

5th Chao Tze Cheng Memorial Lecture—Recent Developments in Informed Consent†

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Introduction

The question of informed consent is a concern of recent origin and has engaged the mind of the medical profession here for only some 5 decades now. The term ‘informed consent’ is very much of American origin and the British have termed it as ‘a duty to warn’. This concern arose due in no small part to the shift in perception, i.e. from the idea of doctor knows best to that of the patient must be left to decide for himself. A great deal has already been written on, as well as discussed about, the subject. But the fact of the matter is that the law on the subject is still evolving. Indeed, so long as doctors cannot guarantee a cure, or that a procedure to be undertaken will be successful, the issue will remain with us and will naturally be canvassed from time to time. Fortunately, today the successful outcome of a procedure is more the norm rather than the exception. I chose to speak on this subject precisely because I think that it is still very much an issue close to the heart of all doctors. Every doctor would like to do right. We have heard of defensive medicine. The question really is: will we in Singapore, in time, witness the emergence of, if I may coin a term, “defensive advice”?

As with many other things in life, an appreciation of history will add colour and depth to the understanding of the topic of this lecture. While doctors have, from the dawn of the profession, undoubtedly sought to do what is best for their patients, the issue of an adequate disclosure of information to patients is a relatively modern phenomenon. This is understandable and I can do no better than to quote what a local author Dr Myint Soe stated in an article which appeared in the Law Society Gazette 12 years ago:¹

The Hippocratic Oath (400 BC) says nothing about information or disclosure by the physician and, understandably, adopts the maxim ‘doctor knows best’. The cynic may well say that as the doctor himself did not know much at that time, there is hardly anything worthwhile to inform or disclose...

An article in 2001 observed that there was “traditional opposition and paternalism of the medical profession to any disclosure requirements”, and that “[a]pparently Hippocrates was so mistrustful of patients, and disdainful

of their inability to understand medically what needed to be done with their own bodies, that he believed it was imperative for physicians to hide most of the facts of treatment and outcomes from them”.² In 1984, a commentator wryly observed that “[t]hrough most of medical history the purpose of disclosure has been to get patients to agree to what physicians have wanted them to do”.³

In recent times, however, the question of informed consent has acquired greater significance in tandem with the rapid advancement of medical science and knowledge. As another article published in the Singapore Medical Journal in 1992 explained:⁴

... The movement towards a more precise code between patients and doctors was part of the general trend of society in its quest for immutable laws of nature, of man and in philosophy which coincided with the scientific revolution. ...

Right up to the end of the First World War the patient-doctor relationship was based on trust and confidence, coupled with a spirit of dedication and *noblesse oblige*. The rapid advancement in knowledge and practice of medical science since then has altered the expectations of the caring profession as well as the public. Whilst in the past cure was taken as a boon, it is now almost automatically taken for granted. Failure to cure is now attributed to ignorance which may amount to negligence.

Many bases have been advanced to explain the foundation for informed consent, one of which is the concept of patient autonomy. The Singapore Medical Council (SMC) Ethical Code states that a doctor is in general expected to “[t]reat patients with honesty, dignity, respect and consideration, upholding their right to be adequately informed and their right to self-determination”.

There is also a practical, positive aspect to the idea of informed consent. As the article in the Singapore Medical Journal explained, “[b]esides being good medicine, good humanity, good public relations, and good medicolegal defence, informed consent has a therapeutic value of its own—the informed, consenting patient, aware of the risk, is not so shocked should the risk turn up in his case and is much less likely to sue his doctor in the first instance”.⁴

Before I go any further, it is necessary for me to state at

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the outset what I will not be dealing with in this lecture. Due to constraints of time, I will not be touching on what is known as “therapeutic privilege” (which deals with whether and in what circumstances can doctors legitimately withhold information from patients if it is objectively in the patient’s best interests), and the question of patients’ mental capacity and competence in relation to a truly *informed* consent (which would arise where, for instance, the patient is a minor, has a mental disorder, or is otherwise incapacitated).

Setting the Stage: Case-law in Other Jurisdictions

England

The Standard of Care

At this juncture I will set out the positions prevailing in some jurisdictions which have the closest connection with, or of direct relevance, to Singapore. First I will look at the English position. The starting point in any discussion of English law on medical negligence must be what appears to be the classical case of *Bolam* decided in 1957, in which *McNair J* expounded that a doctor “is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... [even if] there is a body of opinion who would take a contrary view”.⁵

The House of Lords case of *Sidaway* of 1985 was the first decision where the English courts were faced with the question of whether to adopt a doctrine of ‘informed consent’.⁶ By a majority of 4-1 the House of Lords accepted that the *Bolam* test applied even to the question of consent. However, in a forceful dissent, Lord Scarman took the view that in determining whether a doctor had given sufficient advice, professional practice should not be determinative. The court should decide, in the light of all the circumstances including the probability of the risk materialising, whether a reasonably prudent patient would have regarded the risk which was not disclosed as being significant. His view would amount to making an exception to the *Bolam* test in relation to the giving of advice. I should add that although Lord Scarman dissented on the point of principle, on the facts he held that the plaintiff had failed on the evidence to prove that the surgeon had failed to warn her, effectively making it a unanimous decision on the facts.

As an academic Andrew Harding noted in 1986, the important consequence of *Sidaway* is that “in disclosing to a patient risks involved in medical treatment a doctor need not fully inform the patient of every risk capable of being regarded as relevant, but need only act in accordance with accepted medical practice”.⁷

In 1997 in the case of *Bolitho*, the House of Lords held that the court had to be satisfied that the body of medical opinion relied upon by the doctor had to have a “logical

basis”, and that the relevant experts had “directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter”.⁸ In other words *Bolitho* had added a rider to the application of the *Bolam* test.

Causation

There is one other consideration which may have a bearing on the doctor’s liability even if the doctor were to be in breach of his duty to advise the patient with regard to risks and available options. This relates to the issue of causation. In *Chester v Afshar*, which was decided in 2004, the House of Lords was faced with a hard case.⁹ There the plaintiff argued that as a matter of law it was sufficient to establish causation that “she would not have had the operation at that time or by that surgeon, even though the evidence was that the risk could have been *precisely the same* if she had it at another time or by another surgeon”. The House of Lords by a majority of 3-2 (with a strong dissent by Lord Bingham and Lord Hoffmann) departed from traditional principles of causation to hold the doctor liable even though (a) the patient would have agreed to the same procedure, albeit at a later time, even if the risk was disclosed to her, and (b) the temporary postponement of the procedure would not have modified the nature of the risk.

Referring to Lord Scarman’s description in *Sidaway* that “the patient’s right to make his own decision [is] a basic human right”, Lord Walker opined in *Chester* that “[t]he surgeon’s duty to advise and warn his patient is closely connected with the need for the patient’s consent... The advice is the foundation of the consent. That is why it is so important”. He acknowledged that the majority was departing from traditional principles of causation, but felt that this was justified because “Otherwise the surgeon’s important duty would in many cases be drained of its content”.

Lord Steyn stated, “In modern law medical paternalism no longer rules and a patient has a *prima facie* right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery”, save in “wholly exceptional cases” where it was objectively in the best interests of the patient for the surgeon not to warn him.

In dissenting, Lord Hoffmann noted the illogicality of the argument advanced by the plaintiff there: “this argument is about as logical as saying that if one had been told, on entering a casino, that the odds on the number 7 coming up at roulette were only 1 in 37, one would have gone away and come back next week or gone to a different casino”.

As Assoc Prof Catherine Tay noted, this case “makes it more crucial now than ever to warn patients about significant adverse outcomes, risks and complications

for any procedure. Doctors must ensure that patients are fully informed and understand the information given. The patients must also be given sufficient time to digest the risks disclosed. It is also important to document in the medical notes, if treatment is refused after information disclosure”.¹⁰

The United States (US)

In the United States (US), the root of the doctrine of ‘informed consent’ was sown in 1914 in the case of *Schloendorff*, where Benjamin Cardozo J stated, “every human being of adult years and sound mind has a right to determine what shall be done with his own body”.¹¹ Despite this pronouncement, judicial approaches to the issue of consent remained “saturated with paternalistic overtones”, as one commentator put it.² It was not until 40 years later in 1957 that the court in *Salgo* expressly stated, “A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment”.¹²

In *Canterbury v Spence*, which was decided in 1972, the US Federal Court of Appeal (DC Circuit) reaffirmed that “it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie”.¹³ It held that material risks had to be discussed, with a risk being material “when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy”. On the facts of the case, the risk related to paralysis and was inherent in that kind of procedure (an operation on the spine). This risk had a low chance of about 1% of occurring. The court found that there was a *prima facie* case to go before the jury that the surgeon was obliged to disclose this risk of paralysis. The court held that the surgeon’s argument that disclosure would be unwise was a matter to be decided by the jury as a finder of fact. The court’s basic premise was that self-determination was paramount although it recognised that there would sometimes be a fine line between what should be disclosed and what was too remote to be disclosed.

However, I would hasten to add that the *Canterbury* approach was rejected by many states in the USA partly due to a fear that malpractice suits might be encouraged as a result.

On the point of causation, the court in *Canterbury* held that an *objective* test had to be adopted to avoid placing the doctor “in jeopardy of the patient’s hindsight and bitterness”. Thus, what had to be established was that a prudent person in the patient’s position would have declined surgery if suitably informed of all material risks.

Canada

In Canada, in *Reibl v Hughes*,¹⁴ a 1980 case, the Canadian Supreme Court held that doctors are under a duty to disclose “all material risks” related to the recommended procedure, and that the materiality of a risk would be determined by reference to various matters including the seriousness of its consequences (if it occurred).

As for causation, the Canadian Supreme Court held that the patient had to prove that it was more likely than not that a reasonable person in his position would, after disclosure of all material risks, have opted against the surgery rather than undergoing it at that time. This is the same objective test adopted by the US court in *Canterbury*.

Australia

In Australia, the courts distinguish between diagnosis and treatment on the one hand and the giving of advice, and the disclosure of risks and available options, on the other. For the former, the *Bolam* test would appear to be applicable. However, in the case of *Rogers v Whitaker*, the High Court of Australia firmly rejected the applicability of *Bolam* test in the context of advice.¹⁵ The court said as follows:

The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

In 2001, the High Court of Australia affirmed *Rogers v Whitaker* in its decision in *Rosenberg v Percival*.¹⁶ In so doing, it also clarified that a subjective test of causation applied in this regard. It held that the correct approach to take was whether *that particular* patient would have refused surgery if the relevant risk had been disclosed to him. The court expressly declined to follow *Reibl* in Canada and *Canterbury* in the US which adopted the yardstick of whether a *reasonable* patient would have refused surgery.

Malaysia

In 2006, the Malaysian Federal Court held in *Foo Fio Na*¹⁷ that the *Bolam* test was not relevant when the question concerned advice on the inherent and material risks of a proposed treatment. The court held that a doctor must inform his patient of “the risks involved in any proposed treatment”. The court wholeheartedly endorsed the Australian position, opining that “the *Rogers v Whitaker* test would be a more appropriate and viable test of this millennium than the *Bolam* Test”. The court referred to an academic view that:

[T]he point is for the court to determine what the reasonable doctor would have done, not the profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented.

Summary

To summarise, in a sense, the modern debate about informed consent is not so much about the existence of the right to consent *per se* but the real contents of that consent. Most, if not all, jurisdictions today accept the idea that certain risks should be disclosed to patients so that they can make an informed decision on whether they are willing to accept those risks in return for the anticipated benefits of the medical procedure. As a writer Josephine Shaw aptly observed in 1986:¹⁸

The right to consent, therefore, is not at issue. What is at issue is precisely what doctors must do to facilitate the giving of that consent in circumstances where the patient actually understands what the issues are.

The true question concerns the legal standard of care to which doctors are held: what are the principles which determine which risks should be disclosed to patients? As the brief survey above shows, there is considerable divergence of approach among some of the leading common law jurisdictions. While England adheres to the traditional Bolam approach (supplemented by Bolitho) as to the standard of care expected of doctors, it has relaxed the position in relation to causation so that a doctor will still be held liable even if the patient cannot show that he would have declined the medical procedure at that time if the relevant risks had been disclosed to him. In contrast, while the US, Canada and Australia have adopted a more patient-friendly approach by requiring that all “material” risks should be disclosed, they have adhered to traditional causation principles by requiring that the patient must show that if the relevant risk had been disclosed he (or the reasonable patient) would have declined the medical procedure.

The Position in Singapore

What, then, is the position in Singapore? I will first briefly outline the current legal position on the standard of care expected of doctors and the test of causation. I will thereafter consider a few recent cases where the issue of informed consent has surfaced.

The Law

In 2002, the Singapore Court of Appeal affirmed in *Gunapathy* that the Bolam test (as clarified in *Bolitho*) applied to the issue of advice. For present purposes, *Gunapathy* is important in 2 aspects. First, the court observed that “even if the doctor’s actions were supported by a body of medical opinion, the court would still examine the expert testimony to see if it was founded on a logical basis”. The court approved of the following comments made by Lord Bridge in *Sidaway* that:

[E]ven in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might in certain circumstances come to the conclusion that disclosure of a 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. The kind of case I have in mind would be an operation involving a substantial risk of grave adverse consequences ... In such a case, in the absence of some cogent clinical reason why the patient should not be informed, a doctor, recognising and respecting his patient’s right of decision, could hardly fail to appreciate the necessity for an appropriate warning.

Secondly, despite its acceptance that the Bolam test also applied to the issue of advice, the Court of Appeal indicated that given that the merits of a doctrine of informed consent based on *Canterbury* did not arise in the course of parties’ arguments, it preferred not to foreclose the possibility of departing from the Bolam test in determining informed consent in the future.¹⁹

Therefore, it would appear that in Singapore as of now, Bolam is still the applicable test to determine whether informed consent has been given. Having said that, it is still possible, when an appropriate case arises, that the courts here may well be persuaded to adopt the approaches advocated in *Canterbury v Spence* in the US, *Reibl v Hughes* in Canada, or *Rogers v Whitaker* in Australia, or a combination of these approaches. Ultimately the courts here would have to grapple with the question as to whether it is fair that what should be disclosed to patients, including the risks of the treatment or procedure, should be left entirely in the hands of the doctors.

As for the question of causation, the High Court in 2011 found that a cardiologist had not breached his duty of care to his patient in advising the latter.²⁰ The judge nonetheless went on to opine (albeit obiter) that the patient’s claim would still have failed because there was no causation. Relying on a Court of Appeal case in 2001,²¹ he held that *Chester v Afshar*, which was decided in 2004, “is not the law in Singapore”. The judge observed that *Chester v Afshar*’s emphasis on human rights and autonomy might be due in

part to the European Convention of Human Rights which did not apply in Singapore.

Again, it remains to be seen whether on the question of causation, another High Court or our Court of Appeal will accept or reject the approach taken by the majority in the House of Lords in *Chester v Afshar*.

Recent Cases

In the last 5 years the SMC has had to hear quite a handful of complaints made against doctors on account of an alleged lack of informed consent. Three doctors were found to have breached the rule. I will now allude briefly to these 3 cases.

In the first case,²² a patient consulted the doctor and was diagnosed with a medical condition. Three days later, the patient underwent a staple haemorrhoidectomy (SH) having signed an informed consent form prior to the surgery. The patient later alleged that the doctor had only suggested 1 alternative option and that the doctor was very dismissive and did not mention of the risks and complications which could arise from SH. The doctor disputed these allegations and stated that he had discussed a third option, and had also informed the patient of the risks and common complications of SH.

The disciplinary committee (DC) of the SMC believed the patient's version of events and found that the documentary evidence did not support the doctor's contention that informed consent was obtained. The case notes did not record any discussion of treatment options, apart from the doctor's recommendation of a colonoscopy (the patient's refusal was recorded) and SH. There was also no evidence to support the doctor's claim that there was a discussion of the risks and complications involved in SH. The DC imposed a punishment of suspension. The doctor's appeal was dismissed by the court. The court observed that it was important to obtain informed consent from a patient before performing invasive surgery on him, and noted that it was the SMC's mission to raise the standard of medical treatment of patients in Singapore. The court agreed that a suspension was warranted.

In the second case,²³ a patient who was blind in his right eye, consulted the doctor because he was suffering from severe pain in that eye. The doctor recommended a surgical procedure with an implant. Something went wrong with the implant some time after the surgery was completed. One of the 2 charges brought against the doctor was that he had failed to inform the patient of all treatment and surgical options available to him, and to sufficiently explain the risks, side effects and nature of the procedure which was carried out. The DC found, based on the evidence, that the doctor had not offered other options of treatment to the patient, and that there was "no balanced discussion of risk

versus benefit in this case to allow the patient to make an informed consent". The DC imposed a \$7000 fine on the doctor and censured him.

On appeal by the doctor, the High Court found, on the basis of the evidence, that he had not informed the patient of any alternative treatment options. One reason for the court's upholding of the DC's finding in this regard was because the doctor's case notes made no mention of any of the options which he had allegedly informed the patient about. The court also upheld the DC's finding that the doctor had failed to explain the risks, side effects and nature of the surgical procedure.

It will be noticed that in both these cases the issue of contention related to findings of fact, i.e. as to what the doctor had informed the patient of and whether the doctor had advised the patient of the available options. No serious questions of law had arisen which required a ruling by the court.

In the third case, the charge against the doctor related to his failure to record his discussion with the patient of (a) a possible lobectomy and (b) the patient's consent to the lobectomy in his medical records.²⁴ The doctor admitted to the charge. He was fined \$5000 and censured by the DC, which considered that in this case, consent was obtained but unfortunately not recorded. Guideline 4.1.2 of the SMC Ethical Code states amongst others that "All ... discussion of treatment options, informed consents and treatment by drugs or procedures should be documented". The DC opined that apart from being an important part of the treatment of patients, proper medical record keeping is also crucial in avoiding disputes between a doctor and his patient.

I now turn to consider the suggestions which various commentators have made on what steps doctors can adopt to avoid pitfalls in this area.

Consent Forms

In the first 2 SMC cases which I mentioned earlier, the patients had each signed a "consent form". Nonetheless, the doctors were found to have failed to have sufficiently disclosed the risks of the medical procedures. In 2008, a commentator suggested that doctors should use "a more detailed consent form, where the risks and benefits of the procedure (including those of the alternatives discussed) are printed legibly and in plain English so as to ensure a minimum level of disclosure".²⁵ He pointed out that such detailed consent forms are frequently used in Singapore in relation to clinical trials and have proven successful in avoiding complaints of lack of informed consent. However, he cautioned that "while the signing of a consent form may be used as evidence to show that the patient had made an informed consent, it should not be recognised as conclusive

if, in reality, the relevant information had not been presented to the patient”. In other words, “[i]nformed consent is not a matter of form but substance”.²⁶

As early as 1984, one commentator warned that consent forms should not be used in a mechanistic manner:³

For a medical staff as bureaucracy, informed consent represents another form to be complete and filed in satisfaction of regulatory requirements. Medical staffs often use consent forms in an impersonal way; such forms may allow an almost total separation and dissociation of the information presented and the person presenting it.

In May 2011, 2 lawyers also suggested in an article in the Singapore Medical Association (SMA) News that “[i]mportant points in the form should be specifically drawn to the patient’s attention and clearly indicated on the form itself (eg. have the patient countersign against the points)”, and that patients should sign the consent form only after the relevant discussions with them so that the consent form reinforces the points discussed and carries corroborative weight in any future dispute.²⁶

In 2006, a survey of 100 specialists and general practitioners in Singapore suggested that “it is good practice to have consent forms in the different main languages, and call upon an interpreter if the patient has difficulty with understanding what is being said”.²⁷ This is a point which is particularly important given the multilingual composition of our society. Patients may still be more comfortable speaking in their mother tongue even if they are able to converse in English.

Apart from the substance of the consent forms used, the underlying procedures should also be safeguarded from abuse and tampering in order to maintain public confidence. It was reported in a Straits Times article of 2 October 2011 that a surgeon had accidentally severed some nerves in a patient’s hand during surgery. He then reattached the nerves without express consent, and instructed a nurse to edit the patient’s consent form to include the reattachment procedure without telling the patient. There was an indication in the news article that the reattachment should be done immediately. Perhaps the reattachment could be justified on the ground of necessity or implied consent. What the surgeon should have done was to inform the patient subsequently of what actually transpired and of the added procedure performed. Unilaterally amending the consent form is clearly wrong. On the question of ensuring the sanctity of the consent form, the news article noted that one possible way of preventing such improper acts would be to adopt electronic consent forms which could not be cancelled or altered after the forms had been submitted.

Case Notes of Patients

In the second SMC case which I mentioned earlier, the doctor’s defence to the claim of lack of informed consent was based on the phrase ‘guarded prognosis’ which he wrote in his case notes on the patient. The High Court observed that this phrase was “woefully inadequate” in the light of guideline 4.1.2 of the SMC Ethical Code on medical record documentation which I mentioned just now.

In the May 2011 SMA News article, the 2 lawyers also observed that “the lengthier the discussion, the more entries one would expect to see in the case notes. The case notes should clearly reflect all the treatment options discussed and why a particular option is recommended”.²⁶ They recommended that it would be “prudent to adopt a rule of thumb that if in doubt, always document more within the case notes to show the essential points discussed with the patient”.

Suggestions on What Matters Should Be Disclosed

The survey in 2006 of 100 specialists and general practitioners in Singapore arrived at the following conclusion:

More physicians may be encouraged to inform their patients of changes that they might have to make to their lifestyle before and after treatment, what would happen on admission, and how they would feel during and after the treatment. A significant number of patients were not told whether the proposed treatment was experimental, the failure rate, and the benefits and success rate for each treatment modality if there were multiple options. Many physicians failed to inform their patients that they could change their mind about the consent at any time, or remind them that they could ask for a second opinion.

The authors of the survey thus recommended that doctors should:

- let the patient know the identity of the senior doctor with overall responsibility for the treatment procedure, whom the patient can contact for further information;
- tell the patient who the other senior members of the team are, if applicable;
- inform the patient of changes that he/she may have to make to his/her lifestyle before and after treatment, and what happens on admission;
- let the patient know whether the proposed treatment is experimental;
- explain to the patient the failure rate, success rate and benefits for each treatment modality if there are multiple options;
- make it known that the patient has the right to change his/her mind about the consent at any time; and

- remind the patient that he/she can ask for a second opinion.

It has even been suggested that a doctor should generally disclose *his individual experience* with the particular medical procedure which he recommends (as opposed to merely disclosing *general statistics* in relation to the medical procedure). In 1996, the Wisconsin Supreme Court in *Johnson v Kokemoor* stated:²⁸

In this case information regarding a physician's experience in performing a particular procedure, a physician's risk statistics as compared with those of other physicians who perform that procedure, and the availability of other centers and physicians better able to perform that procedure would have facilitated the plaintiff's awareness of "all the viable alternatives" available to her and thereby aided her exercise of informed consent. ...

One commentator, while noting that other courts in the US have disagreed with this approach, nevertheless said that the Wisconsin court's approach is correct and should be followed because:²

... [I]t defies logic to assert that the experience of a physician is immaterial to a patient's consent. Since the patient must bear the expense, pain, and suffering of any medical procedure, he or she is certainly entitled to know before consenting whether the physician wielding the scalpel has only practiced the procedure on animals, as was the case in *Whiteside v. Lukson*, or is truly experienced in the performance of the particular procedure.

Comprehension and Too Much Disclosure

While the focus of the law has predominantly been on the question of *disclosure* of risks, there is also another aspect of the idea of informed consent which is equally, if not more, important. It is the question of comprehension by the patient. A recent article in 2007 highlights this aspect:²⁹

Although understanding is a very important element in the obtaining of informed consent, it has not been given the attention it deserves in law. Very little consideration has been paid to defining the reasonable steps a doctor must take to ensure some level of understanding. One of these steps is, of course, to discuss things using the risk/benefit ratio so the patients can conceptualise and place into context the nature of the procedure they are agreeing to. Consideration of risk/benefit ratios are at the heart of negligence calculations and are of central concern in questions of breach of duty generally. Since doctors presumably want patients to take their advice, it would be surprising if they did not emphasise why the procedure they recommend is a good idea.

Another article in 1998 observed as follows:³⁰

In seeking to involve patients more in decisions which vitally affect their most personal interests, the doctrine of informed consent does not require that an overdose of information be inflicted on unwitting patients, nor that to justify disclosure of certain information the patient must manifest an ability to grasp dense esoteric details which doctors have spent a large part of their lives studying. Rather, informed consent doctrine encourages a more sensitive communication to patients of information which has been distilled down from the technical jargon by which it is known within the profession into language which is comprehensible to the layperson and which is conveyed contextually, having regard to the relative scale of risks and success rates.

Put simply, as the United Kingdom (UK) General Medical Council's guidance states:³¹

Before accepting a patient's consent, you must consider whether they have been given the information they want or need, *and how well they understand the details and implications of what is proposed*. This is more important than how their consent is expressed or recorded.

[emphasis added]

General Principles

Informed consent is both a necessity as well as a noble ideal. However, difficulties and uncertainty could arise when the issue is placed in a particular factual matrix. Ultimately the question is: did *this patient* obtain sufficient information about this procedure *in the circumstances*? As the Medical Protection Society observes, "[c]onsent is a process – it results from open dialogue, not from getting a signature on a form".³² The factual circumstances of each patient (and, indeed, each session with the same patient) will often differ, sometimes significantly. I do not think I can do anything more specific by way of rounding up other than to refer to some general principles that may provide some measure of guidance.

In this regard, guideline 4.2.2 of the SMC Ethical Code provides a useful starting point:

It is a doctor's responsibility to ensure that a patient under his care 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, the patient *shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him*.

[emphasis added]

Such discussions should be documented in case notes with adequate particulars. The Medical Protection Society suggests as follows:³²

... It is ... crucial that the essential elements of discussions with the patient are documented in the patient's medical record.

The notes do not need to be exhaustive, but should state the nature of the proposed procedure or treatment and itemise the risks, benefits, possible complications and alternatives brought to the attention of the patient. Any particular fears or concerns raised by the patient should also be noted...

Further, it is essential that the patient must provide his informed consent at all stages of the medical procedure or treatment, not just at the outset. As the UK General Medical Council's guidance states:

52 Before beginning treatment, you or a member of the healthcare team should check that the patient still wants to go ahead; and you must respond to any new or repeated concerns or questions they raise. This is particularly important if:

(a) significant time has passed since the initial decision was made

(b) there have been material changes in the patient's condition, or in any aspect of the proposed investigation or treatment

(c) new information has become available, for example about the risks of treatment or about other treatment options.

53 You must make sure that patients are kept informed about the progress of their treatment, and are able to make decisions at all stages, not just in the initial stage. If the treatment is ongoing, you should make sure that there are clear arrangements in place to review decisions and, if necessary, to make new ones.

Conclusion

To summarise, Singapore law at present adopts the Bolam test (as amplified in Bolitho) as defining the standard of care expected of doctors, and adheres to traditional principles of causation. Although the English courts apply the same standard of care, they relaxed the test of causation in 2005. Undoubtedly, the legal position in Singapore makes it comparatively more difficult, all other things being equal, for patients to succeed in negligence actions against their former doctors. But I would add that law is never static. It is constantly evolving to reflect the norms and interests of society.

To conclude, I would like to share with you an interesting contrast between 2 articles in *The Straits Times* about a year apart. In an earlier article on 21 June 2011, a spokesman from the Singapore Medical Association was reported as stating, "As far as we are aware, it is not the practice of many doctors and hospitals to list out the alternatives and their possible complications in writing when consent is obtained".³³ However, in a later article on 4 June 2012, it was reported that the Chapter of General Surgeons has created forms that cover 26 common surgical procedures.³⁴

The fact sheet for each procedure lists common or rare complications that can arise from the operation and is meant to be used as a checklist by a surgeon explaining the procedure to his patient. I think this is progress. This is a welcome sign of the medical profession's commitment to upholding its legal and ethical responsibilities in the interests of patients and society.

As in many areas of the law, and in life in general, divergence in opinion or approach is inevitable. It is hardly surprising that different jurisdictions have adopted different positions on the issue of informed consent. There are multiple interests, often conflicting, at stake. There is probably no right answer, and even if there is a right answer, future generations may well think otherwise in the light of changed circumstances. 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. Of course, it cannot be overemphasised that you should always record in the case notes your discussions with the patient, at least in brief point form. At the end of the day, doctors, lawyers and society at large should keep an open mind about this issue, an important and emotive issue, so that the present legal and ethical position and any possible changes to it can continually be assessed in a rational and critical manner in the wider public interest. The dialogue must continue. What I have done today is just that.

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