

SURVIVAL MEDICINE: THE MODIFIED MONTGOMERY TEST

(Part 1)

This is the first instalment of a two-part reprint from the SMA Hobbit's blog. Look out for the continuation of this article in the next issue of SMA News.

Autonomy as the first core ethical principle of prime importance

In the latest and 23rd Gordon Arthur Ransome Oration to the Academy of Medicine, the honourable Chief Justice Sundaresh Menon said: "Most theories of medical ethics recognise four core principles, which are reflected in the 2016 edition of the SMC's Ethical Code and Ethical Guidelines and are described in the SMC's 2016 Handbook on Medical Ethics as 'the foundation of medical ethics'.

The first is patient autonomy. This means respecting the right of the patient to choose, even (with some exceptions) when the choice seems, or is, unwise. As a corollary, this also requires a physician to supply the patient with the knowledge needed for that choice to be meaningfully exercised. The second and third principles are beneficence and non-maleficence. These require a physician

to seek to maximise the good of his patients and to avoid or minimise harm. The fourth principle is justice."

This Hobbit actually looked up the Singapore Medical Council's (SMC) 2016 Handbook on Medical Ethics (HME). Under the section of "Foundation" on pages 9 and 10, the four values are listed in this order: Beneficence, Non-maleficence, Respect for autonomy and Justice. I think they weren't really listed in any order of importance, but patient autonomy wasn't listed first.

In the 2016 SMC Ethical Code and Ethical Guidelines (ECEG; pages 12 to 14), these headings are listed in this sequence: "Ensure beneficence and non-maleficence", "Respect autonomy" and "Uphold justice".

This Hobbit, with his very limited intellect, is in no position to disagree with the Chief Justice. If autonomy is proclaimed to be the first core principle

of medical ethics, then it must be. But this Hobbit has a confession to make. He did not apply to medical school or want to practise medicine with "patient autonomy" as the first and foremost ethical consideration on his mind.

This Hobbit reckons that most 19-year-olds aspire to become doctors and apply to medical school "to do good" (beneficence). With the benefit of a medical education and clinical practice, we also learn the axiom of "first, do no harm". There is a Latin phrase for this – "Primum Non Nocere". But every drug has side effects; every surgery has risks. So, while most doctors start off with beneficence as the chief motivating force, non-maleficence becomes a doctor's guiding beacon as well, to guard against excesses and imprudent exuberance. There is always a healthy tension between these two ethical forces in most doctors: beneficence and non-maleficence.

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What is the MM test and what must I do to comply with it?

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Let us take a look at the
SMC Physician's Pledge:

"I solemnly pledge to:
dedicate my life to the service
of humanity;
give due respect and gratitude to
my teachers;
practise my profession with conscience
and dignity;
make the health of my patient my first
consideration;
respect the secrets which are confided
in me;
uphold the honour and noble traditions
of the medical profession;
respect my colleagues as my
professional brothers and sisters;
not allow the consideration of race,
religion, nationality or social standing to
intervene between my duty and
my patient;
maintain due respect for human life;
use my medical knowledge in
accordance with the laws of humanity;
comply with the provisions of the
Ethical Code;
and constantly strive to add to my
knowledge and skill.
I make these promises solemnly, freely
and upon my honour."

One can see that this Pledge, which
has been in force since 1995, is terribly
doctor-centric. It touches more on
beneficence and justice than autonomy.

To sum up, even though autonomy
is one of the four core ethical principles
of beneficence, non-maleficence,
autonomy and social justice, autonomy
is seldom, if ever, the starting point for
why a person wanted to do medicine.
It is also seldom the first consideration
in a doctor-patient encounter among
ethical doctors. It is there because it is
important, but it certainly isn't there as
a first-among-equals (ie, *primus inter*

pares) principle among doctors. But
now that it is, then I must change and
obey accordingly. If I do not change,
my very professional existence may be
threatened.

The modified Montgomery test: balance between autonomy and beneficence

This is because we have to comply with
the modified Montgomery (MM) test that
the honourable five judges have come up
with recently. For the avoidance of doubt,
in our Common Law system, judges can
make case law through judgements
and such case law is binding unless it
manifestly flies in the face of laws and
statutes passed in Parliament, or if new
case law is created by judges at least as
senior as or more senior than the judges
that created the old case law. Since the
MM test was created by five High Court
Judges that included the Chief Justice
himself, it will not be anytime soon that
the MM test will be replaced by some
new case law. Parliament can pass a law
that renders the MM test illegal, but that
is an even more remote possibility. So,
the MM test is here to stay for a long,
long time.

Many doctors this Hobbit has spoken
to are vexed and asking if the MM test
is the correct thing to do and whether it
is good for patients and for the practice
of medicine in Singapore. *These are the
wrong questions to ask.* The MM test is
now part of case law. Case law is still law.
Doctors in Singapore will have to comply
with the MM test, whether we like it or
not. Some of my friends have also asked
me if I agree with or like the MM test
personally. *That is also the wrong question
to ask.* The law does not require or even
ask for my intellectual agreement or
emotional affinity; it only demands my
full compliance. And therefore, I comply.
Or at least try my best to. So, let us get
these unhelpful distractions out of the
way. *The correct question to ask is, "What
is the MM test and what must I do to
comply with it?"*

The Judges have conveniently divided
a typical patient-doctor encounter
into three parts: diagnosis, advice and
treatment. They took pains to explain
that the MM test only applies to the
"advice" part. They have also said that the
traditional Bolam-Bolitho (BB) tests still
apply "with great force" to the "diagnosis"
and "treatment" phases of the encounter.

The rationale for this approach
is that diagnosis and treatment are
"doctor-centric" activities while advice
has to move from being doctor-centric
to a more "patient-centric" position,
especially with patients becoming more
educated and wishing to be involved
in the decision-making process. The
five judges stated that professional
guidelines and societal context of
the UK, where the Montgomery test
originated, have moved to "recognising
patient autonomy as a principle of prime
importance". Singapore has "undergone
the same transformation" as the UK
(para. 118).²

The five judges also stated in para.
120 that "It is therefore incumbent
on us to reconsider the advice aspect
of the relationship through the lens
of patient autonomy *as well as* the
principle of beneficence and ensure
that both principles are upheld. There
must be a balance between *both*
principles (as well as a balance between
the doctor's perspective and the
patient's perspective); neither should
dominate the other".

That may be the noble aspiration
of the judges, to balance autonomy
and beneficence with and through
the MM test. With all due respect to
the honourable judges, they may have
placed too much confidence on the
capabilities of the average doctor in
Singapore. On the ground, the average
doctor will, in all likelihood, not be able
walk such a fine line (tightrope?). Many
will veer towards patient autonomy
and not seek to strike a balance. Most
psychologists will tell you that over-

compensation in the face of a new, uncertain and challenging environment is the usual and therefore expected response of the human race. Doctors are only human.

One cannot argue with the logic for the MM test to be more patient-centric. However, what this really implies to me at the personal level is another matter. The BB test places beneficence and non-maleficence as the first considerations. When I see a patient and take a history, perform a physical examination, and order some tests so as to get a diagnosis, my state of mind is that of beneficence/non-maleficence ("I am trying to do good without doing unnecessary harm/taking unnecessary risk"). After I have secured a diagnosis or several differential diagnoses, as it were, I now have to change gears quite abruptly to a "patient autonomy" state of mind and offer advice to the patient that is relevant to the patient's context and I let him/her decide (as prescribed by the MM test). "Doing good" takes a backseat and switches to "you, the patient, decide". After the patient has decided, I now have to switch back to a "beneficence and non-maleficence" mental state at the treatment phase as the BB test comes back into play again and MM test no longer applies.

Let me tell you, I tried doing this and I felt my thoughts and emotions go through two rounds of mental and emotional contortions in each patient encounter. My medical training in the past didn't quite prepare me for this roller coaster experience and I felt emotionally exhausted, even pained, from the encounter. I blame this on the limited plasticity of my thought processes and a small brain that is unable to cope with the flexibility of thought processes. Or maybe I am just a mediocre doctor. *But again, I stress, what I feel is irrelevant. The important thing is I must comply with the law which includes the MM test, even when I am emotionally exhausted from trying to do so.*

Hence, this Hobbit thinks the average doctor will just let the consideration of autonomy dominate beneficence when it comes to the "advice" aspect of the patient-doctor encounter. This is already a taxing experience. To move to a *higher plane of balancing* beneficence and autonomy (ie, the thinking behind the MM test) will be even more demanding. Perhaps only a great doctor can achieve this. But greatness is rather a rare commodity by any expectations. Having said that, this Hobbit certainly hopes that the judges are correct, and that most doctors can balance the two core principles and comply with the MM test. This Hobbit hopes that over-compensating a little will not amount to professional misconduct. Certainly, from the patient's interests and perspective, a little over- is better than under-compensation.

Relevant information and acting on relevant information

The original Montgomery test referred only to risk-related information so that the patient can make an informed decision of giving informed consent.³ The MM test in Singapore covers more.

Para. 138 of the Judgement² states "will include other types of information that may be needed to enable patients to make an informed decision about their health". The broad types of material information include those identified in the Canadian case of *Dickson v Pinder* [2010] ABQB 269 ("*Dickson v Pinder*") as follows (at [68]):

- (a) the doctor's diagnosis of the patient's condition;
- (b) the prognosis of that condition with and without medical treatment;
- (c) the nature of the proposed medical treatment;
- (d) the risks associated with the proposed medical treatment; and
- (e) the alternatives to the proposed medical treatment, and the

advantages and risks of those alternatives."

Para. 139 further states: "As to what exactly it is about the various types of information that would be considered relevant or material, in our judgment, this is largely a matter of common sense."

As a third-year medical student, a Professor (now Emeritus Professor) of Surgery told me quite succinctly that "common sense is not common". I can only hope that common sense has become commoner since then.

Delegation of the decision-making process

Singaporeans are getting more educated and want more patient rights. But Singapore remains a very heterogeneous society. There remains a large group of patients, especially the older ones, who do not want to decide for themselves. Many patients will tell their doctors, "Talk to my spouse/son/daughter, etc. I let my spouse/son/daughter decide". Their only decision is the decision of delegation of decision-making to a loved one.

Do the same standards of MM test apply here? What if the spouse/son/daughter knows or expects something that is different from the patient? Is it going to be the patient's perspective or the spouse/son/daughter's perspective? Is delegation of the patient's rights to a family member or even friend the same as a "waiver" (para. 150 of Judgement)? This Hobbit doesn't have the answers to these questions. ♦

References

1. Menon S. 23rd Gordon Arthur Ransome Oration: Law and Medicine: Professions of Honour, Service and Excellence. *Ann Acad Med Singapore* 2017; 46(9):356-63.
2. Hii Chii Kok v Ooi Peng Jin London Lucien and another [2017] SGCA 38.
3. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.