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THE UNIQUE STANDARD OF CARE FOR DOCTORS IN SINGAPORE – PART 1 OF THE HCK SERIES

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I. INTRODUCTION

In the practice of medicine, a doctor's job can be divided into 3 components: diagnosis, treatment, and advice.[1] Traditionally, the legal test for determining the standard of care that a doctor was expected to meet to avoid liability in negligence was the doctor-centric *Bolam-Bolitho* test which focuses on the doctor's perspectives. While this test originally applied to medical advice in the UK[2] and Singapore[3], the position in the UK has since been changed by the Supreme Court in *Montgomery v Lanarkshire Health Board* [*Montgomery*][4] where a patient-centric approach similar to the Australian High Court's approach in *Rogers v Whitaker* [*Rogers*][5] was taken. After considering these and other overseas cases[6], the Singapore Court of Appeal adopted a modified and unique test in the context of medical advice in the landmark decision of *Hii Chii Kok v Ooi Peng Jin London Lucien* [*HCK*][7].

In this two-part series of articles, the *HCK* test will be examined in detail with comparisons drawn with the tests of other jurisdictions. Part 1 of the *HCK* series begins by providing an overview of the *HCK* test followed by an analysis of various aspects of the test such as the balance that was struck in *HCK*, the seemingly additional test of relevancy, the types of information

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[1] A classification that was made in *Dr Khoo James & Anor v Gunapathy d/o Muniandy*, [2002] SGCA 25; [2002] 1 SLR(R) 1024 and elaborated on in *Hii Chii Kok v Ooi Peng Jin London Lucien and Another*, [2017] SGCA 38; 2017 2 SLR 492 at [89].

[2] *Sidaway v Bethlem Royal Hospital Governors*, [1985] AC 871 (HL (Eng)).

[3] *Dr Khoo James & Anor v Gunapathy d/o Muniandy*, [2002] SGCA 25; [2002] 1 SLR(R) 1024 at [65].

[4] *Montgomery v Lanarkshire Health Board*, [2015] 1 AC 1430 (SC (Eng)).

[5] *Rogers v Whitaker*, [1992] 175 CLR 479 (HCA).

[6] Such as the American case of *Canterbury v Spence*, [1972] 464 F 2d 772, the Canadian case of *Reibl v Hughes*, [1980] 2 SCR 880 (SCC) and the Malaysian case of *Foo Fio Na v Dr Soo Fook Mun & Anor*, [2007] 1 MLJ 593 (FC).

[7] *Hii Chii Kok v Ooi Peng Jin London Lucien and Another*, [2017] SGCA 38; [2017] 2 SLR 492.

covered, the scenario where information is unknown, and the remaining ambiguities. Part 2 of the *HCK* series[8] will deal specifically with stage 3 of the *HCK* test relating to the situations where a doctor is justified in withholding information, otherwise known as the exceptions to a doctor's duty of disclosure.

II. OVERVIEW OF THE SINGAPORE TEST

The *HCK* test formulated by the Singapore Court of Appeal is a three-stage test.

1. First Stage

The first stage involves the patient's identification of the information not provided and why it should be regarded as relevant and material.[9] The court held that a doctor must disclose information that would either "be relevant and material to a reasonable patient situated in the particular patient's position", or the doctor knows is important to the particular patient.[10]

The identification of the information not provided is necessary in order "to determine whether the doctor possessed that information at the material time" and therefore "whether the withholding of the information was justified".[11] The underlying concern for this requirement "is to ensure that the scope of the dispute is clearly delineated" and that the process is fair to doctors.[12]

The court will take into account the personal circumstances of the patient to determine what "a reasonable person in the position of the patient in question would consider material".[13] However, such information is only relevant "to the extent that the doctor knew or ought reasonably to have known of them.[14]

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[8] Keith Jieren Thirumaran, "The exceptions allowing for Non-Disclosure of Information by Doctors in Singapore – Part 2 of the *HCK* Series" (2019) Singapore Law Review, 11 Juris Illuminae (online).

[9] *Supra* note 7 at [132].

[10] *Ibid* at [132].

[11] *Supra* note 7 at [134]; *Lam Kwok Tai Leslie v Singapore Medical Council*, [2017] SGHC 260; [2017] 5 SLR 1168 at [31].

[12] *Supra* note 7 at [149]; *Lam Kwok Tai Leslie v Singapore Medical Council*, [2017] SGHC 260; [2017] 5 SLR 1168 at [31].

[13] *Supra* note 7 at [144].

[14] *Ibid.*

The materiality of the information is assessed from the patient's perspective[15] and takes into account what the particular patient was "reasonably likely to have attached significance to" as well as what the doctor knew or should have known the particular patient would have attached significance to.[16] The analysis of relevancy and materiality of the information would be largely matters of "common sense" and would generally exclude "information that reasonable people would regard as immaterial or irrelevant".[17] This analysis would also take into account information that is immaterial to the reasonable person in the patient's position which the actual patient still found material for the patient's own reasons, but would only require disclosure if "the doctor actually knew or had reason to believe that the particular information was relevant and material to the particular patient".[18]

The court in *HCK* also went further than *Montgomery*[19] in terms of the types of information that could be considered material. The court held that it would not confine the information to material risks concerning the treatment and its alternatives[20] but would instead adopt the broad types of material information that were identified in the Canadian case of *Dickson v Pinder*[21]. These include: the doctor's diagnosis of the patient's condition, the prognosis of that condition with and without medical treatment, the nature of the proposed medical treatment, the risks associated with the proposed medical treatment, and alternatives to the proposed medical treatment as well as their advantages and risks.[22] The type of information reasonably material would depend on factors such as certainty, consequence, and context.[23]

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[15] *Ibid* at [137].

[16] Ibid.

[17] *Ibid* at [139] and [143]. In determining materiality, the court gave the example of risks and opined that the likelihood and severity of the risk would determine materiality to a reasonable patient – *Ibid* at [140].

[18] *Ibid* at [145].

[19] In *Montgomery*, the types of information only included "any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments" – See: *Supra* note 4 at [87].

[20] *Supra* note 7 at [132] and [138].

[21] *Dickson v Pinder*, [2010] ABQB 269 at [68].

[22] *Ibid* at [68]. *Supra* note 7 at [132] and [138].

[23] *Supra* note 7 at [143]. For example, "where the diagnosis is uncertain, more information pertaining to other possible diagnoses will also become material" – See: *Supra* note 7 at [143].

2. Second Stage

The second stage involves determining whether the doctor was in possession of the information identified as relevant and material.[24] Where the doctor was not in possession of the information, the case will no longer be assessed under the category of negligent advice, but instead be assessed as a negligent diagnosis or treatment case and therefore be subjected to the normal *Bolam-Bolitho* test.[25]

3. Third Stage

The third stage involves an examination of the reasons why the doctor chose to withhold the information from the patient.[26] While an overview of the third stage is provided at this juncture, a detailed analysis of this stage can be found in Part 2 of the *HCK* series.[27]

The court would determine whether the "doctor was justified in withholding the information".[28] However, whether the doctor was justified would not be measured by the *Bolam-Bolitho* test, even though it is informed by medical considerations.[29] After determining that the doctor's reasons were justified, the court would then determine whether the doctor's decision "was a sound judgment having regard to the standards of a reasonable and competent doctor".[30] At this stage, expert medical evidence will have some significance because there is still "an element of professional judgment involved".[31]

The court did not want to confine or restrict the situations that could be justifiable but held that courts would consider all the circumstances in determining whether the withholding of

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[24] *Supra* note 7 at [133].
[25] *Ibid* at [133].
[26] *Ibid* at [134].
[27] *Supra* note 8.
[28] *Supra* note 7 at [134].
[29] *Ibid.*
[30] *Ibid.*
[31] *Ibid* at [148].

information was justified.[32] However, the court elaborated on 3 non-exhaustive categories of situations that would justify non-disclosure.[33]

The first situation allowing for the withholding of information is where the patient does not wish to know the information.[34] This is treated as a "factual question" on the existence and scope of a patient's waiver of the information, and will not usually involve expert opinion.[35]

The second situation is where there is an emergency scenario, such as when there is a threat of death or serious harm to the patient, while the patient lacks decision-making capacity and there is no appropriate substitute decision-maker.[36] For this situation, the *Bolam-Bolitho* test will apply because medical expert opinion will be "crucial" in determining whether the urgency of the situation is such that seeking opportunities to provide information to the patient can be sacrificed.[37]

The third situation involves therapeutic privilege and applies where a doctor "reasonably believes that the very act of giving particular information would cause the patient serious physical or mental harm".[38] For this situation, expert medical and psychological evidence will "be helpful or even crucial" to the court.[39] However, the *Bolam-Bolitho* test will not be applied because the focus is on whether the court is of the opinion that the patient would likely be harmed when informed of the material information.[40]

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[32] *Ibid* at [149].

[33] *Ibid.*

[34] *Ibid* at [150].

[35] *Ibid.*

[36] *Ibid* at [151]. In this situation, rather than justifying a doctor's withholding of information, the reality is that the duty to advise the patient is itself suspended out of necessity.

[37] *Ibid* at [151].

[38] *Ibid* at [152]. The court also elaborated on some examples such as patients with anxiety disorders or are easily frightened as well as patients "whose state of mind, intellectual abilities or education" make it "impossible or extremely difficult" to weigh the risks and understand the reality.

[39] *Ibid* at [153].

[40] *Ibid.*

III. ANALYSIS OF THE *HCK* TEST

It is clear that while the *HCK* test draws some inspiration from the *Montgomery* test, it also modifies and refines it in several aspects. This section will now explore the reasons and rationale for the approach taken in *HCK* as well as examine the unique aspects of the *HCK* test.

1. The balance struck in HCK

In *HCK*, the court made a "carefully calibrated shift in the standard of care" that is required of doctors in the context of advice.[41] The result is that the new test in Singapore is a middle-ground between the patient-centric position in *Montgomery* as well as the doctor-centric position in *Bolam-Bolitho*. However, in relation to certain aspects that will be discussed below, the court in *HCK* has in fact gone further than the court in *Montgomery* towards patient centricity.

The key reason why this shift was needed, and was indeed made, was that there has been an increase in recognition for the "need to treat patient autonomy seriously" in the law.[42] This is a result of the developments within the medical profession as well as the rest of society which have shifted patient autonomy to a position of prime importance[43] in what has been a "seismic shift in medical ethics, and in societal attitudes towards the practice of medicine"[44].

This evolution in the nature of the patient-doctor relationship in Singapore is in light of the "level of education and access to knowledge" of ordinary people.[45] A patient, during the advice stage, is no longer a passive recipient of care but has become an "active interlocutor in whom ultimately rests the power to decide".[46] This has resulted in a new generation of patients who have become much more informed about "medical matters, their choices and rights".[47]

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[41] *Ibid* at [85].
[42] *Ibid* at [116].
[43] *Ibid* at [118].
[44] *Ibid* at [120].
[45] *Ibid* at [119].
[46] *Ibid* at [113].
[47] *Ibid* at [118], citing Singapore Medical Council, *Ethical Code and Ethical Guidelines*, Singapore: Singapore Medical Council, 2016.

Furthermore, a patient has a right to decide and choose whether or not to undergo medical treatment.[48] Such decisions and choices are "ultimately the patient's to make", while a doctor's function is simply to "empower and enable the patient to make that decision by giving him the relevant and material information".[49] Lastly, a decision on what information patients should be given is only partially a medical science assessment, with the other part being an assessment of a patient's personal concerns and priorities.[50]

However, a balance needs to be struck between patient autonomy and beneficence (i.e. the doctor's provision of benefits to a patient through the fair weighing of benefits against risks and costs).[51] This balance necessitates another balance to be struck between the doctor's perspective and the patient's perspective.[52] A "proper balance"[53] must take into account the fact that a doctor is able to be objective and dispassionate in making judgment calls as to the significance of information while a patient, on the other hand, might be emotional and place inappropriate emphasis on risks.[54]

Another reason that necessitated the "carefully calibrated shift" is that rising healthcare costs as well as defensive medicine are "real concerns" that the courts need to bear in mind when they are approaching the question of legal reform.[55] The court in *HCK* noted that this was not a sufficient reason to "shut the door to reform entirely" and was a minor issue when only a partial reform is attempted.[56] Nonetheless, it is suggested that this may well have been one of the decisive reasons why the court chose to adapt *Montgomery* to better fit the Singapore context, especially given the way healthcare expenditure is funded in Singapore.[57]

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[48] *Ibid* at [125].
[49] *Ibid* at [97].
[50] *Ibid* at [125].
[51] *Ibid* at [120].
[52] *Ibid.*
[53] *Ibid* at [131].
[54] *Ibid* at [113].
[55] *Ibid* at [85].
[56] *Ibid.*
[57] Healthcare in Singapore is largely funded privately or through insurance schemes, although government subsidies may be provided. On the other hand, the UK's National Health Service is financed by the government through taxes. As a result, in the event that an overly patient-centric approach results in defensive medicine, the increase in healthcare costs would have a greater impact on Singapore society that in the UK. This is because it would mean higher out-of-pocket expenditure by those in need of healthcare as well as higher insurance premiums for the general public.

2. "Relevant and Material"

The first unique feature of the *HCK* test is the usage of the phrase "relevant and material" information.[58] Therefore, there appears to be a test of both relevancy and materiality in the *HCK* test. This is as opposed to the use of "material" risks in cases such as *Rogers*[59] and *Montgomery*[60], which imply a test of materiality alone. The UK courts have in fact stressed that the test in *Montgomery* is materiality and not relevance.[61]

As noted by the UK courts, the tests of relevance and materiality might conceivably be different[62], and the author agrees that these concepts are indeed distinguishable. Nonetheless, a difficulty arises in the conceptualisation of information that is material but not relevant to a patient. If the information is material to a patient, it is highly likely that it would also be relevant to that patient.[63] On the other hand, relevant information is not necessarily material.[64] Thus, the test of materiality is a subset of the broader test of relevancy. As such, whether the addition of the requirement of relevancy has any effect on the scope of information that needs to be disclosed remains to be seen in future Singapore cases.

As there was no specified reason in the Singapore judgment as to why the word "relevant" was added in *HCK*, any discussion on this would be entirely speculative. However, it is entirely plausible that the court intended to limit the range of possible information that a patient would be able to claim for by adding the additional requirement of relevancy. This is likely to be because of the expanded scope of disclosure under the *HCK* test that is not confined to risks and alternatives.

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[58] *Supra* note 7 at [132].

[59] *Supra* note 5 at [16].

[60] *Supra* note 4 at [87].

[61] *Regina (M & Another) v Human Fertilisation and Embryology Authority*, [2017] 4 WLR 130 (CA (Eng)) at [79].

[62] *Ibid* at [79].

[63] If a patient is reasonably likely to attach significance to the information (thereby considering it material), then there is no conceivable way for the information to be irrelevant to the patient. This is because where a patient considers information material, the information must logically be in some way related or have some connection to the scenario the patient is in. If the information were not relevant because it was not related or connected to the patient in any way whatsoever, no patient would reasonably attach significance to it in the first place.

[64] This is clear from the facts of *HCK* where certain specific information on the test (like the number of times it had been used before) were not material, although they were relevant to the patient as it was the test that the patient had undergone – See: *Supra* note 7 at [186].

Therefore, it is submitted that the intended effect of including the word "relevant" into the test was to help guard against the practice of defensive medicine by doctors in Singapore by limiting the scope of information that needs to be disclosed.

It is respectfully submitted that defensive medicine[65] is the practice by doctors of adopting "what they think is legally safe", despite their beliefs as to what is best for the patient.[66] The court in *HCK* stated that the "concerns in defensive medicine pertain mainly to diagnosis and treatment."[67] However, in the context of advice, it is possible for defensive practices to exist. It is respectfully submitted that this could take the form of disclosing more information than is necessary in the doctor's attempt to be legally safe, despite the fact that such information may not be necessary or may even entail unforeseen harmful effects.

The disclosure of excessive information may result in the wastage of medical time and resources and risks frightening a patient, thus leading them to reach an unbalanced decision.[68] Defensive medicine also results in higher medical costs and a wastage of precious medical resources.[69] Other foreseeable detrimental effects of defensive medicine may include higher insurance costs[70], compromising of the quality of medical care[71], denial of access to medical care and attention, and a tendency towards unnecessary or sub-optimal medical decisions.[72] The possibility of such defensive practices is exacerbated under the *HCK* test because information is not confined to

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[65] It is important to note that there is a recent Singapore case that takes a different view of defensive medicine and this is discussed later in this commentary: see note 75 below and its accompanying text.

[66] *Supra* note 2 at 887.

[67] *Supra* note 7 at [84] & [87].

[68] *Tong Seok May Joanne v Yau Hok Man Gordon*, [2012] SGHC 252 at [76].

[69] *Supra* note 3 at [144].

[70] Response by Chief Justice Sundaresh Menon at the Opening of the Legal Year 2016 (11 January 2016) at para 43.

[71] *Singapore Parliamentary Debates, Official Report* (1 April 2019) vol 94 "Protecting Patients' Interests and Supporting the Medical Community" (Gan Kim Yong, Minister for Health) – which states: "In the current climate of uncertainty, there is a real risk that medical practitioners will adopt defensive medicine. There is evidence that this is already happening. Fearing that they might be called out should a complication occur, doctors are likely to overwhelm patients with voluminous information on multiple unlikely risks, protecting themselves legally but confusing patients."

[72] Chief Justice Sundaresh Menon, "Evolving Paradigms for Medical Litigation in Singapore", (28 October 2014) Obstetrical & Gynaecological Society of Singapore at [33].

material risks concerning the treatment and its alternatives[73] but instead involves the broad types of material information that were identified in the Canadian case of *Dickson v Pinder*[74].

It is important to note that in a recent Singapore case, defensive medicine was defined differently as encompassing "the situation where a doctor takes a certain course of action in order to avoid legal liability rather than to secure the patient's best interests".[75] In that case, the court stated that overwhelming patients with a deluge of information on unlikely risks is not defensive medicine.[76] The reason given for this is because "giving too much information will not avoid legal liability" because bombarding the patient with information leaves the patient more confused and less able to make a proper decision, thus leading to legal liability for failing to obtain informed consent.[77] This position, unlike the definition adopted above[78], is not dependent on a doctor's subjective belief of what will allow him to avoid legal liability.

While there is merit in framing defensive medicine as excluding situations where legal liability is not avoided, with respect, this definition is under-inclusive and does not fully capture the potential range of behaviour that is defensive in nature. In essence, if a doctor is misguided and therefore fails in his attempt to avoid legal liability, that does not make the attempted defensive actions any less defensive in nature. In any event, misguided attempts at defensive action, whether or not considered to be "defensive medicine", would still have the same detrimental effects as defensive medicine itself. Indeed, the Ministry of Health in Singapore has highlighted that there is a very real possibility of over-disclosure of risks being taken as attempted defensive action.[79] Therefore, it is respectfully submitted that it would be helpful to recognise excessive disclosure of information as "defensive medicine" so that its risk can be properly accounted for.

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[73] *Supra* note 7 at [132] & [138].

[74] *Supra* note 21 at [68].

[75] *Singapore Medical Council v Lim Lian Arn* [2019] SGHC 172 at [53].

[76] *Ibid* at [53].

[77] *Ibid* at [54].

[78] See note 66 above and its accompanying text.

[79] *Singapore Parliamentary Debates, Official Report* (1 April 2019) vol 94 "Protecting Patients' Interests and Supporting the Medical Community" (Gan Kim Yong, Minister for Health) – which states: "In the current climate of uncertainty, there is a real risk that medical practitioners will adopt defensive medicine. There is evidence that this is already happening. Fearing that they might be called out should a complication occur, doctors are likely to overwhelm patients with voluminous information on multiple unlikely risks, protecting themselves legally but confusing patients."

Lastly, the court in *HCK,* although providing a definition and test for materiality, did not do the same for relevancy. As such, there is a lack of a clear distinction between the two requirements of relevancy and materiality. Therefore, despite any intended limiting effect of the introduction of a relevancy requirement, the practical effect of this addition is likely to be negligible. This is because the test is conjunctive, hence the information must have been both relevant and material to a reasonable patient in the patient's position. Thus, the additional requirement will likely have no effect as doctors will not be sure whether a material piece of information is irrelevant and therefore disclose it nonetheless.[80] As such, any intended additional guidance or reassurance is negated and further clarification by the courts is necessary in order to delineate any additional considerations that doctors should be mindful of.

3. Types of Information

The second unique feature of the *HCK* test is that the information that needs to be disclosed is wider than the information defined in *Montgomery*.

As aforementioned, the court in *HCK* expanded the information that could be considered material to include the broad types of material information that were identified in the Canadian case of *Dickson v Pinder*.[81] Furthermore, this list is non-exhaustive and the court left the door open for other types of information. The court made reference to the idea of certainty[82] which could potentially lead to more information being relevant where for example there is uncertainty present (such as information on alternative diagnoses).[83]

It is, however, noted that the case of *Montgomery* was concerned with a patient alleging that she was not informed about the risk of shoulder dystocia in her case.[84] The case of *HCK*, on the other hand, concerned a patient who alleged that the advice on a Gallium scan and its limitations, the importance of the morphological scans, and peculiarity of the pancreas in relation to functional scans were insufficient to allow him to make an informed decision.[85] As a result, while the court

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[80] Being unsure, a doctor is likely to behave defensively in an attempt to remain legally safe, thus resulting in the disclosure of material information whether relevant or irrelevant. This final outcome would also have originated under the *Montgomery* test.

[81] *Supra* note 7 at [132] and [138]. *Supra* note 21 at [68].

[82] *Supra* note 7 at [143].

[83] Ibid.

[84] *Supra* note 4 at [13].

[85] *Supra* note 7 at [47].

in *Montgomery* was solely concerned with risks, the court in *HCK* had a wider range of information that it had to contend with. As a result, forms of information other than risks would not have been the focus of the Supreme court in *Montgomery*.

Therefore, it is possible that future UK decisions might not limit material information to risks of treatment and alternatives and expand them in a similar way to *HCK*. In the UK courts, it was in fact noted in *obiter* that although *Montgomery* involved the provision of information in order to determine whether to undergo a particular treatment, it could potentially be expanded to cover all aspects of advice.[86] As such, in the future, this may no longer be a distinguishing factor of the *HCK* test and may be applicable in other jurisdictions.

4. Unknown Information

The third unique feature of the *HCK* test is that where a doctor is not in possession of the information that is relevant and material, the case will no longer be assessed under the category of negligent advice but instead be assessed as a negligent diagnosis or treatment case and therefore be subjected to the normal *Bolam-Bolitho* test.[87] The cases of *Montgomery* and *Rogers* are silent on this aspect. This scenario involves a doctor who lacks the information through his own fault and not scenarios where the risk was not even comprehended by medical knowledge at the time of the alleged breach.[88]

While the end-result of this re-characterisation is correct in principle, the classification of such a case may not be as straightforward as it seems.

For cases where a doctor is unaware of information due to a failure to conduct certain procedures on the patient, that would rightly fit under the rubric of diagnosis. Diagnosis involves establishing the medical needs of a patient and includes the obtaining, consideration, and analysis

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[86] *Spencer v Hillingdon Hospital NHS Trust*, [2015] EWHC 1058 at [32].

[87] *Supra* note 7 at [133].

[88] This is because in such a scenario, a reasonable medical practitioner cannot be expected to have possession of such information beyond medical science – See: *Rosenberg v Percival*, [2001] HCA 18 at [67], Gummow J.

of information gathered followed by the formation of provisional conclusions on the best way to proceed.[89] An analogous situation to this surfaced in a subsequent recent case.[90]

However, where a doctor is unaware of information due to a lack of factual or technical knowledge of a particular risk, such a situation is not as clear-cut.

Firstly, treatment involves the carrying out of the solution chosen by the patient as well as the care the patient receives.[91] If a patient fails to receive information on a risk of a specific procedure, the treatment of the patient by the doctor is not itself defective. The issue is instead whether the patient would have chosen the same solution had the patient known of the information.

Secondly, diagnosis involves establishing the medical needs of a patient and determining the best way to proceed.[92] Here, an argument can be made that the doctor might have been negligent in not ascertaining the best way to proceed properly.

Thirdly, advice involves the presentation of information to the patient and includes recommendations as well as other material information.[93] While it is agreed that "one cannot give what one does not have" [94], this does not necessarily stop the lack of information from being a negligent advice scenario. It is correct that a doctor without the material information cannot provide that information to the patient. However, this also means that the doctor has failed to advise the patient properly as a result of that lack of information, which is arguably still a failure in advising.

Nonetheless, the outcome of the re-characterisation is that the *Bolam-Bolitho* test is applied to cases where the doctor lacks the information that is considered material which is correct in principle. This is because a failure of a doctor to be aware of medical information due to his own ignorance is essentially a failure of a medical nature and therefore recourse should be sought from the *Bolam-Bolitho* test. It is submitted that an alternative and clearer conceptual approach would be to analyse it plainly from the perspective of whether the doctor "was negligent in not having such information"[95] without the need for re-characterising the case as diagnosis or treatment.

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[89] *Supra* note 7 at [96].

[90] *Noor Azlin Bte Abdul Rahman v Changi General Hospital Pte Ltd* [2018] SGHC 35 at [55]; *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd and others* [2019] SGCA 13 at [80] – [82].

[91] *Supra* note 7 at [98].

[92] *Ibid* at [96].

[93] *Ibid* at [97].

[94] *Ibid* at [133].

[95] *Supra* note 90 at [55].

5. Remaining Ambiguities

While the current framework provided by the *HCK* test has many positive features, there remains some ambiguity and uncertainty that permeates through the test. There are two prominent ambiguities that have yet to be discussed and are important to highlight at this juncture.

The first prominent ambiguity that surfaces from the *HCK* test relates to the level of flexibility that has been injected into the analysis as compared to *Montgomery*. In the *Montgomery* test, once the conditions specified in the definition of materiality[96] are fulfilled, the information is considered material. This is because the definition uses the phrase "is whether", which results in the conditions being phrased as the test of materiality itself.[97]

On the other hand, the definition of materiality in the *HCK* test[98] uses the phrase "having regard to". This means that the *HCK* test does not specify automatic conditions in order for the information to be considered material but provides factors that are taken into account in determining materiality.[99] This approach of treating the conditions as factors results in fluidity in determining what information is material, thus leading to uncertainty.

This fluidity from treating the conditions as factors, coupled with "common sense" playing a more powerful role[100], and further exacerbated by the fact that the "tests" adopted from *Montgomery* are in itself inherently difficult for doctors to determine materiality in practice, results in a problematic level of uncertainty. The combined effect of these would mean that a doctor will have great difficulty in practice in determining whether a particular piece of information is material or not. This would result in defensive practices such as disclosing more information than is necessary in the doctor's attempt to be legally safe, accompanied by the attendant detrimental

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[96] "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." – See: *Supra* note 4 at [87].

[97] *Supra* note 4 at [87].

[98] "Materiality is to be assessed from the vantage point of the patient, having regard to matters that the patient in question was reasonably likely to have attached significance to in arriving at his decision, or matters which the doctor in fact knew or had reason to believe that the patient in question would have placed particular emphasis on." – See: *Supra* note 7 at [137].

[99] *Supra* note 7 at [137].

[100] *Supra* note 7 at [139] & [143].

effects[101]. The Ministry of Health has highlighted that doctors are indeed having difficulty in applying the *HCK* test.[102]

The second prominent ambiguity relates to the classification of a doctor's actions in the three aspects of medical care (diagnosis, treatment and advice). In *HCK*, the Court of Appeal stated that the three aspects of medical care are not monolithic and cannot always be demarcated clearly.[103] The court then noted that the different aspects of medical care will often be in play concurrently.[104] These aspects "emerge and submerge repeatedly" at different points in the doctor-patient relationship.[105] The court acknowledged therefore that the application of differing standards of assessment is not a straightforward task.[106]

While the effect of this makes it difficult for a doctor to determine which standard of care will apply to any given situation, it is submitted that the uncertainty created by this ambiguity will have negligible practical effect on medical advice. This is because defensive practices would result in doctors choosing to apply the more demanding standard of care to the situation and this would indeed be the *HCK* test, a favourable consequence.

IV. CONCLUSION

In conclusion, patient-centricity has come a long way from the days of *Sidaway*. In some respects, the *HCK* test has gone further than the *Montgomery* test in favour of patients but in other aspects it has been more conservative.

The test has many complexities and nuances that strike a delicate balance between the *Montgomery* test and the *Bolam-Bolitho* test. The *HCK* test as a whole highlights a shift in emphasis

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[101] See note 68-72 above and its accompanying text.

[102] *Singapore Parliamentary Debates, Official Report* (11 February 2019) vol 94 "Informed Consent for Medical Procedures Following Recent Case where Orthopaedic Doctor was Fined" (Dr Lam Pin Min, Minister of State for Health) – which states: "There has been feedback on the considerable confusion amongst medical practitioners on the requirements on informed consent and material information, and how the modified Montgomery Test and the ECEG should apply. … I am clearly aware of the concerns of many medical professionals on the Modified Montgomery Test. I have personally received feedback from fellow medical practitioners especially on the requirement on informed consent and material information, and how this new test should be applied. There is also feedback from the medical community that this may lead to defensive medicine and escalation of healthcare cost."

[103] *Supra* note 7 at [90].

[104] *Ibid.*

[105] *Ibid* at [91].

[106] *Ibid* at [92].

towards patient autonomy. The three-stage inquiry separates the various components of the test to ensure that analysis is done in a systematic way. The scope of information that needs to be disclosed appears to be expanded in *HCK*. However, this is balanced against an additional test of relevancy, a test which needs further clarification. Defensive medicine is also mitigated to some extent by the requirement that a doctor does not indiscriminately bombard the patient with information like an information dump.[107] These adaptations by the Court of Appeal were arguably necessary to adapt to Singapore's context.[108]

Nonetheless, what is clear is that the *HCK* test seeks to strike a unique balance in Singapore between patient autonomy and beneficence. The *HCK* test, in light of its various features and aspects, has thus set a new standard of care required of Singapore doctors in advice scenarios that has sought to place an appropriate emphasis on both the patient and the doctor.

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[107] *Ibid* at [143].

[108] *Supra* note 57.