Singapore Law Review
*Juris Illuminae* Vol 7 (2015/16)

# THE DISCLOSURE OF MEDICAL RISKS IN SINGAPORE AND THE CASE OF *MONTGOMERY*

KEITH JIEREN THIRUMARAN

## INTRODUCTION

There are three main areas that doctors engage in when practicing medicine: diagnosis, treatment and advice. In order for doctors to avoid negligence liability, they must meet the applicable standard of care expected of them. However, in the context of advice with respect to disclosure of risks, the test for determining whether a doctor is in breach of the applicable standard of care has attracted a considerable amount of attention. Singapore has retained the traditional doctor-centric test, but several overseas jurisdictions have since developed more patient-focused approaches – notably, the recent UK Supreme Court decision of *Montgomery v Lanarkshire Health Board* [*Montgomery*].[1] This article will examine the various tests used by courts both locally and overseas, after which it will be submitted that the *status quo* in Singapore should be maintained in light of compelling local circumstances.

## TESTS USED LOCALLY AND OVERSEAS

### *The Singapore position pre*-Montgomery

The current position in Singapore is embodied in the Court of Appeal case of *Dr Khoo James & Anor v Gunapathy d/o Muniandy* [*Gunapathy*][2] where the Court applied the *Bolam-Bolitho* test to the disclosure of risks in the medical context.

---

[1] *Montgomery v Lanarkshire Health Board,* [2015] UKSC 11.

[2] *Dr Khoo James & Anor v Gunapathy d/o Muniandy,* [2002] 2 SLR 414.

The *Bolam-Bolitho* test is the *locus classicus* for the standard of care required of doctors and comprises of two separate tests. The plaintiff must show that a doctor defendant has failed either of these tests in order to establish a breach of the standard of care.

The *Bolam* test, formulated in *Bolam v Friern Hospital Management Committee,*[3] requires a doctor to have acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. This means that a doctor will not be found negligent as long as part of the medical profession agrees with what the doctor did, even if there is a body of opinion that takes the contrary view,[4] and even if the court prefers one of the views over the other[5].

The *Bolitho* test, formulated in *Bolitho v City & Hackney Health Authority*,[6] is a threshold test of logic and consistency when accepting the opinion of medical peers. This comprises two stages: the expert must have directed his mind to the comparative risks and benefits of the matter; and the opinion must be a defensible conclusion, meaning that it must be internally consistent and should not ignore known medical facts.[7]

The main reasons the Court of Appeal in *Gunapathy* cited for applying the *Bolam-Bolitho* test was that judicial wisdom has its limits. A judge unskilled in medicine has no business adjudicating matters which medical experts themselves cannot agree on.[8] Furthermore, excessive judicial interference would hamper the proper development of medical science, give rise to defensive medicine, and lead to higher medical costs and wastage of medical resources.[9]

---

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

[4] *Ibid.*

[5] *Maynard v West Midlands Regional Health Authority*, [1985] 1 All ER 635.

[6] *Bolitho v City & Hackney Health Authority*, [1998] AC 232 at 241-242.

[7] *Supra* note 2 at [64] – [65].

[8] *Supra* note 2 at [144].

[9] *Ibid.*

*The development of the "prudent patient" approach*

In the UK case of *Sidaway v Bethlem Royal Hospital Governors* [*Sidaway*],[10] Lord Scarman in his dissent suggested moving from the *Bolam-Bolitho* approach toward a "prudent patient" test similar to that found in the American case of *Canterbury v Spence*.[11] In the Australian case of *Rogers v Whitaker* [*Rogers*],[12] the High Court favoured Lord Scarman's dissent [13] and decided the case on the basis of what risks a "prudent patient" would wish to know, save for the exception of therapeutic privilege cases. The Canadian Supreme Court case of *Reibl v Hughes*[14] and the Malaysian Federal Court case of *Foo Fio Na v Dr Soo Fook Mun & Anor* [15] have also taken similar approaches to the disclosure of risks in the medical context.

In the UK itself, the majority decision in *Sidaway* is no longer good law. The case has since been effectively overruled by the recent Supreme Court decision of *Montgomery*.[16] The *Montgomery* approach[17] is that a doctor must disclose risks that a reasonable person in the patient's position would attach significance to, as well as risks that the doctor should reasonably be aware that the actual patient would attach significance to. The patient need not question the doctor,[18] though the doctor must engage in a proper dialogue with the patient to ensure that the latter is aware of and understands the risks.[19]

There are three exceptions to the above test where a doctor does not have to disclose the relevant risks.[20] The first is when the patient does not wish to know any further information. [21] The second is the therapeutic privilege exception which allows a doctor to withhold information

---

[10] *Sidaway v Bethlem Royal Hospital Governors,* [1985] AC 871.
[11] *Canterbury v Spence*, (1972) 464 F 2d 772.
[12] *Rogers v Whitaker,* (1992) 175 CLR 479.
[13] *Ibid* at [10].
[14] *Reibl v Hughes,* (1980) 114 DLR (3d).
[15] *Foo Fio Na v Dr Soo Fook Mun & Anor,* [2007] 1 MLJ 593.
[16] *Supra* note 1.
[17] *Supra* note 1 at [87].
[18] *Supra* note 1at [58].
[19] *Supra* note 1 at [90].
[20] *Supra* note 1 at [85] and [88].
[21] *Supra* note 1 at [85].

from the patient if the doctor reasonably considers that its disclosure would be seriously detrimental to the patient's health.[22] The third is in circumstances of necessity such as when treatment is required urgently but the patient is unconscious or otherwise unable to make a decision.[23]

Whether the risk is considered material enough to be disclosed depends on various factors such as magnitude of risk, nature of risk, effect of its occurrence upon the life of the patient, importance to patient of the benefits from treatment, alternative treatments and risks of those alternative treatments ("*Montgomery* Factors").[24]

*Singapore's stance on the "prudent patient approach"*

Although the Singapore High Court acknowledged *Montgomery* in the cases of *Thong Jiang Andrew v Yue Wai Mun & Anor*[25] and *Hii Chii Kok v Ooi Peng Jin London Lucien and another*,[26] it left the question of which test should apply open (*Bolam-Bolitho* or *Montgomery*). Nonetheless, on the existing facts, it seems that the Singapore Courts favour the *Bolam-Bolitho* test.

Firstly, the Court of Appeal in *Gunapathy*, in the context of advice and disclosure of risks, did not find favour with Lord Scarman's dissent in *Sidaway*, the foundations for the prudent patient approach as discussed above. Instead, the Court in *Gunapathy* preferred to follow the majority in *Sidaway* in applying the *Bolam-Bolitho* test to the context of advice and disclosure of risks.[27]

Secondly, the Court in *Gunapathy* also noted that Lord Bridge's qualification in *Sidaway* (that if there was a substantial risk and no cogent clinical reason for non-disclosure, a Judge can conclude that no respectable medical expert would have failed to disclose that risk) was already subsumed under the *Bolitho* test and was therefore unnecessary.[28]

---

[22] *Supra* note 1 at [88].
[23] *Supra* note 1 at [88].
[24] *Supra* note 1 at [89].
[25] *Thong Jiang Andrew v Yue Wai Mun & Anor*, [2015] SGHC 119 at [36] – [37].
[26] *Hii Chii Kok v Ooi Peng Jin London Lucien and another*, [2016] SGHC 21.
[27] *Supra* note 2 at [142].
[28] *Supra* note 2 at [141].

Thirdly, Chief Justice Sundaresh Menon, in his address at the Opening of the Legal Year 2016, has also emphasised the importance of preventing doctors from practicing defensive medicine.[29] The Learned Chief Justice also promoted the use of alternative dispute resolution such as mediation, as opposed to litigation, for resolving medical disputes.[30] This is further evidence of the importance of reducing medical litigation in Singapore, which is more in line with the *Bolam-Bolitho* test. The *Montgomery* test, on the other hand, may subject doctors to greater legal liability.

## COMMENTARY ON THE FUTURE POSITION IN SINGAPORE

Since the position in the UK (which Singapore was following) has been changed by the case of *Montgomery*, the Singapore Court of Appeal will have to consider this and other international developments to determine which test should apply in Singapore. While some may be quick to cast their vote for a change to *Montgomery*, this author believes that Singapore should stick to its current position and uphold the *Bolam-Bolitho* test.

### *Underlying policy considerations in support of the* Bolam-Bolitho *test*

Policy reasons form the basis for sticking to the *Bolam-Bolitho* test, in particular, hampering the proper development of medical science, giving rise to defensive medicine, higher medical costs and wastage of medical resources.[31] As Chief Justice Menon pointed out in his address, a fear of litigation would distort medical practice and raise insurance costs.[32] These are fundamental policy considerations that underpin the *Bolam-Bolitho* test and they are still as strong today.

---

[29] Chief Justice Sundaresh Menon: Response at the Opening of the Legal Year 2016 (11 January 2016), online: <http://www.supremecourt.gov.sg/Data/Editor/Documents/Response%20by%20CJ%20-%20Opening%20of%20the%20Legal%20Year%202016%20on%2011%20January%202016%20(Checked%20against%20Delivery%20110116).pdf> at [43].

[30] *Ibid.*

[31] *Supra* note 2 at [144].

[32] *Ibid.*

At first glance, it would appear that the learned Chief Justice's concerns were already considered by the Supreme Court in *Montgomery.* The Supreme Court in that case disagreed that there was a possibility of increased litigation and defensive medicine from its approach. Furthermore, the Court opined that its approach would result in patients being aware that the outcome of treatment is uncertain, and that its approach allows patients to take responsibility for the ultimate choice of undergoing that treatment.[33] This, in the Court's opinion, would therefore lower the likelihood of litigation in the event of an adverse outcome.[34]

However, this author respectfully disagrees with the views expressed in *Montgomery*. While it may be thought that less litigation would directly translate into less defensive practices, this is not necessarily true. The very fact that doctors under the *Montgomery* approach have to disclose more risks is itself a defensive practice which would lead to higher costs. Doctors would never be sure where to draw the line, and would "play safe" by disclosing many, if not all, the risks associated with the treatment.

In *Montgomery*, the Court failed to take into account the increased medical costs involved with their approach.[35] The defensive medical practice of disclosing more risks of treatment (in order to avoid liability for failing to disclose a risk) would lead to "higher medical costs and wastage of precious medical resources".[36] More time will be needed to disclose and explain risks, which could have been spent treating another person or saving a life (which the Court in *Montgomery* did not discuss). Time wastage may be exacerbated where a patient who has been notified of many new risks is inclined to further question the doctor for explanations, elaborations, and evaluations on them, regardless of the significance of the risk. The *Montgomery* approach may raise medical costs, going against the aims that the learned Chief Justice and the Court in *Gunapathy* had sought to achieve.

---

[33] *Supra* note 1 at [93].

[34] *Ibid.*

[35] It is suggested that the UK's National Health Service may have been a contributing factor that would have downplayed the concern of patients' medical costs for the Court in *Montgomery*.

[36] *Supra* note 2 at [144].

Furthermore, even with the therapeutic privilege exception, disclosing every conceivable risk to a patient that is not "at-risk" can still cause unbalanced decisions and frighten the patient.[37] A patient may opt for a more expensive treatment or refuse otherwise viable treatment when frightened by an insignificant risk. It is therefore submitted that in order to avoid higher medical costs and wastage of resources, the decision of which risks are significant enough to the patient and need to be disclosed should best be left to the judgment of the medical profession.

Lastly, the Court in *Montgomery* felt that imposing legal obligations was necessary to force doctors to engage in a discussion with their patients. However, as Baroness Hale said in *Gregg v Scott*,[38] doctors are motivated by their natural desire and professional duty to do their best for their patients. It is this author's opinion that a doctor would therefore engage in the discussion with their patients, even without legal obligations, as long as the doctor feels that it would be in the patient's interest to know of a particular risk.

### Montgomery*'s human rights focus is inapplicable to Singapore*

The decisions in the UK, such as *Montgomery*, may not be applicable in Singapore. This is because, as stated by the Singapore High Court, the UK decisions may have been influenced by the UK's emphasis on human rights and autonomy.[39] This emphasis on human rights and autonomy in the UK may be attributed to the *European Convention of Human Rights* [*ECHR*],[40] enforced under the *Human Rights Act* [*HRA*].[41]

---

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

[38] *Gregg v Scott* [2005] UKHL 2 at [217].

[39] *D'Conceicao Jeanie Doris (administratrix of the estate of Milakov Steven, deceased) v Tong Ming Chuan* [*D'Conceicao*], [2011] SGHC 193 at [123]; *Tong Seok May Joanne v Yau Hok Man Gordon* [2012] SGHC 252 at [64] and [172].

[40] *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953)

[41] *Human Rights Act 1998* (UK), c 42.

However, neither the *ECHR* nor the *HRA* is binding on Singapore Courts.[42] Therefore, in the absence of any rights-based legislation, the Singapore Courts may not be inclined to adopt an approach, such as *Montgomery*, which is based on a strong emphasis of Human Rights.[43]

### Bolam-Bolitho *and* Montgomery *tests likely to reach the same conclusion*

The *Bolam-Bolitho* test would, in this author's opinion, already encompass the bulk of the *Montgomery* approach. It is submitted that the large majority of risks disclosed under the *Montgomery* approach would already be disclosed under the *Bolam-Bolitho* test, ultimately giving rise to same legal conclusions.

Firstly, if a doctor is aware that his patient would attach significance to a particular risk, then in the absence of cogent medical reasons such as the therapeutic privilege exception, there appears to be no reason why that doctor would not disclose that risk to the patient. Therefore, it appears that any reasonable doctor would disclose risks that he is aware his patient finds significant, thereby satisfying the *Bolam* test, while also satisfying the *Montgomery* test.

Secondly, even in the absence of any cognisance of specific significance to his patient, a doctor would disclose risks that the doctor believes should be disclosed. A doctor is likely to take into account the various *Montgomery* Factors listed above (save for "importance to patient of the benefits from treatment") when making an assessment of what to disclose to a patient. Therefore, save for the internal thoughts of a patient, a reasonably doctor who satisfies the *Bolam* test by considering the *Montgomery* Factors would satisfy the *Montgomery* test and disclose all material risks.

Furthermore, in Singapore the minimum that the *Bolam* test requires a reasonable doctor to do would be to adhere to the Singapore Medical Council's Ethical Code and Ethical Guidelines [Ethical Code].[44] The Ethical Code requires doctors to keep a patient "adequately informed" of

---

[42] *Supra* note 38.

[43] *Ibid.*

[44] Singapore Medical Council, *Ethical Code and Ethical Guidelines*, online: <http://www.healthprofessionals.gov.sg/content/dam/hprof/smc/docs/guidelines/SMC%20Ethical%20Code%20and%20Ethical%20Guidelines.pdf>.

his treatment options so that "he is able to participate in decisions about his treatment".[45] The Ethical Code also requires doctors to "provide adequate information" so that a patient can make "informed choices".[46] As the wording is notably broad, it is highly probable that a doctor which satisfies the provision of "adequate information" under the *Bolam* test is likely to have disclosed all material risks and thereby satisfy the *Montgomery* test.

Thirdly, there is no risk of the medical profession exploiting the *Bolam-Bolitho* test. This is because if the responsible body of medical men would not have disclosed the risk, and if this is not founded on a logical basis, the *Bolitho* test would then step in.[47] The *Bolitho* test is not an invasive inquiry into the merits of the medical opinion before the Court.[48] However, if the medical profession illogically omits to warn of certain risks which patients should undoubtedly be informed of, the Court should interfere on the authority of *Bolitho*.[49] This is especially so when the disclosure of that particular risk was so obviously necessary in order for the patient to make an informed choice.[50] An example provided by the Court was if the risk is substantial, of grave consequences and there is no cogent clinical reason for omitting to disclose the risk.[51] Therefore the *Bolitho* test will help to catch risks that should be disclosed under *Montgomery* but where the medical profession as a whole would not have done so.

### *The* Montgomery *test is impractical*

Even with the practical similarities highlighted above, it is acknowledged there are a handful of risks that a prudent patient would want disclosed that a reasonable body of medical men would not have disclosed. This handful of risks would be caught by the *Montgomery* approach but would not have been caught under the *Bolam-Bolitho* test. The existence of these risks stem from

---

[45] *Ibid* at 4.2.2.
[46] *Ibid* at 4.2.4.
[47] *Supra* note 2 at [141].
[48] *D'Conceicao* at [40].
[49] *Ibid* at [124].
[50] *Supra* note 10 at 900.
[51] *Ibid*.

the main difference between the *Bolam-Bolitho* test and the *Montgomery* approach: the perspective from which the test is applied.

It is submitted that the *Montgomery* test provides a very artificial guideline to follow and it would not be realistic to expect a doctor to adhere to such a test. While it is acknowledged that a doctor can attempt to think from the perspective of a reasonable patient, and thereby theoretically be able to cover some of the material risks from a patient's perspective, the reality is that a doctor cannot tell with any precision or certainty what a reasonable patient would wish to know. Therefore, in their bid to escape liability under the *Montgomery* test, a doctor would practice defensive medicine by simply disclosing every conceivable risk. This is undesirable as it would lead to the aforementioned higher medical costs and wastage of medical resources.

Therefore, applying the *Montgomery* approach only gives the appearance of human rights and autonomy. Instead, the *Montgomery* approach would lead to more prevalent defensive practices as well as unnecessarily cause a greater number of doctors to be found negligent merely due to the unrealistic expectation of predicting what a prudent patient would want to know.

## CONCLUSION

In conclusion, the Singapore Courts should not feel pressured to accept the approaches adopted in other jurisdictions but should choose the approach that is most desirable to the Singapore context and society. It may well be that maintaining the *status quo* could be the better approach for Singapore.