

## From Bolam-Bolitho to Modified-Montgomery – A Paradigm Shift in the Legal Standard of Determining Medical Negligence in Singapore

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### Abstract

In a recent landmark litigation, the Singapore Court of Appeal introduced a new legal standard for determining medical negligence with regards to information disclosure – the Modified-Montgomery test. This new test fundamentally shifts the legal position concerning the standard of care expected of a doctor when he dispenses medical advice. Previously, a doctor is expected to disclose what a “reasonable physician” would tell his patient. Now, a doctor must disclose “all material risks” that a “reasonable patient” would want to know under his unique circumstances. Patient-centred communication is no longer an aspirational ideal but has become a legal mandate. Manpower, administrative, logistic and medical educational reforms should start now, so as to support the average physician transit from the era of the Bolam-Bolitho, to that of the Modified-Montgomery.

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### Introduction

A new legal standard has just been passed in the Singapore Court of Appeal, to determine medical negligence with regard to the provision of medical advice. All practising physicians must be aware of this landmark decision arising from a local litigation.<sup>1</sup> The new Modified-Montgomery test compels us to practise at the highest standard of physician-patient communication by fundamentally shifting the legal focus from what a “reasonable doctor” would tell his patient to what a “reasonable patient” would want to know considering his unique circumstances.

Under the Modified-Montgomery test, a physician would be found negligent should an omission of any material risk lead to claimable damages, unless he succeeded in justifying his action. Material risk is defined as either: a) a risk to which a reasonable person in the patient's position would be likely to attach significance; or b) a risk that a doctor knows or should reasonably know is perceived to be of significance by this particular patient. Henceforth, the materiality of risks will be ascertained solely from the patient's perspective.

In the discussion that ensued, physicians express grave concern that such a paradigm shift in legal position may open the door to a precipitous rise in medical litigation, encourage defensive medicine, raise insurance premiums and consequently increase healthcare costs as a result of direct cost-transference to the public. The Court was dutifully warned of these potential repercussions, but was unconvinced that the afore-mentioned consequences would materialise.

### From the “Reasonable Doctor” to the “Reasonable Patient”

Prior to this, the prevailing legal standard governing all aspects of a doctor's professional duty was the Bolam's test and the Bolitho addendum.<sup>2,3</sup> A physician will not be found negligent “as long as there is a respectable body of medical opinion, logically held, that supports his actions.”<sup>4</sup> As the Bolam-Bolitho test relies almost entirely upon a peer-review of what a “reasonable doctor” would do, it has been described as the “physician-centric” approach to the legal determination of medical negligence. In recent years, this approach repeatedly came under international legal scrutiny.

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In the United Kingdom (UK), judges expressed significant concern that this would sanction differences in clinical 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.”<sup>5</sup>

The new ruling by Singapore’s Court of Appeal retains the physician-centric approach in the domain of diagnosis and treatment, but mandates a patient-centric approach with regard to dispensing medical advice. It recognises that a patient’s decision to consent to interventions might not solely depend on medical risks and benefits, but also his unique circumstances, values and therapeutic goals. Physicians must dispense medical advice according to what a reasonable patient should know, as well as what a particular patient would want to know, in order that they can arrive at an informed choice.

Similar legal standards that steered away from the Bolam-Bolitho principle have already been established in Canada, Australia, Malaysia and more recently in the UK.<sup>5-8</sup> Locally, the paradigm of the doctor-patient relationship has also evolved—a new generation of better-educated patients no longer accepts being passive recipients of information and demands to be engaged as active participants in decision-making. Increasingly, patients attempt to narrow the knowledge gap between physicians and themselves, by accessing easily available online resources to counter-balance the unequal dynamics inherent to the traditional therapeutic relationship. Reflecting this seismic change in societal attitudes, the 2016 edition of the Singapore Medical Council Ethics Code and Ethical Guidelines (ECEG) strongly supports a patient-centric approach to information disclosure. Doctors must ensure that their patients understand “the purpose of tests, treatments or procedures to be performed on them, as well as the benefits, significant limitations, material risks (including those that would be important to patients in their particular circumstances) and possible complications as well as alternatives available to them.”<sup>9</sup>

Referencing this aspirational ideal encapsulated in the ECEG, the law now takes the issue further by mandating that patient-centric information disclosure becomes the expected standard of care, below which physicians can be held liable for medical negligence.

### The Modified-Montgomery Test

In its 114-page ruling, the Court of Appeal seeks to balance the conflicting perspectives of the patient-centric and physician-centric approaches by orchestrating a “carefully calibrated shift in the standard of care” – the Modified-Montgomery test.<sup>1</sup> It consists of 3 stages:

- Stage 1: Burden of proof lies on the patient to demonstrate that relevant and material information was withheld from him. The materiality of this information is to be considered from the perspective of the patient.

- Stage 2: If the patient successfully proves the above, the Court progresses to determine whether the doctor was in possession of that information. In the event the doctor does not possess the information, the Court shall apply the Bolam-Bolitho test to examine whether ignorance or carelessness had led to a negligent diagnosis or treatment. This stage of the test is deliberated from the perspective of the medical profession.

- Stage 3: If the doctor possesses the information but elects to withhold it, the Court shall be the ultimate arbiter as to whether the doctor’s justifications are sound, and where relevant, consider whether his decision to withhold information conforms to the standards of a reasonable and competent doctor.

This paradigm shift in the legal position may trigger a backlash where procedurists flood their patients with an uninterpretable slew of documents containing complex medical jargon, in order to minimise their own legal liabilities. At an individual level, this would not only confuse the average patient but could dissuade them from undertaking what physicians would perceive as reasonable risks associated with beneficial treatment. If perpetuated at an institutional level, such practices will inadvertently erode public trust which is fundamental to preventing expensive and media-drawing litigations. However, such irresponsible acts of “information dumping” were never the intent of lawmakers. On the contrary, the Court reiterated in its judgment that doctors are not expected to provide “an encyclopaedic range of information in relation to anything and everything which the patient might wish to know.”<sup>1</sup>

### Materiality of Risks – The “Reasonable Person” and the “Particular Patient”

What then is the appropriate nature and quantity of information disclosure expected of a doctor? The Court interprets materiality both in an objective manner (what a reasonable patient would regard as significant) as well as in a more subjective manner (what the particular patient would likely regard as significant).

Objectively, a doctor’s duty to advise only encompasses that which would enable the reasonable patient to make an informed and meaningful choice. It should not be limited to risk-related information alone and will have to include the patient’s diagnosis and prognosis, the nature of the intervention and its risks and complications, any reasonable alternatives and their associated risks and benefits, as well as the option and consequences of non-treatment.

In addition, the Court proposed a matrix-based analysis that measures the likelihood of a risk against the gravity of its consequences. Applying such a matrix, remote risks with minor consequences will generally be considered immaterial. On the other hand, potentially disastrous consequences may not require disclosure if they are “so plainly unlikely that it would not concern the reasonable person.”<sup>1</sup>

On a more subjective level, risks which the majority would deem minor might very well be perceived to be important by particular individuals. For example, the Australian Court held that the 1:14,000 risk of developing sympathetic ophthalmia was material, and had been wrongly withheld from a patient who unfortunately lost the sight in her good eye following an operation on her blind one.<sup>7</sup> In its judgment, the Singapore Court of Appeal made the observation that a patient’s choice of treatment might not be made on clinical grounds alone, but is also dependent on “circumstances, objectives and values which might lead him to a different decision from that suggested by a purely medical opinion.”<sup>1</sup> The prudent physician should therefore sensibly elucidate relevant information, such as his patient’s occupation, hobbies and lifestyle choices, relevant comorbidities and perhaps most importantly, what he would regard as the single most significant concern relating to the proposed intervention.

However, a doctor ethically should not, and pragmatically cannot spend his time trying to exhaustively investigate minute details of his patient’s private life. The law does not bind him to such an “open-ended duty to proactively elicit information.”<sup>1</sup> Neither will he be held liable for omitting information relating to his patient’s idiosyncrasies, unless these were made known to him via relevant questions or concerns.

### Patient-centric Communication

Evidently, the doctor’s legal obligation to advise no longer stops at merely stating his patient’s diagnoses, prognoses and his recommended treatment. In its judgment, the Court of Appeal explicitly stated that “the mere provision of information is pointless if it is not accompanied by a quality of communication that is commensurate with the ability of the patient to understand the information.”<sup>1</sup> This, coupled with the fact that the law now requires the doctor to appreciate his patients’ subjective appraisal of risks and benefits, means that he must deliver crucial information—in both sufficient quantity and quality—that will empower his patients to make personally meaningful and informed choices.

To do so, it is imperative that physicians understand that a patient’s decision-making process involves both rational

and emotive appraisal of his illness. This frequently involves a complex interplay of potentially conflicting ideas, values, beliefs and expectations. The prudent physician should actively engage his patient in patient-centric conversations where he explores and corrects his patient’s conceptual understanding of his illness, clarifies the perceived impact of the illness on his life, and contextualises his fears and concerns in relation to the socio-cultural fabric within which he operates. In so doing, the doctor ensures the patient “knows and understands”, while the patient feels “known and understood”. Building on this foundation of mutual trust and understanding, the patient collaborates with the physician in formulating appropriate therapeutic objectives and then commits to an educated choice of treatment most aligned with his goals of care. In this therapeutic relationship, the physician plays a fiduciary role of guiding decision-making through provision of professional advice. Whilst ultimately the patient must be responsible for exercising his autonomous choice over the type of intervention that shall be applied to his own body.

The importance of patient-centric communication cannot be over-emphasised, although it remains common knowledge that proficiency varies widely amongst individuals and amongst disciplines. It was as interesting as it was alarming to observe lawmakers issuing stereotypical guidance regarding clinical communication, including the need to ensure information given “is presented ‘in terms and at a pace’ that allows the patient to assimilate it.”<sup>1</sup> Should we not have pervasively adopted good communication practices out of our aspirations to better clinical care, rather than be compelled to do so under the scrutiny of the Law?

### Clear Clinical Documentation

It is noteworthy that the Court did not find the defendant doctors negligent. In fact, the Court has regarded their communication to be “unimpeachable” by both competing standards of the Bolam-Bolitho and the Montgomery tests.<sup>1</sup> Information was found to have been imparted “promptly and in an open way”, as well as in a manner that was “concise, guided and to the point.”<sup>1</sup> However, a process of information disclosure can only be as unimpeachable as the documentation of that which transpired. It was the defendant doctors’ clear documentation, as well as detailed email correspondence with the plaintiff that pivotally convinced the Court that they had professionally discharged their duty to advise. Crucially, the plaintiff’s understanding of his condition and available treatment options, as well as his rationale for choosing the more aggressive surgical intervention was evident in these documented exchanges. On this premise, the claims submitted by the plaintiff were dismissed by the Court, in its entirety.

As illustrated, good documentation provides the Court with an authentic and irrefutable account of the care delivered, in a manner that is more credible and persuasive than the interpretation provided by the plaintiff. Conversely, the old adage, “If it’s not documented, it wasn’t done”, has proven near impossible to refute in medical negligence lawsuits. Documentation should include material information such as the diagnosis of the disease, the patient’s prognosis with and without treatment, the nature, benefit and complications of the recommended procedure, as well as the advantages and risks of available alternatives. Perhaps more importantly, physicians should demonstrate that a value-driven discussion has taken place, including documenting the underlying concerns that motivated his patient to choose one mode of treatment over another. References can also be made to pamphlets, pictures or audiovisual presentations that the physician routinely uses to counsel his patients, thereby making these materials admissible as favourable evidence.

Obviously, both proper communication and documentation takes time. Doctors of today struggle to balance their roles as clinicians, educators, scientists and administrators all at one time, while straining to meet competing institutional key performing indicators (KPIs) of faster patient turn-over and better clinical care. System-level reforms must take place to support physicians in this transition. Institutions should look into improving staffing ratios, re-inventing roles of Advanced Practice Nurses, adopting patient-centric decision-making aids or perhaps importing new technologies that can enhance both speed and accuracy of clinical documentation. Reforms must not come in the form of knee-jerk policies that either overburden patients with a barrage of information, or overburden doctors with more impractical forms. Or else, we risk reducing conscientious clinicians, who while striving to be litigation-safe, becomes soulless in their delivery of care.

Perhaps most importantly, the next generation of physicians must appreciate the evolving needs of the community they are being trained to serve. This landmark legal decision has sent an irrefutable message that society views patient-centric communication to be the expected norm. Medical educators should therefore redesign existing

pedagogue of didactic and bedside teachings to actively integrate aspects of patient-centred care into all core clinical modules.

## Conclusion

Patient autonomy has always been a cornerstone of bioethics. The current ruling simply brings the law into alignment with well established professional standards. A smooth transition from the legal era of Bolam-Bolitho to that of the Modified-Montgomery test will require strategic planning of building a patient-centred care culture, developing supportive institutional policies and effecting changes to individual clinical practice. The change should start now—not under compulsion by law, but motivated by a common aspiration towards higher standards of care.

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