MONTGOMERY AND BOLITHO

IS THERE A PRACTICAL DIFFERENCE?

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Part 1 of this series can be found in the September 2017 issue of SMA News *(https://goo.gl/bPXaRz).*

This is the second of two articles about the Montgomery test for medical negligence. In the first article, it was explained that the Montgomery test applies only to the provision of medical advice. The Montgomery test does **not** apply to the doctors' duties to diagnose and treat the patient. In those two areas of medical practice, the Bolam test continues to apply.

Under the Montgomery test, doctors must strive to ensure that they do not unilaterally decide what treatment would be in the patient's best interests, and omit to inform the patient about the full risks and alternatives. Ultimately, doctors must remember that it is the *patient* who decides and bears responsibility for the choice of treatment. Therefore, doctors must give their patients enough information to allow their patients to properly bear that responsibility. Is there any practical difference between the Montgomery and Bolam tests? That is the question this article seeks to answer.

Practical concerns

One large concern with the Montgomery test is that its adoption would result in "defensive medicine", where doctors provide excessive amounts of information to patients in order to avoid charges of professional negligence.[1]

The adoption of the Montgomery test has already stoked fears that doctors may have to "read his patient's mind" to predict concerns that were not divulged by the patient at the clinic.[2] Such fears are unfounded.

The application of the Montgomery test is largely common sense.[3] The ultimate question is whether a doctor has failed to take **reasonable care** in his relationship with his patient. If, as a matter of common sense, a doctor has given his patient such relevant and material information which the doctor ought to have known his patient would reasonably have wanted, the doctor is unlikely to have been negligent on the Montgomery test.

At the same time, such a doctor is also unlikely to have been negligent under the Bolam test, since it is likely that a responsible body of doctors, using their common sense, would have done the same thing. Indeed, in *Hii Chii Kok*, the Court of Appeal reached the conclusion that the doctor in question had **not** been negligent, whether the Bolam test or the Montgomery test was applied.

Practical differences

In some cases, however, the Bolam test and Montgomery test could lead to different outcomes. Two examples are given below.

Example 1

In the case of Montgomery itself, the doctor had failed to advise the patient, who was of small stature, diabetic and pregnant with a larger-than-usual baby, of a substantial 9% to 10% risk of shoulder dystocia involved in vaginal birth. While the doctor accepted that the risk was high, she stated that her practice was not to discuss such risks in detail (if at all) because her assessment was that the risk of a grave problem resulting from shoulder dystocia was small, and that if she disclosed such information, her experience was that most women would elect to undergo a caesarean section, but, in her view, it was not in the "maternal interest" for a woman to have a caesarean section. In the event, the risk of shoulder dystocia materialised, and the patient's baby was born with severe disabilities.

The doctor produced several expert witnesses who supported her approach, and as their opinions could not be shown to be illogical, the Bolam test was met and the doctor was held not to have been negligent by the lower courts. The UK Supreme Court, however, applied the Montgomery test and held the doctor to have been negligent in failing to advise the patient of the risk of shoulder dystocia.

Example 2

Say a patient is diagnosed by an oncologist of having early Stage 2 Non-Hodgkin Lymphoma. The oncologist advises the patient to undergo CHOP chemotherapy. In the oncologist's professional opinion, CHOP chemotherapy is well established, has a high success rate in such cases, and he is confident that in the present case, CHOP chemotherapy is likely to achieve a complete remission. The oncologist is aware that radiation therapy is available as an alternative, but since he is less experienced with radiation therapy, which is less widely available in Singapore and might even require the patient to go to Australia for treatment,

the oncologist does not tell the patient of that alternative. The patient agrees to CHOP chemotherapy, which does not work. The cancer spreads.

Assume that the doctor's decision not to mention radiation therapy is supported by many of his colleagues. Under the Bolam test, the doctor would not be negligent. But things would be less clear under the Montgomery test: (a) the existence of the alternative of radiation therapy would be relevant and material to the patient, and (b) the doctor knew of the alternative. So Stages 1 and 2 of the Montgomery test are met. The key issue then becomes whether the doctor can persuade the court that he was justified not to advise the patient on radiation therapy (ie, Stage 3 Montgomery test). In our view, the doctor's lack of experience with radiation therapy and its relative lack of availability in Singapore per se are unlikely to be sufficient justification.[4]

Areas of uncertainty

The shift from the Bolam test to the Montgomery test raises many new issues for medical professionals and doctors to consider. Two of them are highlighted below.

Diagnosis, advice, or treatment

Clinical practice does not rigidly demarcate diagnosis, the provision of advice, and treatment. In practice, and as the Court of Appeal recognised, the three aspects of diagnosis, advice, and treatment can sometimes overlap.

For example, a proper diagnosis might first require invasive procedures or exploratory surgery, the nature and risks of which the patient needs to be informed and advised about in order to understand. Similarly, the administration of a course of drugs (treatment) might form part of an initial diagnosis, the preliminary nature of which the patient should be advised of.

It can therefore be quite arbitrary whether a material event is characterised as diagnosis, advice or treatment. Take for example, the case of an obstetrician who notes that a foetus is larger than average, attempts a vaginal delivery and dystocia occurs.[5] The obstetrician takes emergency measures but the baby is born with a brachial plexus injury to the right arm. Does the Bolam test or the Montgomery test apply?

On one hand, the issue could be framed as *negligent diagnosis/treatment* – the obstetrician failed to recognise that a caesarean section delivery was indicated in the circumstances. Under this characterisation, the applicable test for determining whether the obstetrician was negligent would be the Bolam test. On the other hand, the issue could also be framed as *negligent advice* – the obstetrician failed to advise of the risk that shoulder dystocia increases in large foetuses, which resulted in the patient being deprived of the opportunity to opt for delivery by caesarean section. Under this characterisation, the Montgomery test would apply.

Until further guidance from the courts, medical professionals are likely to have to live with this uncertainty of characterisation.

Further modifications to the Bolam test

The Court of Appeal in *Hii Chii Kok* left open the question of whether, in applying the Bolam test, the court ought to take into account the experience and/or special expertise of the doctor.[6] This could, possibly, mean that the standard of care expected from a doctor with special expertise in a field may be higher than one without that special expertise.

For example, an experienced and expert oncologist defending his diagnosis/treatment might have to show that there are oncologists of similar experience and expertise who support his diagnosis/treatment. In the same vein, a GP might not be judged by the standards of a specialist (unless the GP was negligent in not recognising that the matter ought to be referred to a specialist).

Conclusion

The decision in *Hii Chii Kok* represents a landmark change in the law of medical negligence. Medical professionals should be prepared to involve their patients to a greater extent when advising possible therapies or discussing treatment plans. Care should also be taken to record what the patient's particular concerns are, and what medical advice and information has been imparted to the patient as a result. ◆

References

1. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38 at [84].

2. Khoo EKH. Engage patients? Yes, but don't expect doctors to mind-read. The Straits Times 27 May 2017.

3. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38 at [139].

4. Although it may be that the patient would have made the same decision even if told of that alternative – ie, the negligent advice may not have caused any harm.

5. To borrow an example referred to in the Attorney-General's Submissions to the Court of Appeal in Hii Chii Kok dated 30 November 2016.

6. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38 at [105].

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