A FINAL MANY WORDS ON THE LLA CASE

Text by The Hobbit

This article was first published at http://bit.ly/2lH1KTV on 21 August 2019.

And so, it has come to pass, on appeal from the Singapore Medical Council (SMC) against its own Disciplinary Tribunal (DT), our wise Judges have ruled that Dr Lim Lian Arn (LLA) is not guilty of professional misconduct.[1] Everybody has to pay their own costs, including Dr Lim and SMC's lawyers. Other than the lawyers and the DT, everyone lived happily ever after. And so the story comes to a happy ending.

Not quite.

Learning points from the C3J Judgement of the LLA case

First, a few learning points can be gleaned from the Judgement that was issued on 24 July 2019 by the Court of Three Judges (C3J):

One key point was that the SMC's position to call for a five-month suspension of Dr LLA was "wholly unwarranted" and that the "DT also fell into error by too readily accepting Dr LLA's submission (made in response to the five-month suspension) that the maximum fine of $100,000 would be appropriate" (para. 63). This Hobbit couldn't agree more. To me, it means that how a sentence is called for by the SMC must be dependent on the specific facts of the case, and that the several calls (at least in four previous cases), before the LLA case by the C3J, for harsher sentences and sentence re-calibration against doctors must be taken in their specific contexts on these occasions and not to be interpreted as "general instruction" for all cases. This is helpful.

Personally speaking, the most helpful information in the Judgement is it makes out clearly how professional misconduct is to be proven (summarised for brevity and not necessarily for high fidelity):

- Establish what the applicable standard is;
- Establish whether there is departure from this standard; and
- Prove whether this departure is serious enough to constitute professional misconduct. With respect to negligence, it must be "serious negligence" and departure from standards must be "serious disregard" or "persistent failure" to meet the standards set out under the SMC Ethical Code and Ethical Guidelines (ECEG).

The Judges took effort to state that the lawyer for LLA "was mistaken" when he regarded that a breach of a "basic principle" in the ECEG amounted to professional misconduct. They also stated that "there must be a threshold that separates relatively minor breaches and failures from the more serious ones that demand disciplinary action. Were it otherwise, doctors would find it impossible to practise in a reasonable way" (para. 30). *Hurray*.

The extent and coverage of expert evidence was also elaborated on. The Judgement stated that it was not enough for an expert to merely state what he/she thinks how things should be done. The expert must also present "the underlying evidence and the analytical process by which the conclusion is reached" (para. 43) for the expert opinion to hold sway.

On the subject of informed consent, the Judgement reiterated essentially the basic requirements of the Modified Montgomery (MM) test:

- Establish what relevant and material information to the patient is.

Materiality of a risk or complication is generally determined by its severity and likelihood and "largely a matter of common sense" (para. 50).

- Establish that the doctor possesses this information.
- Establish whether the doctor can justifiably withhold this information from the patient.

On the subject of defensive medicine, the Judgement defined or described it as "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". The Judges said that it is a mistake to classify "information dumping" (ie, doctors overwhelming patients with a deluge of information in order to protect themselves legally) as defensive medicine because "giving too much information will not avoid legal liability" (para. 54).

Informed consent

As this Hobbit has said before, in our local context, "**just follow law**". Whatever the Judges have said is case law and therefore has to be adhered to. But perhaps in my senescence and folly, please allow this old coot to blabber a few irrelevant and immaterial things about three points – informed consent, defensive medicine and information dump.

MM test

The MM test is largely a matter of common sense. As my professor (now emeritus professor) once said to me when I was a medical student, "common sense is uncommon". Were it not so, it would not have been necessary to introduce the Bolitho Addendum to the Bolam test. The Bolitho Addendum is essentially an addendum to require common sense when applying the Bolam test. The MM test essentially requires even more common sense than the Bolam-Bolitho (BB) test because it demands the doctor to establish what is material and relevant to the patient.

Don't get me wrong, I think being patient-centric is good. How to achieve this is already cast in legal stone (case law – MM test), even though I am still trying to grapple with implementing this in my clinical practice. To this Hobbit, essentially, the MM test ignores a basic dimension of existence: time.

For one, a three-step test doesn't quite work for me when I see 40 patients a day and I prescribe hundreds of medications and investigations. Secondly, what is relevant and material to the patient changes with time – his/her circumstances changes and his/her memory fades. For the same procedure, what is of concern to him/her one month before the procedure can often be quite different from when it is one week or a day before the procedure. And all this could be quite different one month post-operation, when his/her concerns are quite different from pre-operation. As one doctor wisely said, "Often the only relevant risk or complication is the one the patient develops post-operation".

Also, there are scientific studies to prove that a patient's retention of information or advice given to him/her by the doctor is really quite limited and diminishes with time. You may have told patients to your best effort what you think is relevant and material, but they may have forgotten or ignored what you said and then turn around to sue you.

Another smaller issue about the MM test is the severity and likelihood matrix. As advocated, you should tell the patient the risk if it is more serious, even if it is unlikely. The most serious risk is, of course, death. Another doctor also said "once you mention 'death', the patient's mind goes blank thereafter". But the patient still signs the consent form and undergoes the procedure usually. And then he/she may also turn around and sue you later.

There is little doubt that the MM test brings increased uncertainty to the practice environment and doctors generally don't like it. However, that doesn't mean doctors are against being more patient-centric. It is an argument of **false dichotomy** to say that just because many doctors are uncomfortable with the MM test, it suggests that the medical profession is not supportive of being patient-centric.

Defensive medicine

We now come to the difficult subject of defensive medicine.

Let us return to the Judgement delivered on 12 May 2017 by the Chief Justice and four Judges of Appeal in the Hii Chii Kok vs London Lucien Ooi case (a civil suit and **not** an SMC case). This was when the MM test was introduced as case law. Here are excerpts from paras. 84, 85 and 87 under "The argument for full retention [of Bolam and Bolitho]". The portions I wish to emphasise are in italics.

> **84** What of the view that the Bolam test and Bolitho addendum should not be interfered with to any degree, even as regards advice? *The strongest argument in favour of that view is the contention that if the Bolam test and Bolitho addendum were abandoned in favour of a standard that placed greater emphasis on the interests and perspective of the patient, it would spark an unacceptable increase in medical litigation. This would, it is said, have two deleterious effects: first, it would drive up the cost of medical malpractice insurance, and thus increase the costs of healthcare to the public, and second, it would increase the pressure on doctors to adopt what is commonly referred to as "defensive medicine".* …
>
> **85** It cannot be denied that the cost of healthcare and the practice of defensive medicine (which also feeds into the cost of healthcare to some extent) are both real concerns. However, we do not accept that they provide sufficient reason for the court to shut the door to reform entirely. In the first place, *it has not been distinctly established that any departure from the Bolam test would in fact have the consequences of more medical litigation, higher insurance premiums and greater healthcare costs.* …Furthermore, we note that certain factors which have driven up the cost of medical professional insurance in the US – the jurisdiction in which

such concerns have been perhaps the most prominent – are not present in Singapore. *The US legal system features jury awards which often would, in Singapore, be considered highly inflated; allows contingency fee arrangements (encouraging opportunistic negligence suits); and does not follow a "loser pays" principle of costs (thus reducing the disincentive for litigants or law firms to bring weak or speculative claims). In the absence of such factors in Singapore, we see no reason to believe, without clear evidence, that a carefully calibrated shift in the standard of care is likely to lead to a drastic increase in the frequency and value of medical negligence lawsuits in Singapore.*

87 The problem of defensive medicine falls more squarely within the ambit of the court's inquiry, since it directly implicates the question of whether the proposed standard will fortify or hinder the medical profession's fulfilment of its duties to its patients. In that regard, we note that unlike a wholesale rejection of the Bolam test and Bolitho addendum, which the court in Gunapathy rightly warned against (at [144]), reform of *the more limited nature being considered appears unlikely to contribute significantly to the practice of defensive medicine. The implications of Montgomery are limited to advice, whereas the concerns in defensive medicine pertain mainly to diagnosis and treatment…We therefore do not think the spectre of defensive medicine is a strong reason to shy away from reform in the area of advice specifically.*

Paras. 84 to 87 in the 12 May 2017 Judgement on the Hii Chii Kok case was given as consideration on why a departure from Bolam and Bolitho can be seriously countenanced; the promulgation of the MM test then took place later in this Judgement. To summarise:

- The fear of a rise in malpractice costs and increase in practice of defensive medicine are important considerations as to whether one should depart from the BB test.
- But these fears (as at 2017) were unproven and theoretical at best (ie, not "distinctly established").
- Even if we depart from the BB test, Singapore does not have the pre-existing conditions (like in the US legal system) for a drastic increase in frequency and value of medical legal lawsuits, which in turn will lead to defensive medicine taking root quickly – contingency fees (ie, loser pays) and high jury awards.
- Defensive medicine doesn't quite extend to the realm of medical advice (of which informed consent is a part of) and is limited to diagnosis and treatment.

Departure from BB test

In a study commissioned by the College of Family Physicians Singapore and SMA to examine the effect of the SMC Judgement in the LLA case on doctors' behaviour[2] earlier this year, it has been proven that these fears are clear and present, and very real.

- The number of doctors surveyed who provided an H&L injection decreased by 14.6%.
- The median price for the injection increased from the $0 to $100 band to >$100 to $200 band.
- The number of surveyed doctors who charged more than $1,000 went up eight-fold from eight to 65.

This study therefore documents a quantitative increase in the practice of defensive medicine and healthcare costs when the BB test was departed from. It can be argued that the LLA outcome came about from a botched implementation of the MM test, but it is a departure from the BB test nonetheless.

The "free" SMC process can lead to defensive medicine taking root quickly

The next point that Singapore does not have the pre-existing conditions that the US legal system has is interesting. It is true that Singapore doesn't have high jury awards and contingency fees. But these advantages apply only to civil suits. For SMC complaints, the environment may be just as favourable for an increase in medico-legal complaints as the US – it is practically **free** to the complainant (no financial risk) to embark on an SMC complaint! The whole SMC disciplinary process may be no less frightening and painful to the doctor than a civil suit (if not more); hence the flight to defensive medicine in Singapore may be no less quick and intense as in the US. So this assumption that Singapore's legal system has a more agreeable climate to doctors is correct when applied mainly to civil suits. The doctor does not only flee towards defensive medicine out of fear of being sued in a civil case and paying hefty damages, but also out of fear of getting involved in the SMC complaints and disciplinary process, which is free to the complainant.

Defensive medicine is not static – it goes where the attack is targeted

Lastly, the point on defensive medicine being limited to diagnosis and treatment and not extending to medical advice needs some discussion. Let's break down the words "defensive" and "medicine" for a start.

The practice of medicine is dynamic and ever-evolving. That is why we need to gain 50 continuing medical education points every two years, to keep us up to date with the changes in the practice of medicine. The practice of defensive medicine is no different; it is also evolving with the times. It is not static. Just because the practice of defensive medicine has been limited to diagnosis and treatment does not mean that it will always remain so.

The word "defensive" has military roots, as in "defence" and "attack". Any Singapore Armed Forces serviceman will tell you that defence is not static either. You prepare a robust, in-depth defence where you think the attack will most likely target. High-profile cases involving senior doctors accused of not getting informed consent send a strong signal that patients (and lawyers) are focusing their efforts in this area. These well-known cases include Dr Eu Kong Weng, Dr Ang Peng Tiam, Dr Leslie Lam and this LLA case. It doesn't matter if the

complainants were successful or not; just the pain and trauma of responding to a complaint is sufficient motivation for doctors to focus their defensive efforts to prevent more complaints in this area.

Defensive medicine is divided into avoidance and assurance defensive medicine. Ordering more and unnecessary tests and investigations is a classic example of assurance defensive medicine because a doctor is afraid that he/she will be complained against or sued for a missed diagnosis. Similarly, an information dump carried out because a doctor is afraid he/she will be complained against or sued in the area of medical advice, is in the opinion of this Hobbit, a new form of assurance defensive medicine. The medical profession should not rigidly limit ourselves to what was previously described – that defensive medicine only exists in diagnosis and treatment. Defensive medicine will occur where the doctors think they will be attacked, be it in the areas of diagnosis, medical advice or treatment.

Information dumping

That brings us to the statement that information dumping is not defensive medicine because "giving too much information will not avoid legal liability" by our learned Judges. The judges are of course absolutely correct since from where they sit, what is inefficacious in avoiding legal liability in the courtroom or a disciplinary trial should not be considered as defensive medicine.

But as practising doctors, I suppose, we have to look at things more upstream. As the age-old saying goes, "prevention is better than cure". What is inefficacious in a disciplinary trial or the courtroom is an inefficacious or useless cure. But it may still work as a **preventive measure**. This is because it is human nature to take comfort in numbers or quantity. There are so many examples of this. We usually feel better when we write a longer answer to an examination question when compared to a shorter one (the test scores, of course, may have no correlation to the length of answer). We take psychological refuge in buying a thicker textbook than a thin one (whether we actually finish reading the textbook or understand what's written inside is another matter altogether).

It is for the same reason that our consent forms are getting longer and longer. A longer consent form looks formidable and gives us psychological security. Remember the days when we could combine both the surgical and anaesthesia consent-taking into one page? Those days are gone. And if they still do exist, many would wonder – will such a short form suffice?

Due to information asymmetry, the buyer of a service also derives satisfaction and gauge quality by substitute measures of quantity (even though there is little correlation between quality and quantity). An inpatient given a lengthy discharge summary which is no more than a "cut-and-paste" job may think the medical officer has been diligent, while a medical officer who has assiduously prepared a concise one-page discharge summary may be less appreciated. For about the same amount of money, a patient given five different drugs for common cough and cold often thinks he has been given quality treatment and may consequentially conclude that the other doctor who gave him only two drugs earlier was tardy.

So, both doctors and patients derive comfort and satisfaction from quantity. This is just simple human nature. If that is so, we will also believe that with more information engendering more comfort and satisfaction, complaints are therefore less likely to occur. It is therefore no surprise that information dumping will be adopted in an attempt to prevent complaints from occurring, even though it is inefficacious in avoiding legal liability.

This psychological comfort derived from quantity is accentuated when there is greater uncertainty, as is the case with the MM test when compared with the BB test. The greater uncertainty arises because it is extremely difficult for a doctor to **titrate accurately** the exact amount and nature of information that is material and relevant to a particular patient in a particular context under the MM test. This Hobbit thinks most doctors believe it is more likely that a patient is dissatisfied with less information than more. As such, most doctors will intuitively also believe that it is probably easier to prove that a lack of informed consent arose from insufficient information rather than excessive information.

It should therefore come as no surprise that a doctor will give more information than what is actually needed.

Conclusion

After this long spiel of about 3,300 words, what are the take-home messages? It's still more of the same. We are a law-abiding profession in a society that enshrines the rule of law. Whatever is law, be it legislation or case-law, **must be followed**. There is no other way. Whatever this Hobbit rambles or blabbers about, is irrelevant and immaterial.

In the area of medical advice, this Hobbit will still give substantially more information than he previously did in the BB test era. This is my form of Survival Medicine.

The answer to the question of when and how a generous amount of information limps across the line and qualifies as information dump is best left to minds that are far more brilliant and incisive than this Hobbit, who admittedly suffers from a little lack of this precious commodity called common sense. This lack may be a result of the imperfect Hobbit condition that I am born into. ◆

References

1. Singapore Medical Council v Dr Lim Lian Arn [2019] SGHC 172.

2. Wong CY, Surajkumar S, Lee YV, Tan TL. A descriptive study of the effect of a disciplinary proceeding decision on medical practitioners' practice behaviour in the context of providing a hydrocortisone and lignocaine injection. Singapore Med J. 30 Jul 2019. https://doi.org/10.11622/smedj.2019086. [Epub ahead of print].