in the treatment and that a risk is material if a reasonably prudent patient would think it is significant.[15]

Their lordships also expressed dissatisfaction with a legal framework which places the onus on the patient to ask the doctor questions relating to risk; they noted that patients who do not know what and how to ask are those who are in "the greatest need of information".[16]

They then observed that in some subsequent lower Court cases, most notably *Pearce v United Bristol Healthcare NHS Trust* ("*Pearce*")[17] and *Wyatt v Curtis,*[18] Judges chose not to follow *Sidaway*. In *Pearce*, Lord Woolf MR, in a judgment which Roch and Mummery LLJ agreed with, boldly declared:[19]

> [I]f there is a significant risk which would affect the judgment of a reasonable patient, then… it is the responsibility of the doctor to inform the patient of the significant risk … .

Their lordships then referred to the approach taken by the Supreme Court of Canada in *Reibl v Hughes* ("*Reibl*")[20] and the High Court of Australia in *Rogers v Whittaker* ("*Rogers*")[21] that a doctor owes a duty to inform the patient of material risks. In *Rogers*, the Court held that a risk was material if either a reasonable person in the patient's position would be likely to attach significance or if the doctor is or should reasonably be aware that the particular patient would be likely to attach significance.[22]

## Social and Other Developments

Lords Kerr and Reed observed that the paradigm of the doctor-patient relationship had changed over time and that what was said in *Sidaway* no longer reflects the current reality in the provision of healthcare services. Patients nowadays are regarded as "persons holding rights" and "consumers exercising choices".[23] A related development is that, unlike in the past, patients in this age have better information on and understanding of medical matters.[24]

Their lordships noted that these developments are in fact reflected in statements of professional practice. Good Medical Practice (2013) issued by the (UK) General Medical Council embodies the philosophy of the doctor working in partnership with patients, giving them information and respecting their rights to reach decisions. Another document – Consent: patients and doctors making decisions together (2008) is even more specific:

> The doctor explains the options to the patient, setting out potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option … but they [sic] must not put pressure on the patient to accept their advice. The patient weighs up the potential benefits, risks and burdens … The patient decides.

Further, there had been legal developments on the human rights front and Judges have become increasingly conscious of the need for the common law to reflect fundamental values (such as the right of self-determination) as mandated by the European Convention on Human Rights and other conventions.[25]

These developments cumulatively indicate a move from a doctor-patient relationship model based on "medical paternalism" to one where the patient is able to understand the implications of the treatment, to make the decision and to take responsibility for it.[26] In this model, the doctor has a duty to inform and the patient has right to decide,[27] and the determination of the nature and extent of this right rests not with the medical profession but with the Courts.[28]

Their lordships also made the incisive comment that the application of the *Bolam* test to the question of disclosure is liable to result in the sanctioning of differences in practice which are attributable "not to the divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients".[29]

In view of all the above, the Supreme Court decided that it was time to officially[30] depart from the *Sidaway* position.

## The New Position on Duty of Disclosure

After expressing approval of the propositions of Lord Scarman in *Sidaway*, Lord Woolf MR in *Pearce* and the High Court of Australia in *Rogers*, Lords Kerr and Reed began their formulation of the law with the preamble that a patient is entitled to decide on the form of treatment to undergo and his consent must be obtained before his bodily integrity can be interfered with.[31] Hence:

> The doctor is … 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… a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The paradigm has changed radically. The *Sidaway* position was that the doctor has the right to decide whether or not to make disclosure, except where disclosure is so obviously necessary to informed choice. The new position is that the patient has the right to decide, and the doctor must disclose all material risks of the proposed treatment as well as of alternative treatments.[32] Materiality is both objective (what a reasonable patient would regard as significant) as well as subjective (what the particular patient would likely regard as significant).

Elaborating on the doctor's duty, their lordships pointed out that the assessment of materiality, which "cannot be reduced to percentages",[33] takes into account a variety of factors, such as:

1. magnitude of risk;[34]

2. nature of risk;[35]

3. effect upon the life of the patient;

4. importance to the patient of the benefits sought to be achieved by the treatment;

5. alternative treatments[36] and their risks; and

6. characteristics of the patient.

Elaborating further,[37] their lordships emphasised that the aim of the doctor's advisory role is to ensure that the patient has sufficient understanding so as to be in a position to make an informed decision. The information provided must therefore be comprehensible. Bombarding the patient with technical information or routinely requiring signature on a consent form would not fulfill the duty.

The doctor's duty of disclosure is, however, subject to two exceptions. The first[38] of these, the "therapeutic exception", is where the doctor reasonably considers that its disclosure would be "seriously detrimental to the patient's health".[39] Their lordships cautioned that this is a limited exception and should not be abused; "it is not intended to subvert [the general] principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests".[40]

## Counter-arguments

In deciding to change the law, their lordships were mindful of various counter-arguments but found none of them unassailable. On the first point – that some patients would rather trust their doctors – the rebuttal was that, in the new scheme, the patient can choose not to be informed of the risks, in which case the doctor is not obliged to discuss them. On the point of practicability (impossible to discuss risks within the time available), the retort was that adjustments simply have to be made. On the argument that the change in law would lead to an increase in litigation, their lordships thought the new model of informed choice may be less likely to lead to litigation. Finally, on the argument of increased unpredictability of the outcome of such litigation, the lordships felt such unpredictability was tolerable in view of the attendant benefit of protecting patients. Above all, the "fundamental response" to all these objections is that "respect for the dignity of patients requires no less".[41]

## Comment

The UKSC decision in *Montgomery* has brought about a momentous shift in the law. The *Bolam* test no longer gives doctors protection in respect of non-disclosure or inadequate disclosure. *Montgomery* lays down the following principles:

1. The patient has the right to receive material information regarding his proposed treatment in order that he can make an informed decision;

2. The doctor must respect the patient's right and has a duty of disclosure – he must take reasonable care to ensure that the patient receives such material information;

3. This information includes materials risks and benefits of the proposed treatment and of alternative treatments;[42]

4. The nature and extent of the patient's right (and the doctor's duty) are determined by the Courts and not by the medical profession;[43]

5. Materiality is both objective and subjective;

6. Materiality takes into account magnitude and nature of risk, effect on the life of the patient, benefits sought to be achieved by the patient, characteristics of the paient and other factors;

7. Materiality cannot be reduced to percentages;

8. To facilitate understanding and informed decision, the doctor should ensure that the information provided is comprehensible;

9. The duty is not fulfilled by simply getting the client to sign a consent form;

10. (implicitly) The doctor must have reasonable grounds to believe that the patient understands the information that is given to him; and

11. The duty of disclosure is subject to the therapeutic exception[44] but the exception is a limited one and should not be abused.

As mentioned earlier, the default position has changed. Under *Sidaway*, the doctor need not disclose (so long as he satisfied *Bolam*) unless disclosure was "so obviously necessary". Under *Montgomery*, there is a duty to disclose unless disclosure is "so seriously detrimental" (to the patient's health).[45]

Note also the change to the threshold which triggers the duty to disclose. As observed by Lords Kerr and Reed,[46] while the Bridge qualification refers to "substantial" risk, Lord Woolf MR in *Pearce* used the term "significant' risk; the latter expression, they thought, was more apt. In the new *Montgomery* framework, a material risk is one which is "significant" – a lower threshold than "substantial".

With the change in law, the English Courts now recognise that there is indeed a difference between diagnosis and treatment on the one hand and provision of advice or information on the other. To paraphrase Mason CJ's explanation[47] in *Rogers*, the dynamics of participation is that the patient gives information to the doctor to assist the doctor to diagnose and treat, while the doctor gives information to the patient to enable the patient to make a decision as to the treatment.

The UK Supreme Court has now aligned the law to the expectations of UK's General Medical Council. No doubt, medical practitioners in the UK henceforth have to take their duty of disclosure even more seriously and perform greater due diligence.

## Singapore Position

In Singapore, the legal position is the one adopted by the Court of Appeal in *Khoo James v Gunapathy d/o Muniandy*,[48] where Yong Pung How CJ, after surveying the jurisprudence on the subject, firmly declared[49] that the *Bolam* test and the *Bolitho* threshold of logic apply to the whole of a doctor's duty to diagnose, advise and treat. He also remarked that the *Bolitho* addendum was timely as it "gave voice to a commonsense understanding … that the *Bolam* test did not represent immunity from judicial inquiry over the medical process". Yong CJ commented that the Bridge qualification was a "forerunner" of the *Bolitho* caveat.

The *Gunapathy* stand was applied in subsequent cases, most notably *D'Conceicao Jeanie Doris v Tong Ming Chuan*[50] and *Tong Seok May Joanne v Yau Hok Man Gordon*.[51] In *D'Conceicao*, Justice Tay Yong Kwang discussed the subject at length and remarked that *Gunapathy* was binding on him – the *Bolam* test together with the *Bolitho* addendum applied. In respect of the latter, his honour remarked:[52]

> I do agree … that if the medical profession illogically omits to warn of risks which patients should undoubtedly be informed of, then the court should interfere on the authority of *Bolitho*.

In the next breadth, he said that "in this regard", he would turn to the Bridge qualification and appears to equate it with the *Bolitho* addendum.[53]

It appears, then, that the current state of Singapore law as to a doctor's duty of disclosure is that the *Bolam* test, as qualified by *Bolitho*, applies. A doctor will not be negligent if his conduct (as regards advice to the patient) accords with that of a respectable body of experts and passes the threshold of logic. Also, the *Bolitho* addendum is similar, if not equivalent, to the Bridge qualification.

The question is whether it is time for Singapore Courts to follow the lead of the Canadian, Australian, Malaysian[54] and, now, English Courts and recognise the doctrine of informed consent[55] (also known as the Canterbury

doctrine[56]). An important consideration is whether the paradigm of the doctor-patient relationship has evolved and changed sufficiently. As far as the expectation of the medical profession is concerned, the Singapore Medical Council's Ethical Code and Ethical Guidelines provide as follows:

> 4.2.2 Informed consent
>
> It is a doctor's responsibility to ensure that a patient … is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, that patient shall be made aware of the benefit, risks and possible complications of the procedure and any alternatives available to him.
>
> 4.2.4 Patient's right to information and self-determination
>
> A doctor shall provide adequate information to a patient so that he can make informed choices about his further medical management. A doctor shall provide information to the best of this ability, communicate clearly and in a language that is understood by the patient.

These expectations have also been recognised in recent newsletters of the Singapore Medical Association, as one writer points out.[57]

Clearly, the local guidelines are similar to those in England and encapsulate the concepts of the patient's rights to information and to make informed decision and the doctor's corresponding duty to provide material information.

As for the knowledge of, and ability to comprehend medical matters, anecdotal evidence suggests that the level is reasonably high in the modern city state of Singapore. In such a society, the importance and respect given to human rights in general and the right of self-determination in medical matters[58] in particular is likewise heightened. The absence in Singapore of specific human rights statutes[59] is not critical, for the Courts in *Rogers* and in *Reibl* did not refer to or garner support from any such statute to arrive at their legal position.

More fundamentally, the simple reason Singapore Courts should move to the *Montgomery* position is that it is fair and just that the patient, whose body and/or life are most affected by the treatment, should be informed of the risks and should have the primary say as to whether the procedure should be proceeded with.

## Concluding Remarks

The nature of case law is that desired or desirable changes can take a long time to come to pass. Three decades after the House of Lords decision in *Sidaway*, the UK Supreme Court has finally decided that, on the issue of disclosure, the right of the patient is more important than the protection of the medical profession. Meanwhile, doctors and lawyers in Singapore wait anxiously to see if Singapore Courts would follow in the steps of *Montgomery*.

► **Low Kee Yang**
Associate Professor of Law
Singapore Management University
E-mail: kylow@smu.edu.sg

**Notes**

1 [2015] UKSC 11.

2 More specifically, insulin dependent diabetes mellitus.

3 Medical knowledge indicates that women suffering from diabetes are likely to have babies that are larger than normal and having larger shoulders.

4 The second was the mismanagement of the labour process. Basically, the plaintiff asserted that when complications arose during delivery, the doctor should have performed a caesarean section. This appeal focused on the first ground.

5 [1985] AC 871.

6 The other Judges were Lord Neuberger (President), Lord Clarke, Lord Wilson and Lord Hodge.

7 At [104]. There was, therefore, no need to consider the controversial case of *Chester v Afshar* [2005] 1 AC 134 (where the Court in effect dispensed with the need to establish causation).

8 *Bolam v Friern Hospital* [1957] 1 WLR 582.

9 *Ibid* at 586.

10 [1985] AC 871.

11 Lord Bridge at 900. But there is no duty to disclose where there is an emergency or where there is some other "cogent clinical reason" for non-disclosure.

12 According to Lord Bridge (at [898]), another exception is that when asked by the patient about the risks of the treatment, the doctor must answer "truthfully and as fully as the [patient] requires".

13 [1998] AC 232.

14 At [61].

15 At 889-890.

16 At [58].

17 [1999] PIQR P 53.

18 [2003] EWCA Civ 1779.

19 At para 21.

20 [1980]2 SCR 880.

21 (1992) 175 CLR 479.

22 At p 490.

23 At [75].

24 At [76].

25 At [80].

26 At [81].

27 At [82]. The term actually used in the passage is “entitlement”.

28 At [83]. Whether the risks of a proposed treatment ought to be discussed with the patient is not a matter of purely professional judgment.

29 At [84].

30 As mentioned earlier, some lower Court decisions had already ceased to follow *Sidaway*, even though it was binding on them.

31 At [87]. Similarly, Lady Hale, at [108], said that the law “protects a person’s interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body …”.

32 The New Brunswick Court of Appeal held in *Lemay v Peters* 2014 Carswell NB 444 the patient cannot truly give informed consent if he is not aware that less risky procedures might yield the same or a better result.

33 Although it should be noted that in *Sidaway*, Lord Bridge used a 10 per cent risk of a stroke as an example of “grave adverse consequences”.

34 In this regard, the reader should note that earlier in the judgment (at [78]), their lordships observed that the practice document *Consent: patients and doctors making decisions together* advised that “doctors must tell patients if treatment might result in a serious outcome, even if the risk is very small”. In similar vein, the British Columbia Supreme Court held in *Chen v Ross* 2014 Carswell BC 608 that the duty necessitates informing a patient of even a statistically remote risk where the potential consequences are sufficiently serious that a reasonable patient would likely consider it to be significant.

35 Presumably, the nature of the operation is also part of materiality: see *Hopp v Lepp* [1980] 2 SCR 192.

36 In *Lemay v Peters* 2014 Carswell NB 444, the New Brunswick Court of Appeal held that a patient cannot truly give informed consent if he is not aware that less risky procedures might yield the same or a better result.

37 At [90].

38 The second is the necessity exception, such as where the patient requires treatment urgently but is unconscious or “otherwise unable to make a decision”: at [88].

39 At [88].

40 At [91].

41 At [93].

42 Presumably, the information would include the likely prognosis of not having the procedure, as held in *Brown v Baum* 2015 Carswell Ont 3138.

43 Note, especially, para [83].

44 The exception or defence of necessity remains: [87].

45 To put it more simply (and loosely), there is a shift from “disclose only if grave” to “disclose unless it would be grave to disclose”.

46 At [66].

47 At 489.

48 [2002] 1 SLR(R) 1024.

49 Though His Honour did say (at [142]): “… this is not the appropriate place to address a fully argued appeal on the merits of a doctrine of informed consent”.

50 [2011] SGHC 193.

51 [2013] 2 SLR 18. It was also referred to by the Court of Appeal in *Pang Ah San v Singapore Medical Council* [2014] 1 SLR 1094.

52 At [124].

53 The statements of Tay J were cited at length (and with approval) by Andrew Ang J in *Tong Seok May Joanne* (at [61]-[66]).

54 See *Foo Fio Na v Soo Fook Mun* [2007] 1 MLJ 261, applied in *Chien Tham Kong v Excellent Strategy* [2009] 7 MLJ 261, *Hasan bin Datolah v Kerajaan Malaysia* [2010] 2 MLJ 646 amongst others.

55 While the terms “informed consent” and “informed decision” have been used quite interchangeably, technically speaking, consent provides a defence while inform decision is a right, the violation of which allows the victim a course of action.

56 Named after the US Court of Appeals, District of Columbia case *Canterbury v Spence* (1972) 464 F 2d772.

57 Alicia Zhuang, “Consent: Time to Say Goodbye to Bolam and Sidaway?” *Singapore Law Gazette* (May 2015) 16 at p 21.

58 Which the SMC Ethical Code expressly recognises (at para 4.2.4).

59 Although art 9 of the Singapore Consitution does protect an individual’s right to life and personal liberty.