NUS Law Working Paper 2021/020

Medical Duty to Advise: Legislating the Standard of Care

Kumaralingam Amirthalingam

lawka@nus.edu.sg

[October 2021]

MEDICAL DUTY TO ADVISE: LEGISLATING THE STANDARD OF CARE

Kumaralingam Amirthalingam*

INTRODUCTION

Healthcare professionals have had a torrid time since the Covid-19 pandemic hit in 2020, and the world is in debt to them. Prior to the pandemic, in the period spanning 2017 to 2019, doctors in Singapore were caught in medicolegal turbulence with landmark decisions on the duty and standard of care in medical negligence, as well as controversial professional misconduct cases. The perceived uncertainty in the "reasonable patient" test for the duty to inform and advise, as well as the potential for enhanced exposure to civil liability and disciplinary sanctions have been unsettling for doctors. The shift in medicolegal discourse, placing greater emphasis on patient autonomy while ignoring the realities on the ground, has caused significant stress.

Doctors have a deep-seated anxiety over legal liability largely due to the potential disproportionate, adverse impact on their professional reputation. As fellow professionals sharing a mutual interest in and an innate understanding of the integrity of professional reputation, judges empathize with doctors. Take for example the somewhat melodramatic language of the former Lord President of Malaysia, Syed Agil Barakhbar:

> [I]t would be wrong and bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community. It would mean that a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be forever looking over his shoulders to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body—perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body.[1]

A shield against this existential dagger was found in *Bolam v Friern Hospital Management Committee*,[2] in which the court articulated the peer professional test for medical negligence: doctors could not be found negligent if they "acted in accordance with a practice accepted as proper by a responsible body of [peer professionals]."[3] Thus, the profession regulated itself and set its own standards of care. However, the *Bolam* test does not apply to the duty to inform patients of risks and alternatives. Instead of peer professionals setting the standard of disclosure, doctors must inform patients of material risks, the materiality of which is assessed from the patients' perspective.

This material risk test was first adopted in Singapore by the Court of Appeal in 2017.[4] Soon after that decision, the test became a lightning rod for reform following a medical complaints

---

* Faculty of Law, National University of Singapore.

1 *Swamy v Matthews & Anor* [1968] 1 MLJ 138 at 139-40.

2 [1957] 1 WLR 582.

3 Id at 587.

4 *Hii Chii Kok v Ong Peng Jin London Lucien and another* [2017] 2 SLR 492.

case in 2019, in which a doctor was sanctioned for not informing a patient of a minor risk in a routine procedure.[5] The medical profession was understandably concerned; for many doctors, Barakhbar's dagger had become their Sword of Damocles. A Workgroup was established to review the law and the Civil Law Act (Cap 43, 1999 Rev Ed) was subsequently amended based on its recommendations.[6]

However, it is unclear whether the legislative reform has improved or exacerbated the situation. This article critically examines the new section 37 of the Civil Law Act. In doing so, it first sets out the reasonable person test, explaining how the concept of reasonableness is ubiquitous and indispensable in law. The paper then reviews the key medical negligence and medical complaints cases that gave rise to the impetus for reform. It is argued that the common law is well established and understood, and that the legislation paradoxically introduces greater uncertainties and potentially more onerous duties for healthcare professionals. The experience in Australia and Singapore demonstrate the perils of legislating the standard of care.

STANDARD OF CARE

The standard of care by which a defendant is judged in negligence is that of a reasonable person in the defendant's position.[7] The reasonable person allegedly was born in the cradle of negligence,[8] but has become ubiquitous across the spectrum of law when judges have to determine expected standards of behavior, whether in tort law, contract law, trust law, administrative law, or criminal law.[9] The reasonable person test defies precise definition, remaining sufficiently malleable for judges to balance the scales of justice in individual cases and to develop the law in step with evolving standards. However, its strength is also its weakness, as the ambiguity of the reasonable person allows judges to project their own conceptions of what is reasonable. It has aptly been described as "little more than the anthropomorphic conception of justice as perceived by judges or juries."[10]

In other words, it calls on the common sense and worldliness of judges and juries. This may have been less of a problem in the early years of the reasonable person standard for two reasons. Cases were tried by jurors, who notionally represented reasonable people in the community and the factual scenarios were commonplace with risks that were readily understood by ordinary people. For example, in *Vaughan v Menlove*,[11] the case to which the reasonable person standard is traced, the defendant's hay rick caught fire and damaged the neighbour's property. The defendant was aware of the danger but had not taken adequate steps to avert it. His argument that he had done his best according to his limited intellectual capacity was rejected by the court, which held him to an objective standard. In *Blyth v Birmingham*

5 *Singapore Medical Council v Dr Lim Lian Arn* [2018] SMCDT 9.

6 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019).

7 *Blyth v Birmingham Waterworks Co* (1856) 11 Ex 781.

8 *Vaughan v Menlove* (1837) 132 ER 490 (CP).

9 J Gardner, "The Many Faces of the Reasonable Person" (2015) 131 Law Quarterly Review 563.

10 S Deakin, A Johnston & B Markesinis, *Markesinis and Deakin's Tort Law* (Oxford: Clarendon Press, 6th ed, 2008) 223.

11 (1837) 132 ER 490 (CP).

Waterworks Co,[12] the defendant had installed water mains in the street. After an unduly cold winter that damaged one of the hydrants, water leaked into the claimant's house. The jury found the defendant had acted reasonably in periodically checking the pipes and could not be held liable for the exceptional weather conditions. In both cases, the facts are readily understood, and ordinary people can make sensible judgments about the reasonableness of the defendant's conduct.

Negligence claims today are heard by judges sitting without a jury.[13] Anthropomorphic justice dispensed by an ethnocentric judiciary is not ideal. The historical lack of diversity among judges risks justice being dispensed according to the personal values of the judge, which may not reflect broader conceptions or expectations of justice. Critical legal scholars have demonstrated that apparently neutral concepts such as the reasonable person may discriminate against certain groups, based on race, culture, class, or gender.[14] Historically, most judges and lawyers were male, came from the majority race or culture, and generally belonged to the upper social class.[15] Their worldview, shaped by their lived realities, frequently did not match that of other segments of society. The UK Judiciary has acknowledged this, noting: "In many courts and tribunals there has been a wide gulf in social background and life experience between the parties and the judges making decisions."[16]

The tort of negligence today has expanded considerably since *Vaughan* and *Blyth*; the factual scenarios are no longer simple and easily understood by the layperson. Many of the claims involve complex financial transactions, technical matters, professional judgment, and policy considerations. Judges do not possess the necessary knowledge to judge whether the defendant has acted reasonably in designing the algorithms for an MRI scanner to identify abnormalities in images; to assess risks in cryptocurrency trading; or to determine which complex medical treatment is optimal for a patient. Expert evidence is required both to help judges understand the particular issue on which they are adjudicating as well as to inform the judges of reasonable standards within the industry or profession. It is crucial that the experts stay within their domain of expertise, remain impartial, and refrain from usurping the court's role in determining the ultimate issue.[17]

---

12 (1856) 11 Ex 781.

13 UK, Australia, Canada, Singapore. The US continues to have jury trials for tort cases. For a critique of jury trial and medical malpractice, see N Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* (Ann Arbor: The University Press, 1995).

14 DM Trubek, "Where the Action Is: Critical Legal Studies and Empiricism" (1984) 36 Stanford Law Review 575. For a feminist critique of the reasonable person: M Moran, *Rethinking the Reasonable Person: An Egalitarian Reconstruction of the Objective Standard* (Oxford: Oxford University Press, 2003).

15 See, United Kingdom Parliament, Constitution Committee – Twenty-Fifth Report, *Judicial Appointments* (7 March 2012) Chapter 3 (https://publications.parliament.uk/pa/ld201012/ldselect/ldconst/272/27206.htm, last accessed, 20 October 2021).

16 Judicial College, *Equal Treatment Bench Book* (February 2021 edition) 8.

17 L Wahlberg & C Dahlman, "The Role of the Expert Witness" in C Dahlman, A Stein & G Tuzet (ed), *Philosophical Foundations of Evidence Law* (Oxford: Oxford University Press, 2021) ??? (Available at

There are two interconnected questions that a court must consider when assessing whether there has been a breach of duty. They are the standard of care by which the defendant is to be judged and the reasonableness of the defendant's response to the particular risk. The standard of care at the abstract level is a matter of law; once determined, it sets a precedent. For example, courts have held that the standard of care of a practitioner of Traditional Chinese Medicine is that of practitioners in that field;[18] that inexperience does not lower the standard;[19] that children are judged by a standard appropriate to their age;[20] that an ordinary person who carries out certain household repairs may be held to the standard of a reasonably competent carpenter.[21]

Whether there has been a breach of duty is a fact-sensitive inquiry into whether the defendant had acted reasonably in the face of a reasonably foreseeable risk. What may be a reasonable response in one case may not be so in another case due to the vagaries of the unique circumstances of each case. In coming to its judgment on breach, courts engage in a comparative risk-benefit analysis, balancing, amongst other factors, the probability of harm, the gravity of harm, the practicability of avoiding the harm, the justifiability of taking the risk, and the social utility of the activity.[22] Each case is unique, and a finding of negligence in one case does not mean that there must be a finding of negligence in another similar case.

What is perhaps unusual about medical negligence is that the standard of care and breach of duty inquiries are often fused. Medical negligence is nearly always about whether the doctor has failed to achieve a certain level of competence in diagnosis and treatment or has made the wrong decision, whether with respect to treatment options or advice. Doctors fear that once a court finds a medical act or decision to be negligent, they will have to act according to that legal prescription in the future instead of relying on their own medical judgment; in other words they will practise defensive medicine.[23] This fear, while understandable, is arguably misplaced, as breach of duty is a question of fact;[24] therefore, just because a doctor is found negligent in one instance does not mean that another doctor will be found negligent for doing something similar so long as the facts justify the doctor's actions.

The *Bolam* test has been the subject of considerable criticism, which will not be repeated here.[25] However, there is one philosophical problem with *Bolam* that merits close examination as it is

---

SSRN: https://ssrn.com/abstract=3758820 or http://dx.doi.org/10.2139/ssrn.3758820, last accessed 17 October 2021). See, *Anita Damu v Public Prosecutor* [2020] 3 SLR 825 at [36].

18 *Shakoor v Situ* (2001) 1 WLR 410.

19 *Nettleship v Weston* [1971] 2 QB 691.

20 *Mullins v Richard* [1998] 1 WLR 1304.

21 *Wells v Cooper* [1985] 2 QB 265.

22 *United States v Carroll Towing* 159 F2d 169 (2d Cir 1947); *Morris v West Hartlepool Steam Navigation Co* [1956] AC 522; *Wyong Shire Council v. Shirt* (1980) 146 CLR 40; *BNJ v SMRT Trains Ltd* [2014] 2 SLR 7.

23 See for example, *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [144]: "Furthermore, the lawyer-judge in "playing doctor" at the frontiers of medical science might distort or even hamper its proper development. Excessive judicial interference raises the spectre of defensive medicine, with the attendant evils of higher medical costs and wastage of precious medical resources."

24 *Qualcast v Haynes* [1959] AC 743.

25 D Giesen, "Medical Malpractice and the Judicial Function in Comparative Perspective" (1993) 1 Medical Law International 3; J Keown "The Rise and Rise of 'the *Bolam* test'" [1995] SJLS 342 at 363; H Teff,

especially pertinent to the duty to inform. Applying the *Bolam* test to the fused inquiry of standard and breach results in the reasonableness of the doctor's conduct being judged sociologically or positively, rather than ethically or normatively. The question is simply whether the doctor's conduct accords with acceptable practice. This hands judgment of medical negligence to the expert because judges are not allowed to question whether acceptable practice itself is adequate.[26]

There is a respectable lineage of debate on whether the reasonable person test should be assessed ethically or sociologically.[27] The ethical inquiry asks what a reasonable person *ought* to do while the sociological inquiry asks what the reasonable person *would* do. Montrose, commenting in the wake of the *Bolam* judgment, pithily observed, "it is important to distinguish between average practices and average standards, between what the ordinary man does and what the ordinary man thinks ought to be done."[28] This distinction is apposite to professional negligence. *Montrose* again: "Experts may blind themselves by expertise. The courts should protect the citizen against risks which professional men and others may ignore."[29] In the period following *Donoghue v Stevenson*,[30] English law had clearly adopted the ethical standard to assess negligence.[31]

In applying an ethical standard, it is necessary to identify the underlying normative value or values. Miller and Perry offer three ethical principles that may be relied on to assess reasonableness in negligence: "welfare maximization, equal freedom, and the feminist ethic of care."[32] Welfare maximization is based on the economic analysis of law and is utilitarian in nature. This philosophy has a strong hold on the tort of negligence in the United States,[33] tracing back to the calculus of negligence introduced by Learned Hand J, balancing the probability and gravity of harm against the burden of avoiding the risk.[34] There are pragmatic and normative challenges to the economic analysis approach. Pragmatically, courts are simply not equipped to engage in comprehensive analysis of the social costs and benefits of the

---

"The Standard of Care in Medical Negligence—Moving on from *Bolam*?" (1998) 18 Oxford Journal of Legal Studies 473; Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1; M Brazier & J Miola, "Bye-Bye *Bolam*: A Medical Revolution?" (2000) 8 Medical Law Review 85; R Mulheron, "Trumping Bolam: A Critical Legal Analysis of Bolitho's Gloss" (2010) 69 Cambridge Law Journal 609.

26 *Maynards v West Midlands Regional Health Authority* [1984] 1 WLR634.

27 JL Montrose, "Is Negligence and Ethical or Sociological Concept?" (1958) 21 The Modern Law Review 259; AD Miller & R Perry, "The Reasonable Person" (2012) 87 New York University Law Review 323.

28 JL Montrose, "Is Negligence and Ethical or Sociological Concept?" (1958) 21 The Modern Law Review 259 at 262.

29 Id at 263.

30 [1932] AC 562.

31 WTS Stallybrass, *Salmond's Law of Torts* (London: Sweet & Maxwell, 1945) 437: "the general practice itself may not conform to the standard of care required of a reasonably prudent man. In such a case it is not a good defence that the defendant acted in accordance with the general practice."

32 AD Miller & R Perry, "The Reasonable Person" (2012) 87 New York University Law Review 323 at 327.

33 See generally, RW Wright, "Justice and Reasonable Care in Negligence Law" (2002) 47 American Journal of Jurisprudence 143 for a history and criticism of this approach.

34 RA Posner, "A Theory of Negligence" (1972) 1 Journal of Legal Studies 29 at 32-33.

impugned conduct within the confines of a bilateral legal dispute where the issues are narrowly defined and the evidence is restricted. Normatively, this approach is difficult to reconcile with principles of interpersonal justice and fairness as it "disrespects the fundamental dignity and autonomy of some people by treating them as mere means for furthering the 'greater good' of others."[35]

The equal freedom approach draws on Kantian ethics and stands in opposition to welfare maximization. Just as utilitarianism is consequentialist, Kantianism is deontological. Individuals must never be treated as a means to an end. Autonomy, humanity, and rational agency are at the core of Kant's moral theory, expressed through the Categorial Imperative: "I ought never to act except in such a way that I could also will that my maxim should become a universal law."[36] This supports the idea of equal freedom and has a profound effect on the concept of reasonableness in negligence. As some level of risk is inherent in human action, the universal law would require tolerance of an acceptable level of risk. This level is what reasonable care would require: the equilibrium between the freedom to engage in risky activities and the freedom to be free from harm caused by risky activities.[37]

The feminist ethic of care should resonate with the medical profession. One of the leading feminist theorists on tort law is Bender, who has argued for a reconceptualization of negligence, reorienting it from a negative standard of reason and caution to a positive standard of caring and concern.[38] Bender draws on earlier work by Gilligan, who through empirical research demonstrated that women's moral compass prioritized "responsibility and contextuality" while men prioritized "rights and abstract justice."[39] According to Bender, "Tort law needs to be more of a system of response and caring than it is now. Its focus should be on interdependence and collective responsibility rather than on individuality, and on safety and help for the injured rather than on 'reasonableness' and economic efficiency."[40]

The doctor patient relationship is one of trust and partnership. A sociological approach to the standard of care grounded in utilitarian values is inimical to the doctor's duty to respect the innate humanity and autonomy of the patient. It preserves hierarchy and disregards the "interdependencies and interconnectedness"[41] that affect patients' need for information to make decisions that validate their personal and relational autonomy. The equal freedom and feminist ethic of care on the other hand are aligned with patient autonomy and with nurturing trust in the doctor-patient relationship. A recent empirical study in China demonstrated that better doctor-patient communication and shared decision-making improved trust in the doctor-patient relationship. The authors of the study noted that "patients in China reported suboptimal

---

35 RW Wright, "Justice and Reasonable Care in Negligence Law" (2002) 47 American Journal of Jurisprudence 143 at

36 (G 4:402):

37 AD Miller & R Perry, "The Reasonable Person" (2012) 87 New York University Law Review 323 at 350-351.

38 L Bender, "A Lawyer's Primer on Feminist Theory and Tort" (1988) 38 Journal of Legal Education 1 at 25.

39 Id at 28.

40 Id at 4.

41 L Bender, "A Lawyer's Primer on Feminist Theory and Tort" (1988) 38 Journal of Legal Education 1 at 30.

trust in doctors because of less doctor-patient communication and few shared decision-making processes."[42]

Medical negligence

This section reviews the key common law decisions on the standard of care expected of doctors as well as selected disciplinary cases. The conflation of civil liability and disciplinary sanctions for negligent failure to inform has contributed to serious misunderstanding of the law. *Bolam* is the starting point. The claimant in that case was a patient who had been subjected to electroconvulsive treatment for his mental disorder. He was not administered any drugs to relax his muscles nor restrained during the treatment. When the electric shock was administered, he convulsed violently and suffered injury. He brought an action in negligence, alleging that he should have been administered relaxants and strapped in to avoid injury, and that he should have been informed of the risks. There were different schools of thought within the medical profession on the use of relaxants and restraints in such cases. In his direction to the jury, McNair J stated:

> 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 … a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes the contrary view.[43]

This is the genesis of the peer professional test, which in large measure leaves the determination of negligence in the hands of the professionals. As Miola observes, the problem is exacerbated because McNair J reduced the reasonable person test to an ordinary person test, explaining that a doctor would not be found negligent "if he exercises the *ordinary* skill of an *ordinary* competent man exercising that particular art."[44] The ethical standard is reduced to a sociological standard, allowing medical professionals not only to judge themselves, but to judge themselves not on the basis of how they *should* act but on how some of them *actually* act. Courts abandoned their judicial function of adjudication by deferring unstintingly to the defendants' medical experts.[45]

Recognizing this risk, the House of Lords in *Bolitho v City & Hackney Health Authority*,[46] emphasized that judges should not ignore the requirement in *Bolam* that the expert medical opinion must be respectable, reasonable, and responsible. *Bolitho* did not go so far as to hold that judges may prefer one body of medical opinion over another. However, they could "hold that the body of opinion is not reasonable or responsible" if it were "demonstrated that the professional opinion is not capable of withstanding logical analysis."[47] This logical defensibility addendum to *Bolam* was applied in Singapore in *Dr Khoo James v Gunapathy d/o*

---

42 Du, et al, "Rebuild Doctor-Patient Trust" Nature: Scientific Reports (2020) 10:21956.

43 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587.

44 Id at 586 (emphasis added).

45 *Maynards v West Midlands Regional Health Authority* [1984] 1 WLR634; *De Freitas v O'Brien* [1993] 4 Medical Law Review 281; *Whitehouse v Jordan* [1981] 1 WLR 246. See, Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1.

46 [1998] AC 232.

47 Id at 243.

Muniandy,[48] in which the Court of Appeal explained that the courts could only scrutinize the process and not the conclusion of medical experts. It articulated a 2-stage test: first, judges must be satisfied that the medical experts had considered "the comparative risks and benefits related to the matter" and reached a "defensible conclusion."[49] Secondly, for the conclusion to be defensible, it must be "internally consistent" and "not fly in the face of proven extrinsic facts relevant to the matter."[50]

Despite its shortcomings, the *Bolam/Bolitho* test, judiciously applied, is an appropriate "heuristic"[51] to determine whether a doctor has acted negligently, except with respect to the doctor's duty to inform patients of risks inherent in any procedure or alternative option. *Bolam/Bolitho* is justified on two grounds. The judge is not competent to adjudicate on medical matters without expert guidance and it is accepted that there may several legitimate schools of thought or treatment options. Thus, it would be unfair to find negligent a doctor who conforms to an accepted practice.

These arguments do not apply to the duty to inform. The information required by a patient does not turn on medical expertise but on what a patient would reasonably require. There is no way of applying a comparative risk/benefit analysis without undermining patient autonomy As the court in *Hii Chii Kok* pithily observed, the *Bolam/Bolitho* test is incompatible with any notion of informed consent.[52] It is also absurd to speak of different schools of thought on what information should be disclosed to the patient. There is only one standard – information that is material to the patient. The Kantian philosophy permits for this information to be modulated by reasonableness as explained above.[53]

Not surprisingly, none of the major common law jurisdictions apply *Bolam* to the duty to inform, but instead apply a material risk test.[54] The UK Supreme Court in *Montgomery v Lanarkshire Health Board* set it out thus:

> 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.[55]

---

48 [2002] 1 SLR(R) 1024.

49 Id at [64]-[65].

50 Id at [65].

51 *Hii Chii Kok v Ong Peng Jin London Lucien and another* [2017] 2 SLR 492 at [104].

52 Id at [69].

53 See above, text at n 37.

54 *Canterbury v Spence* 464 F 2d 772 (1972) (US); *Reibl v Hughes* (1981) 114 DLR 1 (Canada); *Rogers v Whitaker* (1992) 175 CLR 479 (Australia); *Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor* [2018] 1 MLRA 535 (Malaysia); *Montgomery v Lanarkshire Health Board* [2015] AC 1430 (UK); *Hii Chii Kok v Ong Peng Jin London Lucien and another* [2017] 2 SLR 492 (Singapore).

55 [2015] AC 1430 at [87].

This was adopted in Singapore in *Hii Chii Kok v Ong Peng Jin London Lucien and another,*[56] with some modification:

> Unlike the court in Montgomery, *we do not confine the scope of the information in question to material risks* concerning the recommended treatment and any reasonable alternatives or variant treatment. In our judgment, 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 doctor knows is important to the particular patient in question.[57]

There is one significant point of departure in *Hii Chii Kok.* Unlikely *Montgomery*, which refers to the duty to inform of *risks* in recommended procedures and alternatives, *Hii Chii Kok* extends the material information test to the doctor's general duty to advise. This potentially encroaches on an area of the doctor's duty that should be resolved according to *Bolam*. *Montgomery* has been interpreted recently in the United Kingdom as being confined to risks only. The court in *Malik v St George's University Hospitals NHS Foundation Trust* applied the *Bolam/Bolitho* test to the surgeon's duty to advise the patient of alternatives:

> Whilst the leading case of *Montgomery* identifies that there is a duty to take reasonable care to ensure a patient is aware of any reasonable alternative treatments … in the circumstances of this case I consider that a responsible, competent and respectable body of skilled spinal surgeons would have reasonably concluded that there were no reasonable alternative treatments available in the context of the parameters and discussion that the claimant had with Mr Minhas.[58]

The particular patient limb of the material risk test gave rise to ill-informed concern that a subjective test would be applied. Under *Montgomery*, a risk is material "if a reasonable patient in the patient's position would attach significance to it" or "if the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." However, in either case, the test remains objective. For example, a risk of a negligible tremor in one's little finger is unlikely to be a material risk to a reasonable patient, but it would objectively be material to a concert pianist. That both limbs are objective is acknowledged in *Hii Chii Kok.*[59] Even when the court explored the relevance of "idiosyncratic reasons" of certain patients, which may give a subjective gloss to the test, it reiterated that the test "is ultimately still objective."[60]

Hii Chii Kok offers a carefully reasoned framework that balances beneficence and autonomy. The court sets out three sequential questions. First, was the information objectively material? Secondly, did the doctor know of the risks and alternatives, and if not, ought the doctor have known? Here, the court reverts to the *Bolam/Bolitho* test to determine whether the doctor ought to have known of the risks and alternatives. A doctor who is not aware or has no reason to be aware of the risks and alternatives judged by peer professionals is not negligent. Thirdly, if the first two stages are satisfied, the doctor is obliged to disclose the information unless there is

---

56 [2017] 2 SLR 492.

57 Id at [132] (emphasis added).

58 [2021] EWHC 1913 at [93].

59 *Hii Chii Kok* at [144].

60 Id at [145].

reasonable justification, which includes necessity, express waiver of the right to be informed by the patient, and a limited therapeutic privilege.

The court takes pain to highlight that a commonsense approach must prevail, reassuring doctors that remote risks of severe adverse outcomes, including death, may not always be material information that needs to be disclosed as reasonable patients would always be aware of the remote possibility of death in any procedure. Similarly, the court notes that obvious risks that laypersons should be aware of need not be disclosed.[61] Peer professional standards remain relevant: all the court has done is to adapt the professional negligence test for the purpose of the duty to inform and advice:

> It bears reiterating that in applying this three-step test in the context of advice, we are not departing from the general professional standard. Rather, the test outlined above is intended merely to reflect – in the form of a more specific test tailored to the context of advice – what an ordinary and reasonable doctor would have done in the circumstances. We prefer this approach over applying the *Bolam* test and *Bolitho* addendum as the default approach in this particular context in order 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. The ultimate question therefore is whether the doctor was justified not to furnish that information. To the extent the defendant doctor, in withholding that information, *acted in accordance with what the court finds an ordinary and reasonable doctor would and should have done, he would not be considered to have been negligent in advising the patient.*[62]

Medical complaints

Coincidentally, in the two years following *Hii Chii Kok*, several controversial professional misconduct cases were decided by the SMC Disciplinary Tribunal against doctors, raising concern amongst medical professionals. There were three significant decisions, all of which were appealed to the Court of Three Judges: *Chia Foong Lin v Singapore Medical Council*;[63] *Singapore Medical Council v Lim Lian Arn*;[64] *Singapore Medical Council v Soo Shuenn Chiang*.[65] In *Chia Foong Lin*, a paediatrician diagnosed an infant with viral fever, failing correctly to diagnose incomplete Kawaski Disease (KD) or to carry out tests to rule out Kawaski Disease. Her clinical notes showed she had considered the possibility of KD but dismissed it as there were no full features present. The Court of Three Judges upheld the Disciplinary Tribunal's finding of guilt, agreeing with the Disciplinary Tribunal that a paediatrician should always maintain a "high index of suspicion when [a patient] presented with features of KD."[66] This is due to the inherent vulnerability of an infant.

Soo Shuenn Chiang was an unusual case in which a psychiatrist was sanctioned for providing confidential patient information to a third party without verifying their identity. The facts were that an individual, identifying himself as the husband of the complainant, called Dr Soo, informing him that the complainant was suicidal but refused to allow herself to be taken to the

---

61 Id at [141].

62 Id at [135] (emphasis added).

63 [2017] SGHC 139.

64 [2019] SGHC 172

65 [2019] SGHC 250.

66 *Chia Foong Lin v Singapore Medical Council* [2017] SGHC 139 at [46].

Institute for Mental Health (IMH). The caller asked for a memorandum confirming that the claimant did not have capacity to make decisions so the police could take her by ambulance to IMH. Dr Soo, believing that the complainant was at real risk of suicide given her past medical history, provided the memorandum. Subsequently, the memorandum came into the possession of the complainant's brother and the complainant alleged that it was the brother who had called Dr Soo.

The Court of Three Judges, referring to *Hii Chii Kok* and *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd and others*,[67] reiterated that an assessment of reasonableness was always context specific. Thus, in *Noor Azlin*, the standard of care had to be calibrated against the exigencies of the accident and emergency department, giving doctors greater latitude for what might otherwise be considered a lapse. In *Soo Shuenn Chiang*, the court held that it was justifiable for Dr Soo to release the information under the circumstances as it would not have been practicable to verify the identity of the caller when time was of essence due to the suicide risk.[68] The court went on to praise Dr Soo for doing "precisely what was called for in the circumstances."[69]

The doctor in *Lim Lian Arn* was charged for breaching Guideline 4.2.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition) ("ECEG 2002"). He was accused of failing to obtain informed consent from his patient due to his alleged failure to advise the patient of risks and possible complications arising from a routine steroid injection in the patient's hand. Some crucial facts bear highlighting. First, the charge was based on SMC's ethical guidelines on informed consent and not the common law on the duty to inform. Secondly, not once did the Disciplinary Tribunal refer to the common law standard, including *Hii Chii Kok*. Thirdly, Dr Lim pleaded guilty to the charge and offered to pay the highest fine to avoid possible suspension, a penalty sought by the SMC.

Following public outcry, the Ministry of Health instructed the SMC to review the matter. The case went on appeal to the Court of Three Judges, which not only reversed the penalty but went further to acquit Dr Lim.[70] Menon CJ, who gave the court's judgment, reviewed the law on professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed). Doctors could be guilty of professional misconduct if "there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency" or if "there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner."[71]

The court was especially critical of the SMC's approach to informed consent, which apparently required Dr Lim to disclose all known risks of the procedure, regardless of whether they were material. Menon CJ reiterated that it "was made clear by the Court of Appeal in *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] 2 SLR 492 ("*Hii Chii Kok*") that a doctor is not under a duty to convey to his patient every conceivable risk.[72] Based on the totality of

---

67 [2019] 1 SLR 834.

68 *Singapore Medical Council v Soo Shuenn Chiang* [2019] SGHC 250 at 62.

69 Ibid.

70 *Singapore Medical Council v Lim Lian Arn* [2019] SGHC 172.

71 Id at [26], referring to *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612.

72 Id at [48].

the evidence, the court found that Dr Lim had not failed properly to inform the patient despite the absence of clinical notes documenting the provision of information. Moreover, even if the failure to disclose was negligent, it would never have met the high threshold of "serious negligence" that amounts to "an abuse of the privileges which accompany registration as a medical practitioner."

The judgments of the Court of Three Judges in *Soo Shuenn Chiang* and *Lim Lian Arn* reaffirm that the expert opinion of medical professionals remains relevant to reasonableness; that the threshold to be found guilty of professional misconduct is high; and that judges take a holistic assessment of the circumstances when evaluating complaints against doctors. The irony is that it was the SMC (the doctors themselves) which insisted on a higher standard than that required by the law.

REFORM

In March 2019, the Ministry of Health appointed a Workgroup to review and make recommendations on "the taking of informed consent by a medical practitioner from a patient and the Singapore Medical Council ("SMC") disciplinary process."[73] In November 2019, the Workgroup presented its report containing 29 recommendations, three of which were on informed consent. Two preliminary observations are made here. First, there is an apparent conflation of two distinct issues, namely the taking of informed consent on the one hand and the duty to advise the patient of material risks and alternatives on the other. Secondly, there is an assumption that the *Hii Chii Kok* decision was responsible for the unwarranted outcome in *Lim Lian Arn* at the Disciplinary Tribunal level.

There are two ways in which consent is relevant to the doctor-patient relationship – legal and clinical.[74] Legal consent is required to give the doctor lawful authority to treat the patient, absent which the doctor would commit battery and be liable in the tort of trespass. Under English law, it is well established that the patient only needs to be "informed in broad terms of the nature of the procedure which is intended."[75] There is no requirement to provide information that will satisfy the *Montgomery/Hii Chii Kok* test.[76] Clinical consent on the other hand is to secure the cooperation and confidence of the patient, factors that are important in establishing trust and "contributing to the treatment's success."[77] However, if the doctor

---

73 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019) at [1].

74 J Montgomery, *Health Care Law* (Oxford: Oxford University Press, 2nd ed, 2003) 227.

75 *Chatterton v Gerson* [1981] 1 QB 432 at 443. See also, *Hills v Potter* [1984] 1 WLR 641.

76 See for example, *XYZ v Warrington & Halton NHS Foundation Trust* [2016] EWHC 331 in which case the court held that consent was properly taken based on the standard information on the nature of the procedure and associated risks. See also the observation in *Shaw v Kovac & Or* [2017] 1 WLR 4773: "It has long been the law that where a doctor has failed to provide proper information as to risk prior to a medical procedure and that failure leads to consent being given which otherwise would have been withheld, and loss results, then that is actionable in negligence. The consent so given is not regarded as a nullity; and accordingly in the usual case the claim is not to be pleaded as one of trespass to the person (in the absence of fraud or bad faith, which has never been pleaded in the present case); see, for example, *Chatterton v Gerson* [1981] 1 QB 432 at 443 (per Bristow J)

77 *Re W (A Minor) (Medical Treatment: Court`s Jurisdiction)* [1993] Fam 64 at 76.

negligently fails to inform the patient of a material risk, which materializes and results in damage to the patient, the doctor may be liable in negligence. Tan Keng Feng put it succinctly:

> There are two aspects to the patient's participation in medical decision-making: one pertaining to the patient's exclusive non-clinical right to self-determination, and the other pertaining to the patient's right, shared with the doctor, to participate in clinical matters in the medical treatment process.[78]

This distinction between legal and clinical consent is crucial because trespass is actionable per se, ie the patient may sue even if the patient does not suffer any damage. Further, if the patient does suffer damage and brings an action in trespass, the remoteness rules that limit the extent of liability in negligence do not apply. Thus, the doctor may be liable for all damage that flows from the trespass. Finally, punitive damages are more likely to be available in a trespass action than in a negligence action. Failing to distinguish between taking informed consent (trespass) and the duty to inform the patient of material risks/information (negligence) risks inadvertently importing the *Montgomery/Hii Chii Kok* test into trespass, which would be catastrophic for doctors. The lines are already becoming blurred.[79]

The informed consent standard for trespass is rightly set at a level that is relatively easily satisfied by medical practitioners. The more demanding *Montgomery/Hii Chii Kok* test is appropriate for negligence because here, even though the standard demands more of doctors, they will only be liable if the patient suffers some damage. Further, even when damage is suffered, the patient must still prove that it was the negligent failure to inform that caused the damage. This will require the patient to prove that he or she would have avoided the risk by refusing consent and foregoing treatment or opting for an alternative;[80] not an easy task for serious, non-elective procedures.

On the second preliminary point, it was unfortunate that the Disciplinary Tribunal decision in *Lim Lian Arn*, roundly criticized on appeal, was used to launch a collateral attack on *Hii Chii Kok*, a carefully reasoned Court of Appeal decision by a full bench of five experienced judges, which brought the law in Singapore into line with the law in the major common law jurisdictions.[81] The Workgroup rightly acknowledged that the *Hii Chii Kok* test was "nuanced and well balanced" and that it did "not require doctors to disclose all risks to the point of blanketing patients with the minutiae of various treatment options."[82] Unfortunately, some doctors and lawyers misunderstood the reference to the "particular patient" in *Hii Chii Kok*, mistakenly believing that they had to satisfy the informational desires of the most unreasonable, idiosyncratic patient.[83]

---

78 Tan Keng Feng, "Failure of Medical Advice: Trespass or Negligence?" (1987) 7 Legal Studies 149 at 167-168.

79 J Herring, et al, "Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care" (2017) 25 Medical Law Review 582 at 583.

80 *Tong Seok May Joannev Yau Hok Man Gordon* [2013] 2 SLR 18 at [170]-[172]; cf *Chester v Afshare* [20014] 1 AC 134.

81 See cases listed in n 54 above.

82 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019) at [13].

83 In a petition to the Ministry of Health following the *Lim Lian Arn* decision, the signatories noted, "If patients need to be informed of even the most minor or uncommon side effects of treatment, then the

The proposed reform to the standard of care will make absolutely no difference to doctors' exposure to complaints of professional misconduct. The judgment of the Court of Three Judges in *Lim Lian Arn* makes that clear. However, by encouraging patients to ask endless questions to protect their interests, the new section 37 of the Civil Law Act encourages a less trustful and collaborative doctor-patient relationship, risking the likelihood of more disgruntled patients making complaints about the doctors' refusal to answer all of their questions. Commenting on section 37(3)(a) during the Second Reading Speech of the Bill, the Second Minister for Law gave this assurance: "In short, in that scenario, the patient can be assured that when he walks into a clinic and sees the doctor, there really are no "stupid questions". *Every question that this patient raises with this doctor is a valid, relevant question that has to be addressed*."[84] Beware, the "sovereign" patient!

The Workgroup's three recommendations on informed consent are as follows:

1. Provide a clear legal standard for medical professionals' duty to advise which is one that is patient-centric, but ultimately based on the opinion of a responsible body of doctors

2. Revise the SMC's ECEG provisions on informed consent down to basic irreducible principles with helpful illustrations to guide doctor on how these principles apply.

3. Develop nationally agreed specialty-specific and situational guidelines to deal with standard commonplace procedures in each specialty.

ANALYSING SECTION 37

The Australian experience in legislating negligence is instructive as there are some similarities with the Singaporean experience. The immediate trigger for the reform process there was an unprecedented healthcare insurance crisis. Instead of addressing the insurance crisis directly, medical negligence law became a scapegoat, blamed for encouraging litigation and increasing costs. The medical profession, insurers, and Government demanded reform, which was carried out in record time. The legislative history of the various Acts shows that there are challenges to legislating the standard of care for medical professionals, challenges which section 37 may also encounter.

Reforms were introducing following a health insurance crisis when Australia's biggest medical insurer, HIH Insurance Group collapsed in 2001, followed soon after by United Medical Protection, in 2002. Medical litigation and the demise of the *Bolam* test in Australia were blamed for the crisis, which was allegedly responsible for the withdrawal of healthcare services and lack of access to affordable healthcare. However, no empirical evidence was provided and the available evidence did not support the claims.[85] The Federal Government promptly

---

cost and time of treatment must necessarily increase. … The practice of medicine in Singapore will henceforth be completely legalistic, if all complications and side effects must be told to each and every patient" (https://www.change.org/p/what-is-the-ministry-of-health-s-stand-on-informed-consent-for-minor-procedures, last accessed 12 October 2021).

84 Singapore Parl Debates; vol 95, Sitting No 8; Sitting Date: 6 October 2020 (Mr Edwin Tong, Second Minister for Law) (emphasis added).

85 C Sappideen, "Bolam in Australia – More Bark than Bite? (2010) 33 UNSW Law Journal 386 at 389 and references at nn 73-75.

established an Expert Panel in July 2002 with instructions to prepare a report within three months; the final report was submitted in November 2002, recommending a modification of the *Bolam* test. Given the short timeframe, the Panel did not challenge the underlying assumptions on which the call for reform was made, but recorded them in the report:

> "The Ministerial communiqué, the Terms of Reference, and the breadth and range of the responses the Panel received in submissions and consultations, indicate that there is a widely held view in the Australian community that there are problems with the law stemming from perceptions that:
>
> (a) The law of negligence as it is applied in the courts is unclear and unpredictable.
>
> (b) In recent times it has become too easy for plaintiffs in personal injury cases to establish liability for negligence on the part of the defendants.
>
> (c) Damages in personal injuries cases are too frequently too high.

A judge, writing extra-judicially, expressed bemusement that decades of careful deliberation by generations of lawyers and judges could be ignored because "some unidentified persons can neither understand nor predict the common law of negligence."[86] Further, far from litigation being the main cause of the crisis (for which no credible evidence was produced), there was evidence that the insurance crisis was due to a range of factors including poor industry regulation, chronic underfunding, deliberate underpricing by insurers to gain market share, risky bets in the capital markets, and the black swan event of the September 11 terrorist attacks which had a catastrophic effect on global markets and insurance companies in particular.[87] The crisis was an opportunity for insurance companies and a conservative government to rush through ill-informed tort law reform. The Law Council of Australia noted:

> The changes to personal injury laws implemented in several jurisdictions in response to the insurance crisis has lead [sic] to a patchwork of laws which have invariably weakened the common law rights of people injured due to the carelessness of others. The reforms have also enabled insurers to reap a massive windfall of profits in public liability, motor accidents and workers compensation insurance, due to the dramatic reduction in the number of compensable claims caused by changes to personal injury laws.[88]

The aim of the reform exercise was to have uniformity in the law of negligence across Australia. However, each State enacted legislation with slight variations, creating a fractured national regime.[89] The legislative reform was also intended to deliver clarity and certainty. Instead, the statutory regimes in the Australian States have been the subject of litigation for almost 20 years as courts work on interpreting the various provisions. Some of the developments were unanticipated, suggesting that there may have been a disjunct between what the Expert Panel intended, what the Government accepted, and what the legislative drafters

---

86 P Underwood, "Is Mrs Donoghue's Snail in Mortal Peril?" (2004) 12 Torts Law Journal 39 at 45.

87 P Underwood, "Is Mrs Donoghue's Snail in Mortal Peril?" (2004) 12 Torts Law Journal 39; P Cashman, "Tort Reform and the Medical Indemnity Crisis" [2002] UNSWLJ 888 at 890; JJ Spigelman, "Negligence and Insurance Premiums: Recent Changes in Australian Law" (2003) 11 Torts Law Journal 291.

88 https://www.lawcouncil.asn.au/policy-agenda/access-to-justice/tort-law-reform, last accessed 17 October 2021.

89 D Butler, "A Comparison of the Adoption of the Ipp Report Recommendationsa and Other Personal Injuries Liability Reforms" (2005) 13 Torts Law Journal 203.

produced. However, while extrinsic material is relevant to statutory interpretation, the law is to be found in the statutory text, not in the minds of the reformers.

In an appeal involving the interpretation of section 5PB of the Civil Liability Act 2002 (WA), on the standard of care of medical practitioners, the Western Australian Court of Appeal had this to say:

> It would be a mistake, therefore, to reduce the task of interpreting s 5PB to a matter of identifying 'what does *Bolam* require?' or 'what did the Ipp Report propose?' The task of construing s 5PB must begin, and end, with the statutory text. Indeed, insofar as the Ipp Report is concerned, it is apparent that the text of s 5PB of the Civil Liability Act departs quite markedly from the recommendation in that report.[90]

In some ways, the Australian legislation was unremarkable as it merely reintroduced a watered down *Bolam* test for the medical duty to diagnose and treat. The duty to inform was not affected as the various Acts codified the material risk test set out in *Rogers*. Conceptually, the statutes work. Section 37, however, in attempting to fuse the *Montgomery/Hii Chii Kok* test with the *Bolam/Bolitho* test, has tried to fit a square peg in a round hole. Beyond this conceptual dilemma, there are several aspects of the legislation which are ambiguous and which may potentially expose healthcare professionals to greater liability than the common law.

Section 37(1) and (2) are set out for convenience:

Standard of care for medical advice

Section 37—

(1) A healthcare professional meets the standard of care in relation to the provision of medical advice to a patient if —

(a) subject to subsection (2), the manner in which the healthcare professional acts in the matter (at the time the medical advice is provided) is accepted by a respectable body of medical opinion (called in this section the peer professional opinion) as reasonable professional practice in the circumstances; and

(b) the peer professional opinion is logical.

(2) In order for the peer professional opinion mentioned in subsection (1) to be relied on for the purposes of that subsection, the peer professional opinion must —

(a) require the healthcare professional to have given (or caused to be given) to the patient —

(i) information that a person in the same circumstances as the patient (which circumstances the healthcare professional knows or ought reasonably to know) would reasonably require to make an informed decision about whether to undergo a treatment or follow a medical advice; and

---

90 *Child and Adolescent Health Service v Sunday John Mabior by Next Friend Mary Kelei* [2019] WASCA 151 at [303-[305].

(ii) information that the healthcare professional knows or ought reasonably to know (in accordance with subsection (3)) is material to the patient for the purpose of making an informed decision about whether to undergo the treatment or follow the medical advice; and

Explanation. — Sub-paragraph (ii) refers to information which a person in the same circumstances as the patient would not reasonably require to make an informed decision (about whether to undergo a treatment or follow a medical advice), but which is important to the patient, for the patient's own reason (including an idiosyncratic reason), for the purpose of making an informed decision.

(b) support the non-provision of any information mentioned in paragraph (a)(i) or (ii) to the patient only where there is reasonable justification for that.

The conceptual problem

The aim of the reform exercise was to revive the *Bolam/Bolitho* test with respect to the medical duty to inform and advise. That much is clear from the Workgroup Report and the Parliamentary Debates. However, the legislation also attempts to give a nod to patient autonomy by including the *Montgomery/Hii Chii Kok* test. There are two difficulties here, one philosophical and the other legal. Philosophically, the *Bolam/Bolitho* test and the *Montgomery/Hii Chii Kok* test are mutually exclusive. *Bolam/Bolitho* approaches material risk from a medical perspective: this is something that peer professional opinion can shine a light on. Experts can make a comparative risk/benefit analysis and offer an opinion on what risks are medically material. *Montgomery/Hii Chii Kok* approaches it from the patient's perspective. Subjecting the patient's decision to be vetted by peer professional opinion is anathema to patient autonomy.

To help the patient make an informed choice is the hallmark of collaborative autonomy. This is a middle ground between medical paternalism and isolated autonomy.[91] Collaborative autonomy is especially relevant to the duty to inform and the tort of negligence. Unlike the taking of consent for treatment, which typical occurs at a finite moment, the duty to inform is continuous as the doctor-patient relationship develops, the patient's condition and circumstances evolve, and new treatment options present themselves or are eliminated. This dynamic requires a partnership of trust, but as the Workgroup acknowledged, "The choice is ultimately the patient's, and the doctor's duty is to help *the patient make an informed choice*."[92]

The practical challenge is that patients often are not confident to make the decision on their own and prefer to be advised on what to do or to leave it to the doctor to decide.[93] However, this is not necessarily evidence that patients do not want to exercise autonomy. In some cases, patients are consciously outsourcing the professional decision-making to a trusted professional, but retaining the right to ask further questions, and ultimately to have the right to make an

---

91 MA Rubin, "The Collaborative Autonomy Model of Medical Decision-Making" (2014) 20 Neurocrit Care 311 at 312.

92 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019) at [53] (emphasis added).

93 See studies cited in MA Rubin, "The Collaborative Autonomy Model of Medical Decision-Making" (2014) 20 Neurocrit Care 311 at 314.

informed decision. This is described in the literature as a form of "conscientious autonomy" or "intellectual outsourcing."[94]

"Autonomous choice-making requires two essential psychological elements: an internal locus of control and a sense of competent self-efficacy."[95] Persons with an internal locus of control believe that they have control over their lives while those with an external locus of control do not, believing that others or circumstances have control over them. Self-efficacy refers to "a sense of having the ability to successfully carry out a task and achieve a result."[96] This provides a better understanding of the type of patients who are capable of exercising autonomy, the type who need assistance to achieve autonomy, and the type for whom decisions have to be made.

	Has self-efficacy	Lacks self-efficacy
Internal locus of control	1	2
External locus of control	3	4

Patients in Grid 1 are fully capable of exercising autonomy and are able to process complex information. Patients in Grid 2 have the capacity for exercising autonomy but lack the ability to do so as they may not fully understand their health condition and options. Too much information can become stressful as they want to exercise control, but are not competent to do so. Patients in Grid 3 are competent to make their own decisions but lack the confidence to do so. Instead of presumptively making decisions for them, doctors can help these patients realize their autonomy by providing the necessary information and advice through dialogue. Patients in Grid 4 may need the doctor to hold their hands and guide them.

This understanding demonstrates that there cannot be a one-size fits all approach to the duty to inform. The type and degree of information may vary according to the patient. This will be daunting for doctors, but at the same time, courts will also be aware of this reality and will therefore assess reasonableness according to the context and the nature of the patient. To override the prudent patient test for the duty to inform with the peer professional test is not in the best interests of the patient. Studies show that having some degree of control through adequate information is important to the patient's health.[97] "If the basic rule of medicine is 'First, do no harm,' then the harm done to patient autonomy by paternalistic medical environments and overcontrolling caregivers must be scrupulously avoided."[98]

---

94 VA Entwistle et al," Communicating about Screening" (2008) 22 British Medical Journal 337:a1591; R Kukla, "Conscientious Autonomy: Displacing Decisions in Health Care" (2005) 35(2) Hastings Center Report 34. I am grateful to Dr Anantham Devanand for these references.

95 BN Waller, "The Psychological Structure of Patient Autonomy" (2002) 11 Cambridge Quarterly of Healthcare Ethics 257.

96 Id at 258.

97 KE Dennis, "Patients' Control and the Information Imperative" (1990) 39(3) Nursing Research 162.

98 BN Waller, "The Psychological Structure of Patient Autonomy" (2002) 11 Cambridge Quarterly of Healthcare Ethics 257 at 263.

In terms of applying section 37, it is unclear how peer professional opinion is qualified to determine what is a material risk to a patient. Who is the relevant peer or expert? Should it be a peer in the same field as the defendant, should it be an expert on risk assessment, or should it be an expert on behavioural psychology? Regardless of who the expert is, they are only qualified to assess the risks based on their professional expertise; they are not qualified to divine what a reasonable patient would consider material. At best, they can opine on what information *they* believe should be disclosed to a reasonable person.

Leaving aside the disconnect between expert opinion and patient's need for information, it is also unclear how the logical defensibility test will apply. According to section 37(5) "a peer professional opinion is logical where — (a) the body of healthcare professionals holding the opinion has directed its mind to the comparative risks and benefits relating to the matter." This makes sense in the context of diagnosis and treatment. But what is the risk/benefit analysis when it comes to the duty to inform? It can only mean that the professional has to determine whether the risk of disclosing information would outweigh the benefit to the patient. However, "benefit to the patient" has to be judged from the patient's perspective, otherwise one cannot sensibly speak of patient autonomy. This risk/benefit analysis harks to the economic model of negligence, which does not seem as natural a fit with medical practice as the equal freedom or ethics of care models.[99]

Section 37 does not only present philosophical challenges, but legal ones too. Section 37(1) encapsulates the peer professional test of *Bolam/Bolitho* and section 37(2) encapsulates the prudent patient test of *Montgomery/Hii Chii Kok*. The way the section is drafted is to subjugate section 37(1) to section 37(2), that is to say, the latter is a precondition to the former. The text cannot be clearer. Section 37(1) provides, "A healthcare professional meets the standard of care in relation to the provision of medical advice to a patient if — (a) *subject to subsection (2),* …" Section 37(2) reinforces this by opening with these words: "*In order for the peer professional opinion mentioned in subsection (1) to be relied on* for the purposes of that subsection, the peer professional opinion *must* — …"

Thus, for the peer professional opinion to be relied on, the defendant *must* be required to disclose to the patient information that a prudent patient would require, ie it is mandatory to satisfy the *Montgomery/Hii Chii Kok* test before the *Bolam/Bolitho* peer professional test may be invoked. This was clearly not the intention of the Workgroup:

> The medical advice provided, and the materiality of the information and risks, would ultimately be assessed based on the practice and opinion of a responsible body of doctors. However, we clarify that this approach explicitly requires that a responsible body of doctors must have regard to patient autonomy and choice and consider what is material to the patient when providing medical advice. It would not represent the view of a responsible body of doctors, or meet the threshold test of logic, if it failed to do so.[100]

Had section 37 been drafted as the Workgroup had intended, then textually section 37(1) would not have been strangled by section 37(2). However, as argued above, the two subsections nonetheless are substantively incompatible and thus would not work as the Workgroup had intended. This raises the question whether the legislative drafters, having considered the

99 Discussed above, text at nn 32-40.

100 Id at [51].

Workgroup's recommendation and its express language,[101] deliberately revised the final language of section 37. It is not uncommon for legislators to differ from the recommendations of reform committees, expert panels, or workgroups. The Australian experience is a case in point.[102] So too the Penal Code reform exercise that resulted in the 2020 amendments to the Penal Code.[103] The language of section 37 is unambiguous, and while contextual material is relevant, the High Court of Australia has rightly noted:

> This Court has stated on many occasions that the task of statutory construction must begin with a consideration of the text itself. Historical considerations and extrinsic materials cannot be relied on to displace the clear meaning of the text. The language which has actually been employed in the text of legislation is the surest guide to legislative intention.[104]

It follows logically that section 37 codifies *Montgomery/Hii Chii Kok* and gives it primacy over *Bolam/Bolitho* in assessing the healthcare professionals' duty to advise. This interpretation fosters collaborative autonomy, with the medical professional helping the patient to make an informed decision instead of making the decision for the patient. Further, this interpretation is bolstered by section 37(2)(b) which sets out that non-disclosure of material information is only permitted when there is "reasonable justification." The examples of what constitute reasonable justification in the illustration are drawn from *Hii Chii Kok*, which applied the prudent patient test. The examples include necessity and waiver. Therapeutic privilege, the third example in *Hii Chii Kok*, is expressly excluded; instead, the third illustration highlights that a doctor is *not justified* in withholding information merely because it is perceived to be in the best interest of the patient.

The existence of section 37(2)(b) supports the argument made here that section 37(1) is subordinate to section 37(2). If peer professional privilege is the final arbiter, then the reasonable justification clause is superfluous. Surely, peer professional opinion would support non-disclosure in cases of necessity or waiver. Section 37(2)(b) would only be necessary if the standard of care is determined by the *Montgomery/Hii Chii Kok* test, based on information that a reasonable patient would consider significant. However, it is acknowledged that the interpretation set out in this paper appears to be contrary to the stated aim of the reform process, which was to make the medical professionals the ultimate arbiters of what information should be provided.[105] This ambiguous state of affairs will have to be resolved by courts.

The real problem with the prudent patient test is that it has become synonymous with patient autonomy. This invariably results in an overly subjective approach that focuses on the

---

101 Ibid.

102 See above text at n 90.

103 For example, the Penal Code Reform Committee recommended that the unsoundness of mind defence in section 84 of the Penal Code (Cap 224, 2008 Rev Ed) include situations where the accused person did not know that the conduct was either morally wrong or legally wrong, ie a disjunctive approach was recommended. See, Penal Code Review Committee Report (August 2018) 264. However, the legislation was drafted to restrict the defence by requiring a conjunctive approach, ie the accused must not know that the conduct was both morally and legally wrong.

104 *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* (2009) 239 CLR 27 at [47] (internal footnotes omitted).

105 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019) at [49].

particular patient's desire for information *ex post* instead of the reasonable patient's desire for information *ex ante*. Commenting on *Montgomery*, Banja astutely observes, "The court's decision will derive from a moral respect for an individual's autonomous right to construe and protect his or her welfare interests, not from some notion of what a reasonable person would or wouldn't do ex ante."[106] Informed consent and patient autonomy belong to the tort of trespass and the ethics of medical research. It should not cast too long a shadow over the tort of negligence. This must be acknowledged in order to have sensible reform of the standard of care pertaining to the duty to inform.

Specific issues

This part of the paper examines some specific issues in the legislation that potentially expose doctors to a more onerous duty than the common law, properly understood, does. Alternatively, if some of these matters are indeed what the common law demands, perhaps the legislation should have taken the opportunity to restrict the scope of doctors' liability instead of codifying the common law in these areas. The codification of the standard of care in section 37 gives rises to some challenges. There are four issues: the scope of the duty, the subjectivation of the standard of care, the judgment of reasonableness, and the potential reversal of the burden of proof.

Section 37 has adopted the wider duty to advise recognized in *Hii Chii Kok* instead of the narrower *Montgomery* duty.[107] Unlike the United Kingdom and Australia where the doctor's duty is limited to advising the patient of material risks in the proposed treatment and alternatives,[108] section 37 requires the doctor to advise the patient of treatment options and provide material information to enable the patient to make an informed decision. However, the duty to advise of treatment options properly should be governed by *Bolam/Bolitho/Gunapathy* as this is within the sphere of professional judgment.

The standard of care under *Hii Chii Kok* is ultimately objective. As explained above, it is based on the reasonable patient, and where the information has to be tailored to the particular patient, the information ultimately must be objectively material because the doctor knew or ought to have known that it was. Further, in practice, it would only arise when the patient has actually informed the doctor of the special circumstances, or where it is readily apparent from the doctor's interactions with the patient. This is reasonable. Section 37(3)(b), however, imposes a positive obligation on the doctor to review the patient's record to assess whether there are any idiosyncrasies that demand further information.[109]

---

106 J Banja, Reasonable Persons, Autonomous Persons, and Lady Hale Determining a Standard for Risk Disclosure Hasting Centre Report (March-April 2020) 25 at 29.

107 See above, text at nn 56-58.

108 *Malik v St George's University Hospitals NHS Foundation Trust* [2021] EWHC 1913; *Makaroff v Nepean Blue Mountains LHD* [2021] NSWCA 107.

109 37(3) In subsection (2)(a)(ii), an assessment as to whether any information is material to the patient for the purpose of making an informed decision about whether to undergo a treatment or follow a medical advice must be based on any specific concern or query the patient has in relation to the treatment or medical advice —

(a) which the patient expressly communicates to the healthcare professional; or

This raises a question of how courts should interpret what medical records the healthcare professional has "reasonable access to and ought reasonably to review." Is it based on peer professional standards or does the court exercise its own judgment as to reasonableness? Criticism that doctors would be required to delve deeply into patients' histories has been dismissed with confidence on the basis that doctors would only have to carry out reasonable inquiry. "The litmus test is that of reasonableness, … What is reasonable is a matter to be assessed in the context of each case, and it is not possible to define upfront at the start all the categories in a closed fashion of information that will be regarded as reasonable or not reasonable."[110] Yet, it is this very concept of reasonableness in the standard of care that was attacked for being uncertain and which prompted the reform exercise to "provide a clear legal standard."

The National Electronic Health Record (NEHR) brings together all the patient's medical records which are accessible by doctors participating in the programme.[111] Doctors may now be obliged to be familiar with the patient's idiosyncrasies not just from the doctor's relationship with the patient, but from the patient's interactions with other doctors. However, a study in 2019 showed that only 27% of private doctors had signed up to the NEHR.[112] The study also showed that older doctors (above 40 years) and those who were less computer savvy were unlikely to update the NEHR or review patients' records.[113] The Government has encouraged private doctors to sign up to the NEHR and has provided generous support.

The NEHR grants easy access to patients' records. Section 37(3)(b) fairly raises the possibility that a doctor who refuses to sign up to the NEHR and therefore fails to know that certain information is material to the particular patient might be negligent. The alternative would be to envisage variable standards to determine reasonable access to the NEHR. Section 37(3)(b) also raises ancillary issues of liability for systems errors and the effect of negligent recording of, or failure to update, patient information by other doctors. According to the study, such failure is not uncommon.[114]

While this was not intended,[115] the language of section 37 reverses the burden of proof on the peer professional standard. Section 37(1) provides that a "healthcare professional meets the standard of care in relation to the provision of medical advice to a patient if" his or her conduct is accepted by peer professional opinion. Section 37(2) then provides, "In order for the peer professional opinion mentioned in subsection (1) to be relied on for the purposes of that subsection, …" Read together, section 37 is a provision for healthcare professionals to rely on

---

(b) which the patient does not expressly communicate to the healthcare professional but which ought to be apparent to the healthcare professional from the patient's medical records that the healthcare professional has reasonable access to and ought reasonably to review …

110 E Tin, & AWR Cheng, "New Section 37 on Standard of Care for Medical Advice" (2021) 53(1) SMA News 18 at 20.

111 https://www.ihis.com.sg/nehr/home, last accessed 19 October 2021.

112 Qin Yong See, "Attitudes and Perceptions of General Practitioners towards the National Electronic Health Record (NEHR) in Singapore" (2020) 5(1) European Medical Journal 86 at 88.

113 Id at 92.

114 Id at 91.

115 Singapore Parl Debates; vol 95, Sitting No 8; Sitting Date: 6 October 2020 (Mr Edwin Tong, Second Minister for Law).

to prove that they had met the standard of care. The burden is therefore on the healthcare professional. This was the interpretation of the Civil Law Act 2002 (NSW) s 5O and the Wrongs Act 1958 (Vic) s 59,[116] which use language similar to that in section 37. This is still consistent with the legislation, as the claimant may establish the cause of action based on the common law, which is preserved by the legislation.[117]

There are further matters that will require clarification by courts when the legislation comes into effect, including which healthcare professionals are affected by the legislation. According to the legislation, "A healthcare professional is defined by the new section to mean an individual who practises a profession that provides medical advice – this includes a medical practitioner, a dentist and an oral health therapist." Thus, it remains to be seen who else may be included as "an individual who practices a profession that provides medical advice. The legislation restricts healthcare professionals to individuals. Thus, it does not apply to healthcare institutions.

CONCLUSION

The *Rogers/Montgomery/Hii Chii Kok* material risk test was a natural development in striking the right balance between medical beneficence and patient autonomy. It may take some time to achieve an optimal state; until then, the equilibrium will be dynamic and imperfect. However, there is a wealth of jurisprudence around the common law world explaining the test and providing examples of its application from which courts can draw lessons. It is a test that aligns with medical ethics, promotes a positive standard of caring, and respects patients as partners in the doctor-patient relationship.

The Workgroup's assumption that Singapore is not ready for this because "the jurisdictions that have earlier departed from the *Bolam-Bolitho* test are advanced Western societies"[118] is disputable factually and normatively. For example, Malaysia, Hong Kong, Indonesia, South Korea, and China all have laws requiring doctors to provide material information to patients to enable informed decision-making.[119] The Indian Supreme Court has recently referred with approval to *Montgomery* while noting the problems with *Bolam*, [120] especially in light of Article 21 of the Indian Constitution "which encompasses within its guarantee, a right to medical treatment and medical care."[121]

---

116 *South Western Sydney Local Health District v Gould* [2018] NSWCA 97 at [123]; *Boxell v Peninsula Health* [2019] VSC 830 at [21].

117 See the Explanatory Statement to the Civil Law (Amendment) Bill (Bill No 33/2020).

118 Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (*Report on Recommendations*, 28 November 2019) at [14].

119 *Dr Hari Krishnan & Anor v Megat Noor Ishak Megat Ibrahim & Anor* [2018] 1 MLRA 535; *Chan Siu Yim v Dr Cheung Sheung Kin also known as Dr Samuel Kinneth Cheung* [2017] HKDC 174; Law of the Republic of Indonesia Number 29 Year 2004 regarding the Medical Practice, arts 45, 52; BY Park et al, "Informed Consent as a Litigation Strategy in the Field of Aesthetic Surgery: An Analysis Based on Court Precedents" (2016) 43(5) Archives of Plastic Surgery 402; Tort Law of the People's Republic of China (2010) art 55 (https://www.wipo.int/edocs/lexdocs/laws/en/cn/cn136en.pdf, last accessed 21 October 2021).

120 *Maharaja Agrasen Hospital v Master Rishabh Sharma* [2019] INSC 1286.

121 *V Kishan Rao v Nikhil Super Speciality Hospital* (2010) 5 SCC 513 at [25].

Instead of legislatively reversing *Hii Chii Kok*, a better approach would have been to curtail some of the far-reaching effects of *Hii Chii Kok* and the over-reliance on patient autonomy in the tort of negligence. Thus, section 37 could have clarified that the duty is restricted to informing patients of material *risks* in proposed treatments and alternatives. This prevents the *Hii Chii Kok* test from encroaching into the domain of medical professional judgment of appropriate treatment options. Section 37 should not have codified an overly subjective approach to the particular patient test nor imposed a positive obligation on doctors to review patients' records to assess whether there are any idiosyncrasies to be addressed. The particular patient test should have remained under the control of an objective test and restricted to cases where the patient has expressly alerted the doctor to idiosyncratic concerns.

The rush to reform the law has produced legislation that introduces greater uncertainty than the common law, and which may subject healthcare professionals to higher standards and more onerous responsibility with respect to the duty to advise. It puts Singapore out of sync with the major common law jurisdictions and risks affecting the international reputation of its healthcare sector and its healthcare professionals. Ultimately, section 37 may not be in the interests of doctors, although it may well benefit lawyers and insurance companies if it complicates the law.