230-260 Singapore Academy of Law Journal (2019) 31 SALJ

# Meeting Medical Standards: *Bolam* and Beyond

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The classic *Bolam* test for medical negligence, controversial for its doctor-centric approach, has long been under attack when applied to a particular aspect of the doctor's duty, namely the duty to inform. Leading common law jurisdictions around the world, moved by considerations of patient autonomy, have abandoned or modified the *Bolam* test. The UK, in a recent landmark decision, departed from its earlier jurisprudence applying *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 to the duty to inform. However, Singapore continues to apply the *Bolam* test. This article argues that in light of the recent UK decision rejecting its earlier authority, which underpinned Singapore's approach to the duty to inform, the time may be ripe for Singapore to reconsider its position on the continued relevance of *Bolam* to the duty to inform, and perhaps more generally in medical negligence cases.

## I. Introduction

1 Medical negligence and patient autonomy are twin topics of considerable academic, judicial and professional interest. My foray into this field began 15 years ago with a case note entitled, "A New Dawn for Patient's Rights?",[1] which discussed the High of Court of Australia's decision in *Rosenberg v Percival*[2] ("*Rosenberg*"), in which Kirby J, analysing the doctor's duty to inform, observed: "Fundamentally, the rule is a recognition of individual autonomy that is to be viewed in the wider context of an emerging appreciation of basic human rights and human dignity."[3] That view, although not endorsed by the other judges in *Rosenberg*, has remained an integral – albeit contentious – issue in the doctor-patient relationship.

2 The tension is uppermost in the context of the duty to inform, an aspect of the comprehensive duty owed by a doctor to the patient. The test for medical negligence, set out in *Bolam v Friern Hospital*

[1] Kumaralingam Amirthalingam, "A New Dawn for Patient's Rights?" (2001) 117 LQR 532.

[2] (2002) 205 CLR 434.

[3] *Rosenberg v Percival* (2002) 205 CLR 434 at [145].

*Management Committee*[4] ("*Bolam*"), to be elaborated upon later, has long been criticised for perpetuating medical paternalism as courts routinely deferred to medical opinion in determining the standard of care that could reasonably be expected in any particular case. When *Bolam* is applied to the duty to inform,[5] the conflict between "doctor knows best" and patient autonomy is accentuated. Much of the academic criticism of *Bolam* rides on the horns of this dilemma.

3 This dilemma was resolved with respect to the duty to inform in a recent UK Supreme Court decision, *Montgomery v Lanarkshire Health Board*[6] ("*Montgomery*"), in which the court unanimously rejected the application of the *Bolam* test to the duty to inform on the ground that it violated patient autonomy. Lady Hale captured the underlying philosophy of the judgment in this pithy observation:[7]

> It is now well recognised that the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body …

However, the test in Singapore remains that stated in *Bolam*, which was reaffirmed in Singapore in the landmark decision of *Dr Khoo James v Gunapathy d/o Muniandy*[8] ("*Gunapathy*") in 2002, and recently applied to the duty to inform.[8] Just before *Gunapathy* was decided, the Malaysian Court of Appeal in *Foo Fio Na v Dr Soo Fook Mun*[9] vexed over the *Bolam* test before affirming it. Following these decisions, the author published an article[10] arguing for a relaxation of the *Bolam* rules on the basis of the evolving nature of the doctor-patient relationship. This paper is a sequel of sorts to that piece, picking up on developments in Singapore and Malaysia in the period after the publication of that article. Interestingly, the law in the two jurisdictions has diverged, with the Malaysian courts largely rejecting *Bolam* and the Singaporean courts

[4] [1957] 1 WLR 582.

[5] *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871.

[6] [2015] 2 WLR 768.

[7] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [108].

[8] [2002] 1 SLR(R) 1024.

[8] *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18.

[9] [2002] 2 MLJ 129.

[10] Kumaralingam Amirthalingam, "Judging Doctors and Diagnosing the Law: *Bolam* Rules in Singapore and Malaysia" [2003] Sing JLS 125.

continuing to apply it – even enhancing its effect – thus giving rise to very real concerns about patient autonomy.

4 This paper begins by providing some background to medical negligence and the *Bolam* test. It then sets out recent developments in the UK, culminating in the landmark decision of *Montgomery*, before

analysing the jurisprudence in Singapore and Malaysia over the last ten years. The core argument is that the law in Singapore is now out of step with the rest of the common law world and it is timely for the Court of Appeal to reconsider *Gunapathy*, especially with respect to the doctor's duty to inform. The discussion identifies two theoretical bases that have driven judicial reform of the duty to inform, which may be described as the patient's rights model (the English approach) and the common law adjudication model (the Australian approach).

5 While the end result may be the same with respect to the duty to inform, the underlying philosophy is different: the patient's rights model emphasises patient autonomy and shifts the focus from the doctor's duty to disclose to the patient's right to information. This introduces unnecessary complexities and risks collapsing medical trespass and medical negligence actions. It also raises questions as to the nature of the loss for which compensation is sought: is it the physical harm that eventuates or the intangible loss of the right to make an informed decision?[12] Further, an over-emphasis on patient autonomy encourages plaintiffs' counsel to allege failure to inform as a default strategy when the real issue is negligent diagnosis or treatment.

## II. Medical negligence and the standard of care

6 Doctors have always occupied a special position in negligence law. This is partly due to historical reasons when medical practice was viewed as a noble profession and doctors were treated with considerable deference and respect. While that view is under challenge in light of modern medical practices,[13] there are nonetheless other valid

[12] This question has never been squarely resolved by courts but is implicit in the duty to inform cases. This theme has been explored by the author in a series of publications: Kumaralingam Amirthalingam, "A New Dawn for Patient's Rights?" (2001) 117 LQR 532; Kumaralingam Amirthalingam, "Medical Non-disclosure, Causation and Autonomy" (2002) 118 LQR 540; Kumaralingam Amirthalingam, "Loss of Chance – Lost Cause or Remote Possibility?" (2003) 62 Camb LJ 253; Kumaralingam Amirthalingam,

"Causation and the Gist of Negligence" (2005) 64 Camb LJ 32; Kumaralingam Amirthalingam, "The Changing Face of the Gist of Negligence" in *Emerging Issues in Tort Law* (Jason Neyers, Stephen Pitel & Erika Chamberlain eds) (Oxford: Hart Publishing, 2007) at p 467; Kumaralingam Amirthalingam, "Causation and the Medical Duty to Refer" (2012) 128 LQR 208.

[13] Much has changed with medical services becoming a highly profitable business, not just domestically but internationally through medical tourism supported by governments for economic reasons. See Lila Skountridaki, "The Internationalisation of Healthcare and Business Aspirations

reasons for having special rules for medical negligence, principally the uncertain scope of liability and the subjective nature of medical practice. Doctors may be exposed to potentially wide-ranging liability as the scope of a doctor's duty is subject to uncertainty at several levels.

7 First, there is the question as to when the duty of care arises. The general rule is that the duty of care only comes into existence after the doctor-patient relationship is established,[14] although there have been rare instances where the duty was held to arise with respect to a stranger.[15] Secondly, the duty is multifarious, including diagnosis, treatment and care; information and advice; and timely referral. Thirdly, the doctor may be exposed to a variety of potential plaintiffs, including spouses, children, unborn children and employers of patients: the consequences of medical decisions can be far reaching. Where infants are involved, the statute of limitation typically commences at the age of maturity, which may leave doctors, particularly obstetricians, under the Sword of Damocles for over 20 years.[16]

8 The subjectivity inherent in medical practice is another reason for caution. The doctor's choice of treatment is determined by the particular – sometimes complex – circumstances of the patient, including the patient's personal choice of treatment, and consent to the doctor's preferred treatment. It would be unfair to blame the doctor for a mishap when the patient has insisted on a particular option. In many cases, the health of the plaintiff is already compromised and unrealistic expectations may be placed on the doctor. The doctor's paradox is that *ex ante*, he is asked to play God; *ex post*, she is accused of playing God. Finally, while a cliché, it remains true that medical practice is as much an art as a science, calling for nuanced judgments, which would be unfair to second guess with the benefit of hindsight.

9 For these reasons, amongst others, courts have recognised that medical practitioners deserve to be treated differently. The classic test

for medical negligence is found in the case of *Bolam*, where McNair J held as follows:[17]

Professionals" (2015) 49 Sociology 471 and Chee Heng Leng, "Medical Tourism and the State in Malaysia and Singapore" (2010) 10 *Global Social Policy* 336.

14 See *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593 and *JU v See Tho Kai Yin* [2005] 4 SLR(R) 96.

15 *Lowns v Woods* (1996) Aust Torts Reports 81-376.

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16 This has become an acute issue in Singapore following the decision of the UK's Medical Protection Society, which provided insurance coverage to many Singaporean medical practitioners, to change their insurance cover from occurrence based to claims based. This would have the biggest impact on obstetricians who may be sued over 20 years after the occurrence of the alleged negligence injuring an infant during childbirth.

17 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. … A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. … Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

The strength of this judgment lies in its recognition that professionals may legitimately differ in their assessment of problems and choice of solutions. Therefore, it would be wrong to hold a professional negligent merely because there exists a different professional opinion which appeals to the particular judge. The problem with the *Bolam* test was its formulaic application by subsequent courts,[11] giving rise to a culture of medical paternalism and a judicial approach that bordered on abdicating its adjudicative function.[12]

[11] *Gold v Haringey Health Authority* [1988] 1 QB 481; *Blyth v Bloomsbury Health Authority* (1993) 4 Med LR 151.

[12] Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Med Law Rev 1 at 15:

> The problem with *Bolam* is that it inhibited the courts exercising a restraining influence. The courts must recognise that theirs is essentially a regulatory role and they should not interfere unless interference is justified. But when interference is justified they must not be deterred from doing so by any principle such as the fact that what has been done is in accord with a practice approved of by a respectable body of medical opinion.

10 Inroads were slowly made following the House of Lords' decision in *Bolitho v City of Hackney Area Health Authority*[13] ("*Bolitho*"), where the court emphasised that a judge could find a defendant negligent despite a body of professional opinion supporting the defendant if the professional opinion was "not capable of withstanding logical analysis". In such cases, the judge could "hold that the body of opinion [was] not reasonable or responsible".[14] However, despite the apparent incursion into *Bolam*, in practice there was little, if any, change to the application of *Bolam*.[15] Courts have interpreted *Bolitho* not as permitting judges to compare and prefer one medical expert's view over another, but only to scrutinise the logical basis of the medical opinion. If the medical opinion is logically defensible, then even if the judge prefers a contrary view, the judge is not permitted to find the defendant negligent.[16] Interestingly, some Malaysian courts have given *Bolitho* a much more liberal interpretation, equating it with the underlying approach in *Rogers v Whitaker*[17] ("*Rogers*") giving judges the power to choose between conflicting medical opinion.[18]

### *A. The standard of care and the duty to inform*

11 The duty to inform, while part of the comprehensive duty owed by the doctor, to some extent stands on its own, as elegantly expressed by the High Court of Australia in the landmark decision of *Rogers*:[19]

> Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be

[13] [1998] AC 232.

[14] *Bolitho v City of Hackney Area Health Authority* [1998] AC 232 at 243. For an illustration of this, see *Marriott v West Midlands RHA* [1999] Lloyd's Rep Med 23.

[15] See Lord Irvine, "The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties" (1999) 7 Med Law Rev 255 and Alasdair Maclean, "Beyond *Bolam* and *Bolitho*" (2002) 5 *Medical Law International* 205.

[16] This was the view adopted in Singapore in *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024.

[17] (1992) 175 CLR 479.

[18] See, for example, *Chien Tham Kong v Excellent Strategy Sdn Bhd* [2009] 7 MLJ 261 at [55]–[56] and *Zulhasnir bt Hassan Basri v Dr Kuppu Velumani P* [2014] 7 MLJ 899 at [169]–[170].

[19] *Rogers v Whitaker* (1992) 175 CLR 479 at 489–490.

> provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards of practices.

The rejection of *Bolam* in *Rogers* was affirmed in subsequent High Court of Australia decisions and extended to all aspects of the doctor's duty, including the core aspects of diagnosis, treatment and care,[20] although

medical expert opinion continued to be given considerable weight.[21] Legislative reforms following the health insurance crisis in 2001 have reversed some of the effect of *Rogers* with respect to diagnosis, treatment and care, but preserved *Rogers* with respect to the duty to inform.[22] Interestingly, the rejection of *Bolam* with respect to the duty to inform in *Rogers* was not done on the basis of patient's rights or autonomy, but on the far simpler ground that the determination of the standard of care was a judicial function that could not be abdicated to the profession that was being judged.[23] This approach may be described as the common law adjudication model and Bolam allowed narrow, traditional groups to set standards, disguising their own professional interests and enabling courts to avoid their responsibility of defining proper norms.

[20] *Naxakis v Western General Hospital* (1999) 197 CLR 269.

[21] See *Rosenberg v Percival* (2002) 205 CLR 434 at 439, *per* Gleeson CJ.

[22] For a concise description of the Australian position, see Margaret Fordham, "Doctor Does Not Always Know Best" [2007] Sing JLS 128 at 135–136.

[23] *Naxakis v Western General Hospital* (1999) 197 CLR 269 at 275, *per* Gaudron J: The *Bolam* rule, which allows that the standard of care owed by a doctor to his or her patient is 'a matter of medical judgment', was rejected by this Court in *Rogers v Whitaker*. In that case it was pointed out that, in Australia, the standard of care owed by persons possessing special skills is that of 'the ordinary skilled person exercising and professing to have that special skill [in question]'. In that context, it was held that 'that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade'.

12 The UK developments on the other hand have followed a different trajectory. Unwilling to reject *Bolam*, and at the same time uncomfortable with the impact of *Bolam* on the duty to inform cases, UK courts drew on autonomy-based arguments to dilute the effect of *Bolam* or to avoid it entirely. The key judgments leading up to the landmark case of *Montgomery* are Lord Scarman's dissenting opinion in *Sidaway v Governors of Bethlem Royal Hospital*[24] ("*Sidaway*"), Lord Woolf's opinion in *Pearce v United Bristol Healthcare NHS Trust*[25] ("*Pearce*") and Lord Steyn's opinion in *Chester v Afshar*[33] ("*Chester*"). This approach may be contrasted with the common law adjudication model and described as the patient's rights model.

13 In all three cases of *Pearce*, *Chester* and *Montgomery*, the emphasis was on the right of the patient to have sufficient information to make an informed decision. *Chester*, despite being concerned with causation, rather than breach of duty, was the most explicit in grounding the doctor's duty to inform in the patient's right to autonomy. The plaintiff in *Chester* underwent spinal surgery at the hands of the

defendant, who failed to inform her of a small risk of neurological damage. It was accepted that the defendant had breached his duty of care based on the prevailing law under *Bolam*.

14 The issue was whether the plaintiff could prove that the breach had caused the injury. To do this, the plaintiff had to show that, had she been warned of the particular risk, she would have chosen not to undergo the surgery. On the facts, the surgery was the only option available to the plaintiff, and she candidly admitted that, had she been informed of the risk, all she might have done would have been to postpone the surgery. Thus, even if informed, she would have been exposed to the same risk, and it could not be said that but for the defendant's negligence the plaintiff would not have suffered the injury.[26]

[24] [1985] 1 AC 871.

[25] [1999] PIQR P 53. 33
[2005] 1 AC
134.

[26] For a recent critique of this case, see Tamsyn Clark & Donal Nolan, "A Critique of *Chester v Afshar*" (2014) 34 OxJLS 659.

15 The House of Lords, by a 3:2 majority decision, referring with approval to the Australian decision of *Chapel v Hart*,[27] held that causation was established. The majority grounded their decision firmly in the notion of the patient's right to autonomy. Lord Steyn was unequivocal:[28]

> The starting point is that every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised.
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> A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient.

16 The minority in *Chester*, while sympathetic to the patient's right to autonomy, held that on ordinary principles of torts, it could not be said that the defendant's negligence had caused the damage. At most, it could be argued that the defendant had violated the plaintiff's right to choose, for which Lord Hoffmann was willing to award a modest quantum of damages by way of solatium.[29] This implicit recognition of

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the violation of a right as giving rise to compensation raises important – and challenging – questions as to the evolving nature of damage in the tort of negligence, which are beyond the scope of this paper.[30] The significance of *Chester* is that it placed patients' rights and autonomy at the heart of the doctor's duty to inform, and opened the door to reconsideration of *Sidaway*, which the Supreme Court undertook in *Montgomery*.

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[27] (1998) 195 CLR 232.

[28] *Chester v Afshar* [2005] 1 AC 134 at [14] and [18].

[29] See, for example, *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309 where conventional damages were awarded in a wrongful birth claim for loss of autonomy.

[30] See Kumaralingam Amirthalingam, "The Changing Face of the Gist of Negligence" in *Emerging Issues in Tort Law* (Jason Neyers, Stephen Pitel & Erika Chamberlain eds) (Oxford: Hart Publishing, 2007) at p 467. See also Margaret Fordham, "The Protection of Personal Interests – Evolving Forms of Damage in Negligence" (2015) 27 SAcLJ 643.

*(1)* Montgomery

17 The facts in *Montgomery* were that an infant was born with cerebral palsy due to complications during delivery.[3132] The mother was diabetic and likely to have babies that were larger than normal, especially around the shoulders. This gave rise to the risk of the baby not being able to pass through the pelvis during vaginal delivery due to its large shoulders, a risk known as shoulder dystocia. In this case, the mother was slightly built, which increased the risk. The claim in negligence was based on two separate grounds. It was alleged that the defendant obstetrician and gynaecologist had negligently failed to inform the mother of the risk of shoulder dystocia and that the defendant had failed to perform an emergency caesarean section. It was accepted that had the child been delivered by caesarean section, he would not have suffered injury.

18 Applying the test in *Bolam*, or its Scottish equivalent in *Hunter v Hanley*,[40] the Court of Session found that the failure to provide relevant information as well as the failure to perform a caesarean section were accepted as proper by a responsible body of medical opinion, and that the opinion was not logically indefensible under the *Bolitho* test. Thus, the defendant could not be found negligent. The court also found that even if the defendant had informed the mother of the risk, it would have made no difference as she would in all likelihood have proceeded with vaginal delivery. Thus, even if there had been a breach of duty, there would have been no causation of damage. The Court of Session's

findings were upheld on appeal to the Inner House. The appeal to the Supreme Court focused on the duty to inform, with the court invited to overrule *Sidaway*.

19 The Supreme Court was unanimous in its decision. The leading opinion was written by Lords Kerr and Reed (with Lords Neuberger, Clarke, Wilson and Hodge agreeing). Lady Hale wrote a separate concurring judgment. The court undertook a detailed analysis of the opinions in *Sidaway*, noting that only Lord Diplock unequivocally applied *Bolam* to the duty to inform. Lords Bridge of Harwich and Keith of Kinkel

[31] For a review of this case, see Rob Heywood, "RIP *Sidaway*: Patient-oriented Disclosure – A Standard Worth Waiting For?" (2015) 23 Med Law Rev (forthcoming) and Alicia Zhuang, "Consent: Time to Say Goodbye to *Bolam* and *Sidaway*?" *Singapore Law Gazette* (May 2015) at p 16.

[32] SC 200.

accepted that while *Bolam* applied to the duty to inform, there might be some instances when a judge might:[33]

> … come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.

Lord Templeman was further removed from Lord Diplock, holding that a doctor had to provide the patient with sufficient information "to enable the patient to reach a balanced judgment".[34]

20 Lord Scarman, who dissented in *Sidaway*, based his opinion on "the patient's right to make his own decision", which he viewed as "a basic right protected by the common law".[35] Lord Scarman viewed the decision to consent to a procedure as a matter that was not solely determined by medical considerations, but one which depended largely on the patient's personal values and choice. *Montgomery* endorsed this view emphatically:[36]

> This is an important point. The relative importance attached by patients to quality as against length of life, or to physical appearances of bodily integrity as against the relief of pain, will vary from one patient to another. … the doctor cannot form an objective, 'medical' view of these matters, and is therefore not in a position to take the 'right' decision as a matter of clinical judgment.

21 Having reviewed *Sidaway*, Lords Kerr and Reed concluded that it would "be wrong to regard *Sidaway* as an unqualified endorsement of the application of the *Bolam* test to the giving of advice about

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treatment".[37] While diagnosis and treatment were largely matters pertaining to medical skill and judgment, and appropriately covered by *Bolam*, the duty to advise and inform rested on very different foundations, being predicated on the patient's right to make an informed decision. It was noted that the paradigm of the doctor-patient relationship had evolved and patients today were no longer passive

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[33] *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 900.

[34] *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 905.

[35] *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 882.

[36] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [46].

[37] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [56].

recipients of medical services but persons holding rights.[38] Their Lordships then went on to consider and approve *Pearce*, *Wyatt v Curtis*[47] and *Chester*, cases which had in practice departed from *Sidaway* and embraced the dissent of Lord Scarman. In concluding their opinion, Lords Kerr and Reed referred to the Australian position under *Rogers*, before stating the test to be applied to the duty to inform:[39]

> The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. 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.

This test was subject to therapeutic privilege, although the court emphasised that the privilege should not be abused to enable a doctor to prevent a patient from making a choice that the doctor considered to be contrary to the patient's best interest. *Montgomery* is by any account a landmark decision that has changed the law to reflect modern standards and expectations. It is a bold decision: the court recognised that the decision would require behavioural change amongst doctors, resulting in additional work and costs, and that it would introduce some degree of unpredictability by departing from *Bolam*. Nevertheless, the court was firm that change was necessary as the paramount consideration was respect for the dignity of patients.[40] It should be noted in passing that the Supreme Court disagreed with the lower courts on the causation finding, holding that had the information been disclosed, the mother would in all likelihood have opted for a caesarean section and avoided the harm to the baby.

## III. *Bolam* rues in Malaysia

22 The Malaysian jurisprudence on medical negligence and the standard of care is interesting because *Bolam*, while long applied, never

[38] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [75]. 47 [2003] EWCA Civ 1779.

[39] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [87].

[40] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [93].

had strong roots. The first two Federal Court decisions on medical negligence were decided without reference to *Bolam*,[41] although the Privy Council did refer to *Bolam* in deciding one of the appeals from the Federal Court.[42] The third Federal Court decision on medical negligence, *Kow Nan Seng v Nagamah*[43] ("*Kow Nan Seng*"), relied on a liberal interpretation of *Bolam* in the High Court decision of *Elizabeth Choo v Government of Malaysia*,[44] where Raja Azlan Shah J stated:[45]

> To say the least I am no advocate of the right of medical men occupying a position of privilege. They stand in the same position as any other man. Their acts cannot be free from restraint; where they are wrongfully exercised by commission or default, it becomes the duty of the courts to intervene.

23 Unlike the courts in Singapore, which have steadfastly applied *Bolam*, the Malaysian courts have been ambivalent, with some cases applying *Bolam* and others applying *Rogers*.[46] The matter finally came before the Federal Court in 2007 in the case of *Foo Fio Na v Dr Soo Fook Mun*[50] ("*Foo Fio Na*").

24 The plaintiff in *Foo Fio Na* had been involved in a motor car accident in which she suffered injury, including to her cervical vertebrae, resulting in considerable pain in the neck region. She was treated by the first respondent orthopaedic surgeon who, after a few failed attempts to rectify the plaintiff's condition non-surgically, operated on her vertebrae. After the operation, the plaintiff was unable to move her limbs or body. The first respondent assured her that the paralysis was temporary and that she would recover within two weeks. When she did

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[41] *Government of Malaysia v Chin Keow* [1965] 2 MLJ 91; *Swamy v Matthews* [1968] 1 MLJ 138.

[42] *Chin Keow v Government of Malaysia* [1967] 2 MLJ 45. Until the right was abolished in 1985, the judicial committee of the Privy Council could hear appeals from the Federal Court of Malaysia.

[43] [1982] 1 MLJ 128.

[44] [1970] 2 MLJ 171.

[45] *Elizabeth Choo v Government of Malaysia* [1970] 2 MLJ 171 at 172.

[46] See cases listed in Kumaralingam Amirthalingam, "Judging Doctors and Diagnosing the Law: *Bolam* Rules in Singapore and Malaysia" [2003] Sing JLS 125 at 142, fnn 87–88. See also Mathews Thomas, "*Rogers v Whitaker* Lands on Malaysian Shores – Is There Now a Patient's Right to Know in Malaysia?" [2009] Sing JLS 182 at 190–192. [50] [2007] 1 MLJ 593.

not, the first respondent performed a second procedure, after which the plaintiff regained the use of her hands but remained paralysed. The plaintiff alleged that the first respondent had negligently performed the surgery and that he had negligently failed to inform her of the risks inherent in the surgery.

25 The trial judge found that the cause of the paralysis was compression of the spinal nerve by the loop wire inserted by the first respondent during the first surgery. Referring to *Bolam*, *Rogers* and *Kow Nan Seng*, the trial judge held that the first respondent had been negligent in performing the surgery and in failing to inform the plaintiff of the risk of paralysis. The Court of Appeal allowed the respondent's appeal, although Gopal Sri Ram JA, in applying *Bolam*, noted the attraction of the *Rogers* approach.[47] The Federal Court in granting leave to appeal noted that the main question sought to be determined was the following:[58]

> [W]hether the *Bolam* Test as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence?

In granting leave, the court noted that:[48]

> … the particular aspect of medical negligence relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment.

26 Unfortunately, it is not clear whether the Federal Court intended to grant leave to determine the application of the *Bolam* test to medical negligence generally (the original question) or only with respect to the duty to advise or inform (the narrow question). The Federal Court that heard the appeal was equally ambiguous. Siti Norma Yaakob FCJ, who gave the judgment in the appeal, held that:[49]

[47] *Dr Soo Fook Mun v Foo Fio Na* [2001] 2 MLJ 193 at 207–208. 58 *Foo Fio Na v Dr Soo Fook Mun* [2002] 2 MLJ 129 at 130.

[48] *Foo Fio Na v Dr Soo Fook Mun* [2002] 2 MLJ 129 at 130.

[49] *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593 at [36].

> … the *Bolam Test* has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment.

However, she went on to consider with approval the Australian decision of *Naxakis v Western General Hospital*,[50] which extended *Rogers* to all aspects of the medical practitioner's duty, as well as Malaysian decisions applying *Rogers* to the duty to diagnose and treat.[51] Toward the end of the judgment, she noted the importance of ensuring that it was the courts that set the standard of care, before concluding that "the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium then the *Bolam Test*".[52]

27 The cases immediately following *Foo Fio Na* interpreted the Federal Court as jettisoning the *Bolam* test altogether, taking the view that courts, as the ultimate arbiter of medical negligence, had the power to choose between competing expert testimony and make an independent finding of negligence.[53] The case of *Dominic Puthucheary v Dr Goon Siew Fong*[65] ("*Dominic Puthucheary*") is particularly interesting as the Court of Appeal's judgment was given by Gopal Sri Ram JCA, who gave the Court of Appeal's judgment in *Foo Fio Na*, which was overturned by the Federal Court. The deceased in *Dominic Puthucheary* had been rushed to hospital after suffering a fall. He was allegedly poorly monitored and died a few hours later. The court found that the plaintiffs had not discharged the burden of proof with respect to causation of damage and breach of duty. On the latter point, Gopal

[50] (1999) 197 CLR 269.

[51] *Kamalam a/p Raman v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore* [1996] 4 MLJ 674; *Tan Ah Kau v The Government of Malaysia* [1997] 2 AMR 1382.

[52] *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593 at [69].

[53] *Dominic Puthucheary v Dr Goon Siew Fong* [2007] 5 MLJ 552; *Chien Tham Kong v Excellent Strategy Sdn Bhd* [2009] 7 MLJ 261; *Dr Ismail Abdullah v Poh Hui Lin* [2009] 2 MLJ 599; *Hasan bin Datolah v Kerajaan Malaysia* [2010] 2 MLJ 646; *Abdul Ghafur bin Mohd Ibrahim v Pengarah, Hospital Kepala Batas* [2010] 6 MLJ 181; *Chai Hoon Seong v Wong Meng Heong* [2010] 8 MLJ 104; *Ang Yew Meng v Dr Sashikannan a/l Arunasalam* [2011] 9 MLJ 153; *Ramanaidu a/l C Simansalom v Kerajaan Malaysia* [2011] MLJU 1199; *Sanmarkan a/l Ganapathy v Dato' Dr V Thuraisingham* [2012] 3 MLJ 817; *Gurmit Kaur a/p Jaswant Singh v Tung Shin Hospital* [2012] 4 MLJ 260; *Ku Jia Shiuen (an infant suing through her mother and next friend, Tay Pei Hoon) v Government of Malaysia* (*cont'd on the next page*)

Sri Ram JCA noted the following:[66]

> The plaintiffs quite rightly rely on the recent decision of the Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593. In that case, the Federal Court held that the standard of care that a medical attendant should exercise is now a question which is for the ultimate consideration of the courts and no longer one for the medical profession alone to decide through a responsible body of medical opinion. While I must reserve my comments on the correctness of the decision on the actual facts of that case, *it is one that is plainly binding on this Court*. [emphasis added]

It bears reiterating that *Dominic Puthcheary* involved the duty to diagnose and treat, and not the duty to inform. Despite this clear pronouncement from the Court of Appeal, there is a line of cases where the courts have held that the *Bolam* test continues to apply with respect to the duty to diagnose and treat, apparently taking the view that *Foo Fio Na*'s adoption of *Rogers* was restricted to the duty to inform.[67] Equally, there are cases which seem to confuse the *Rogers* and the *Bolitho* tests.[68] For example, in *Abdul Razak bin Datuk Abu Samah v Raja Badrul Hisham bin Raja Zezeman Shah*[69] ("*Abdul Razak*"), the court, having held that *Foo Fio Na* had adopted the *Rogers* test across the board, went

[2013] 4 MLJ 108; *Abdul Razak bin Datuk Abu Samah v Raja Badrul Hisham bin Raja Zezeman Shah* [2013] 10 MLJ 34; *Norizan Bte Abd Rahman v Dr Arthur Samuel* [2013] MLJU 81; *Gun Suk Chyn v Kartar Kaur a/p Jageer Singh* Civil Appeal No N01-706-12/2011 (unreported) (11 October 2013). 65 [2007] 5 MLJ 552.

66 *Dominic Puthucheary v Dr Goon Siew Fong* [2007] 5 MLJ 552 at [16].

67 *Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk* [2008] 1 MLJ 115; *James Kenneth Eng Siew Goh v Lee King Ong* [2009] 4 MLJH 396; *Mohd Shafie bin Abdul Samat lwn Penguasa Perubatan dan satu lagi* [2011] 9 MLJ 254; *Gleneagles Hospital (KL) Sdn Bhg v Chung Chu Yin* [2013] 4 MLJ 785; *Zulhasnir bt Hassan Basri v Dr Kuppu Velumani P* [2014] 7 MLJ 899; *Lai Ping @ Lai Wai Ping v Dr Lim Tye Ling* [2015] 8 MLJ 62.

68 See, for example, *Chien Tham Kong v Excellent Strategy Sdn Bhd* [2009] 7 MLJ 261 at [55]–[56] and *Zulhasnir bt Hassan Basri v Dr Kuppu Velumani P* [2014] 7 MLJ 899.

69 [2013] 10 MLJ 34.

on to apply the test to diagnosis and treatment by relying on a misconception of *Bolitho*.[54]

28 *Abdul Razak* is an interesting case as it demonstrates how patient autonomy may be a double-edged sword. The deceased in *Abdul Razak* was a 71-year-old woman who was admitted to hospital following stomach problems. She was initially treated conservatively but as her condition deteriorated, the first defendant decided on more intervention, including the insertion of a Ryle's tube, which would help

pump out excess stomach fluid. Two days later, emergency surgery was deemed necessary. The Ryle's tube, however, had not been inserted as the deceased refused consent due to her fear that the insertion of the tube would be painful. Prior to surgery, it was explained to the deceased that a Ryle's tube was necessary to reduce the risk of aspiration during anaesthesia. The deceased continued to refuse consent and insisted the tube be inserted after the anaesthesia was administered. The defendants (surgeons and anaesthetists) made the necessary contingency plans to proceed without the prior insertion of the Ryle's tube. Unfortunately, during the induction of anaesthesia, the deceased aspirated and eventually died as a result. The court held that the defendants could not be found negligent as it was accepted practice to proceed with anaesthesia without the insertion of a Ryle's tube as long as necessary precautions were taken, as was the case here.[55]

29 The plaintiff, the deceased's husband, argued that the defendants should have done more to allay the deceased's fears and obtain her consent. Failing that, the plaintiff argued that the first defendant should have explained the risks to him so that he could have persuaded the deceased to consent. The court found that the defendants had failed to provide the deceased with sufficient information and advice to enable her to make an informed decision. In particular, the court found that the defendants had not impressed upon the deceased the serious risk of death in proceeding without the Ryle's tube. On that basis, the court found the defendants negligent.

[54] *Abdul Razak bin Datuk Abu Samah v Raja Badrul Hisham bin Raja Zezeman Shah* [2013] 10 MLJ 34 at [14].

[55] *Abdul Razak bin Datuk Abu Samah v Raja Badrul Hisham bin Raja Zezeman Shah* [2013] 10 MLJ 34 at [36]. 72 [2012] 4 MLJ 260.

30 Surprisingly – and arguably unnecessarily – the court went on to consider whether the first defendant owed the plaintiff a duty to inform the plaintiff of the risks to the deceased. The court noted that a doctor's duty was ordinarily only owed to the patient, but that there could be exceptions to this. Referring to *Gurmit Kaur a/p Jaswant Singh v Tung Shin Hospital*[72] ("*Gurmit Kaur*"), the court held that in some cases a doctor might be held to owe a duty to the spouse of the patient subject to the medical treatment. The plaintiff in *Gurmit Kaur* was a 38-year-old woman who consented to surgery for the removal of a cervical polyp. The defendant surgeon, during the operation, proceeded to remove her uterus as he was of the view that this was in her best interest. The plaintiff was naturally devastated as she had planned to have another child. The court found that the plaintiff had not been informed of the proposed procedure and had certainly not consented to it.

31 The matter should have ended there with the proper action being in trespass.[56] However, the court went on to refer to the particular consent form in that case, which required the consent of the husband or wife in any procedure that might result in sterility. Since a hysterectomy clearly had that effect, the court held that the husband's consent should have been sought. Two points may be made here. First, the hysterectomy appears to have been an afterthought and clearly not contemplated at the time of the taking of consent, at which time the only option was limited to the removal of the polyp. The removal of the polyp was unlikely to result in sterility; hence, the consent of the husband would not have been required. Secondly, as the patient herself had not consented to the hysterectomy, there should have been no need to consider the husband's lack of consent.

32 The requirement of the husband's consent to make a decision about the wife's own body raises serious questions about women's rights to autonomy. Is it permissible – morally or legally – for a doctor to refuse to operate on a woman who has sought a particular medical procedure simply because her husband refuses permission? Lady Hale's concurring opinion in *Montgomery* is a salutary reminder of the law's responsibility in protecting the autonomy of women whose rights in medical cases are often subjugated to others, particularly when

[56] Curiously, although the judgment proceeded on the basis of a negligence action, the judge noted under assessment of damages that the plaintiff was claiming for assault and battery.

reproductive rights are at issue.[57] Leaving that aside, there is nothing in *Gurmit Kaur* suggesting that there is an independent common law duty owed by doctors to the spouses of patients, the breach of which would sound in damages to the spouse.

33 *Abdul Razak*'s reliance on *Gurmit Kaur* to create a common law duty owed to spouses is problematic.[58] Is this duty parasitic on the patient's right or does it exist independently? What is the damage suffered by the spouse, and how would damages be calculated? A better way of rationalising *Abdul Razak* is to read it as setting down a rule that in some cases, a doctor's duty to inform will not be discharged simply by providing information to the patient. The doctor must ensure that the patient understands the information and is able to make a truly informed decision.[59] In such cases, it may be necessary for the doctor to explain the risks to the next of kin who can ensure that the patient's autonomy is protected.

34 The law on medical negligence in Malaysia is clearly in a state of confusion. There are three reasons for this. First, the Federal Court judgment in *Foo Fio Na* was itself ambiguous on whether its rejection of *Bolam* was limited to the duty to inform or was more general. Secondly, Malaysian courts have not adhered strictly to the doctrine of precedent. The early line of authorities after *Foo Fio Na*, beginning with the significant Court of Appeal decision of *Dominic Puthucheary*, established that the *Bolam* rule had been rejected as a general proposition, yet subsequent decisions by various High Courts were made without adequate reference to previous authorities. It is worth noting that *Foo Fio Na* has been interpreted in Singapore as rejecting *Bolam* with respect to all aspects of medical negligence.[64]

35 Despite the confusion, the trend in the Malaysian Court of Appeal appears to favour the view that *Foo Fio Na* should be interpreted as rejecting *Bolam* with respect to all aspects of medical

[57] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [108] and [114]–[116].

[58] See, from the perspective of a medical practitioner, S S Siddhu, "Spousal Consent and Medical Negligence: A Bridge Too Far?" [2014] 4 MLJ cix.

[59] See generally, John Coggon & José Miola, "Autonomy, Liberty, and Medical Decisionmaking" (2011) 70 Camb LJ 523.

negligence.[60] The clearest statement is seen in the Court of Appeal's judgment of March this year, in the case of *Norazleen bt Mohammed Mustafa v Dr Omar Md Isa*:[61]

> Though we are well aware that in *Foo Fio Na*, the Federal Court confined the legal principle of *Rogers v Whitaker* to a doctor's duty and standard of care in the field of providing advice to a patient on the inherent risks of a proposed treatment, nevertheless, *we take the view that for all intent and purpose, the Federal Court would have extended*

[64] *Surender Singh s/o Jagdish Singh v Li Man Kay* [2010] 1 SLR 428 at [152].

> *the principle on the standard of care of a doctor in* Rogers v Whitaker *to the areas of diagnosis and treatment as well as advice*. This is apparent from the fact that in arriving at its decision, the Federal Court referred to case laws from various jurisdictions dealing with the standard of care required of a medical professional in areas of treatment and diagnosis. *As such, we are inclined to hold that the* Foo Fio Na *decision ought to apply in the area of not just medical advice, but also to diagnosis and treatment.* Therefore, we find that the test of the standard of care which is expected of a medical profession in the realm of diagnosis and treatment should be a matter of judicial determination as opposed to medical judgment. [emphasis added]

36 Thirdly, there was no clear theoretical basis for the decision in *Foo Fio Na*, which appeared simply to choose between *Bolam* and *Rogers*. The two jurisprudential bases are the patient's rights model and the common law adjudication model. The patient's rights model views the doctor's duty to inform from the perspective of patient autonomy.

[60] Of the six Court of Appeal decisions applying *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593, four treated it as rejecting *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ("*Bolam*") altogether, one treated it as retaining *Bolam* with respect to the duty to diagnose and treatment, and one took a more nuanced approach of treating *Bolam* merely as setting guidelines, rather than a clear rule. The four cases are *Dominic Puthucheary v Dr Goon Siew Fong* [2007] 5 MLJ 552; *Hasan bin Datolah v Kerajaan Malaysia* [2010] 2 MLJ 646; *Gun Suk Chyn v Kartar Kaur a/p Jageer Singh* Civil Appeal No N-01-706-12/2011 (unreported) (11 October 2013); and *Norazleen bt Mohammed Mustafa v Dr Omar Md Isa* Civil Appeal No P02-2969-12/2012 (unreported) (17 March 2015) ("*Norazleen*"). The case retaining *Bolam* with respect to diagnosis and treatment is *Gleneagles Hospital (KL) Sdn Bhg v Chung Chu Yin* [2013] 4 MLJ 785. It should be noted that in that case, the court uncritically accepted counsels' assertion that *Bolam* applied to the facts. The case with a more nuanced approach is *Dato Dr Thuraisingam v Sanmarkan a/l Gunapathy* Civil Appeal No 02-2280-09/2011 (unreported) (15 July 2015). Unfortunately, this case was decided without reference to the written judgment delivered four months earlier by the same court in *Norazleen*.

[61] Civil Appeal No P02-2969-12/2012 (unreported) (17 March 2015) at 14–15.

The question is not what a reasonable doctor would disclose, but what a reasonable patient would want to know. On the patient's rights model, the doctor's duty is bifurcated, with a different underlying rationale for the duty to inform as compared to the duty to diagnose and treat. This, not surprisingly, seems to be the approach of the UK courts, influenced as they are by human rights considerations. The danger with this approach is the risk of conflating medical negligence with medical trespass.[67] The common law adjudication model on the other hand is about preserving the role of judges in common law adjudication and retreating from the miscalculated view of "doctor knows best". This appears to be the approach of the Australian courts.

37 The Federal Court of Malaysia, recognising the unsatisfactory state of affairs in its medical negligence jurisprudence, in March this year granted leave to appeal in two related cases to determine, *inter alia*, the following question:[68]

> Whether it is the *Bolam* test or the test in the Australian case of *Rogers v Whittaker* [1993] 4 Med LR 79) which should be applied to the standard of care in medical negligence, following, after the decision of the Federal Court in *Foo Fio Na Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, conflicting decisions of the Court of Appeal of Malaysia, conflicting decisions of the High Court in Malaya, and legislative changes in Australia, including the re-introduction there of a modified *Bolam* test.

[67] This conflation was evident in the recent Malaysian decision of *Abdul Razak bin Datuk Abu Samah v Raja Badrul Hisham bin Raja Zezeman Shah* [2013] 10 MLJ 34.

[68] Leave Questions Allowed by Federal Court Malaysia (From May 2014) *Dr Hari Krishnan & 1 Lagi v Megat Noor Ishak bin Megat Ibrahim & 1 Lagi; The Tun Hussein Onn National Eye Hospital v Megat Noor Ishak Bin Megat Ibrahim & 2 Lagi*, available

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## IV. *Bolam* rules in Singapore

38 While the Malaysian courts have engaged with the pros and cons of *Bolam* and *Rogers*, Singaporean courts have consistently applied *Bolam* to all areas of medical negligence.[82] As alluded to earlier, the leading authority in Singapore remains the 2002 decision of *Gunapathy*. The facts were that the first defendant had performed brain surgery on the plaintiff to remove a tumour. MRI scans after the surgery showed the presence of a nodule in the vicinity of the operated area. The

radiologist was of the view that the nodule was simply scar tissue that required no further treatment. The first defendant took the view that the nodule was a tumour and advised the plaintiff to undergo radiosurgery to remove it. The treatment resulted in the plaintiff suffering from paralysis to one side of her body and having severe speech defects.

39 The plaintiff sued the defendant, alleging negligent diagnosis of the tumour, negligent performance of radiosurgery and negligent failure to advise of the inherent risks. The trial judge, preferring the evidence of the radiologist, held that the tumour was in fact a scar. Treating this as a purely factual finding, the judge held that the *Bolam* test was not relevant and that he could make the finding based on his own assessment of the facts and evidence. Having found that the nodule was in fact a scar, the judge then held that the opinion of the defendant's experts failed the logical defensibility test of *Bolitho*, as it would have been wholly irrational to recommend radiosurgery to remove harmless scar tissue. The judge also found that the defendants had been negligent in administering the treatment by using a higher than acceptable dose of

at <http://www.thomasphilip.com.my/data/uploads/pdf/federal_court/leave.pdf> (accessed 2 June 2015).

82 *Jason Carlos Francisco v Dr L M Thng* Suit No 573/1998 (unreported) (6 August 1999); *Denis Matthew Harte v Dr Tan Hun Hoe* Suit No 1691 of 1999 (unreported) (24 November 1999); *Vasuhi d/o Ramasamypillai v Tan Tock Seng Hospital Pte Ltd* [2001] 1 SLR(R) 303; *Yeo Peng Hock Henry v Pai Lily* [2001] 3 SLR(R) 555; *Supuletchimi d/o Rajoogopal v Tay Boon Keng* Suit No 210 of 2000 (unreported) (22 February 2002); *F v Chan Tanny* [2003] 4 SLR(R) 231; *JU v See Tho Kai Yin* [2005] 4 SLR(R) 96; *Surender Singh s/o Jagdish Singh v Li Man Kay* [2010] 1 SLR 428; *D'Conceicao Jeanie Doris v Tong Ming Chuan* [2011] SGHC 193; *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18.

radiation. Finally, the judge found that the defendants had been negligent in failing to advise the plaintiff of the inherent risks in the surgery.

40 The judgment was overturned on appeal with the Court of Appeal delivering a powerful judgment upholding the *Bolam* test and cautioning against judges second-guessing doctors. Yong Pung How CJ did not mince his words when he stated:[62]

[62] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [3].

> In determining whether a doctor has breached the duty of care owed to his patient, a judge will not find him negligent as long as there is a respectable body of medical opinion, logically held, that supports his actions. Beyond this time-honoured test of liability, neither this court nor any other should have any business vindicating or vilifying the acts of medical practitioners. It would be pure humbug for a judge, in the rarified [*sic*] atmosphere of the courtroom and with the benefit of hindsight, to substitute his opinion for that of the doctor in the consultation room or operating chamber. We often enough tell doctors not to play god [*sic*]; it seems only fair that, similarly, judges and lawyers should not play at being doctors.

Referring to *Bolitho*, the court emphasised that *Bolitho* was not intended to dilute the *Bolam* test by allowing judges to choose between conflicting expert testimony. Yong CJ noted that the *Bolitho* test had two parts. The first required the court to be satisfied that the expert had considered the comparative risks and benefits. The second required the court to be satisfied that the expert "had arrived at a 'defensible conclusion' as a result of the balancing process".[63] Here, Yong CJ cautioned that defensibility could not be equated with reasonableness, as that could allow judges, rather than doctors, to decide on medical negligence. Yong CJ clarified that as long as the expert's opinion was internally consistent and did not "fly in the face of proven extrinsic facts relevant to the matter",[64] the judge had no choice but to accept the evidence and find the defendant not negligent.

41 Having read the *Bolam*/*Bolitho* test narrowly, Yong CJ went on to note that while *Bolam* applied to non-medical professionals in the UK, it should not apply to non-medical professionals in Singapore. Referring to cases where courts had found solicitors negligent despite adhering to

commonly accepted practice on the ground that the common practice itself was adjudged to fall below reasonable standards,[65] Yong CJ emphasised that the "willingness of the court to adjudicate over

[63] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [65].

[64] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [3].

[65] *Edward Wong Finance Co Ltd v Johnson Stokes & Master* [1984] AC 296; *Yeo Yoke Mui v Ng Liang Poh* [1999] 2 SLR(R) 701.

differing opinions in other professions should not be transposed to the medical context".[66]

42 Yong CJ then went on to consider whether the *Bolam* test applied to the doctor's duty to advise. The trial judge, relying on Lord Bridge's opinion in *Sidaway*, had taken the view that *Bolam* should not apply to the duty to inform. Yong CJ held that the trial judge's reading of Lord Bridge's opinion:[67]

> … was not an accurate representation of the latter's view in *Sidaway* … nor was its extrapolation at all reflective of the *ratio decidendi* of the majority view of the House of Lords in that case.

Yong CJ then proceeded to analyse *Sidaway* at some length, holding that both Lords Diplock and Templeman had clearly taken the view that *Bolam* applied to the duty to advise.[68]

43 On Lord Bridge's apparent qualification of *Bolam*'s application to the duty to inform, Yong CJ stated as follows:[76]

> He took the view that if a risk was substantial and there was no cogent clinical reason why disclosure should not be made, the judge was at liberty to conclude that no respectable medical expert would have failed to make it. To our minds, Lord Bridge's comment seems very much a forerunner to the more general qualification made by *Bolitho*. At its essence the message is one and the same – even if the doctor's actions were supported by a body of medical opinion, the court would still examine the expert testimony to see if it was founded on a logical basis. Lord Bridge's qualification, in retrospect, seems quite clearly vindicated by and subsumed under the ruling in *Bolitho*.

In light of the recent reappraisal of *Sidaway* in *Montgomery*, it is suggested that the position in Singapore needs to be reconsidered. Lord Bridge's qualification of *Bolam* should not be viewed in the same vein as the logical defensibility test of *Bolitho*. Lord Bridge clearly recognised the significance of the patient's right to information, as evidenced in the

subsequent decisions of *Pearce* and *Chester* reading Lord Bridge's *dictum* as permitting judges to make a decision as to the materiality of a

[66] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [69].

[67] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [134].

[68] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [138].

[76] *Dr Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 at [141].

risk without being constrained by the narrow logical defensibility test of *Bolitho*.[69] While *Gunapathy* technically left open the question whether *Bolam* should apply to the duty to advise, two recent decisions by the High Court have chosen to treat *Gunapathy* as closing the door on this question.[70]

44 The first case is *D'Conceicao Jeanie Doris v Tong Ming Chuan*[93] ("*D'Conceicao*") in which the deceased underwent a coronary artery bypass graft surgery ("CABG") to restore blood supply to his heart. Two months later, the deceased had chest pains and was diagnosed as having suffered a heart attack. Tests showed that two of the grafts from the CABG had occluded. The defendant, a cardiothoracic surgeon, recommended the deceased undergo another CABG ("redo-CABG"). It was undisputed that a redo-CABG so close in time to the first carried additional risks as the heart was still recovering from the first procedure. The redo-CABG was performed and unfortunately the deceased succumbed to complications and died 42 days later.

45 The plaintiff, the deceased's wife, sued the defendant, alleging negligence in recommending the redo-CABG; in failing to advise on the inherent risks of a redo-CABG; and in the actual performance of the redo-CABG. Tay Yong Kwang J, applying *Gunapathy*, found against the plaintiff on all the allegations of negligence. What is significant in this

> I fully appreciate the force of this reasoning, but can only accept it subject to the important qualification that a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice as to whether or not to undergo a particular treatment must primarily be a matter of clinical judgment. It would follow from this that the issue whether nondisclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test. But I do not see that this approach involves the necessity 'to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty'. Of course, if there is a conflict of evidence as to whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict. But even in a case where, as here, no expert witness in the relevant medical

[69] The relevant passage in Lord Bridge's opinion, reproduced in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P 53, is as follows (*Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 900C):

(*cont'd on the next page*)

[70] *D'Conceicao Jeanie Doris v Tong Ming Chuan* [2011] SGHC 193; *Tong Seok May Joanne v Yau Hok Man Gordon* [2013] 2 SLR 18. 93 [2011] SGHC 193.

> field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it. The kind of case I have in mind would be an operation involving a substantial risk of grave adverse consequences, as, for example, the ten per cent risk of a stroke from the operation which was the subject of the Canadian case of *Reibl v Hughes* 114 DLR (3d) 1. In such a case, in the absence of some cogent clinical reason why the patient should not be informed, a doctor, recognising and respecting his patient's right of decision, could hardly fail to appreciate the necessity for an appropriate warning.

case is that the judge squarely addressed the question of whether *Bolam* applied to the duty to advise. The plaintiff argued that the law under *Bolam*, *Sidaway* and *Bolitho*, as applied in *Pearce*, required a doctor to disclose any significant risk that would affect the judgment of a reasonable patient. The plaintiff also referred to the developments in Canada, Australia and Malaysia supporting the rejection of *Bolam* with respect to the duty to advise.[71]

46 Tay J rejected the plaintiff's arguments on three grounds. First, he held that the High Court in *Surender Singh s/o Jagdish Singh v Li Man Kay*[80] had already rejected the comparative jurisprudence, holding itself bound by *Gunapathy*. With respect, as *Gunapathy* did not expressly rule on the point of the application of *Bolam* to the duty to advise, as recognised by Tay J himself,[72] it was in fact open to the High Court to determine the issue for itself. Secondly, Tay J held that *Pearce* and *Sidaway* had not departed from the application of *Bolam* to the duty to advise. This conclusion is now undermined following *Montgomery*, where the Supreme Court held that *Pearce* and *Sidaway* did in fact mark a shift away from *Bolam* with respect to the duty to advise.[73]

47 Thirdly, Tay J rejected the patient autonomy approach in *Chester*, holding that *Chester* was inapplicable to Singapore as it was

[71] The respective leading authorities being *Reibl v Hughes* (1980) 2 SCR 880; *Rogers v Whitaker* (1992) 175 CLR 479; and *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593. [80] [2010] 1 SLR 428.

[72] *D'Conceicao Jeanie Doris v Tong Ming Chuan* [2011] SGHC 193 at [116].

[73] See paras 19–21 above.

likely influenced by the European Convention on Human Rights[74] and the English Human Rights Act 1998.[75] While these instruments may have been part of the background, *Chester* did not refer to them. Instead, the

court in *Chester* justified its rights-based approach purely by reference to the common law, referring in particular to *Pearce* and the Australian decision of *Chappel v Hart*,[76] as well as academic writing. It is also pertinent to note that Lord Scarman's dissent in *Sidaway*, long before the Human Rights Act 1998 was enacted, recognised that the patient's right to know "was a basic right protected by the common law".[77] The absolute rejection of patient autonomy or a rights-based approach in resolving duty to inform cases in Singapore can have serious implications, as seen in the following case.

48 The plaintiff in *Tong Seok May Joanne v Yau Hok Man Gordon*[78] ("*Joanne Tong*"), pregnant with her sixth child, was advised that she needed to have a lower segment caesarean section to deliver her baby safely. The surgery was performed under general anaesthesia administered by the defendant. Following the surgery, the plaintiff suffered neck pain and her condition degenerated over the next three years before she brought the action. She sued the defendant in negligence, alleging failure to obtain her informed consent for the general anaesthetic ("GA") procedure; failure to take proper care when manipulating her neck during the GA procedure; and failure to provide reasonable post-surgery care. The court found against the plaintiff on all the claims, holding that the defendant had not breached his duty of care.

49 Of significance is the analysis of the law on the duty to advise. Referring extensively to *D'Conceicao*, Andrew Ang J affirmed the *Bolam*/*Gunapathy* approach and rejected arguments based on *Pearce* and *Chester*. There were three specific aspects of the failure to advise, relating respectively to: (a) the nature and risks of GA; (b) the specific risk of neck injury; and (c) alternatives to GA. On the first point, Ang J found on the facts that the defendant had advised on the general risks

[74] Convention for the Protection of Human Rights and Fundamental Freedoms (4 November 1950; entry into force 3 September 1953) (Eur TS No 5; 213 UNTS 221; 1953 UKTS No 71).

[75] c 42.

[76] (1998) 195 CLR 232.

[77] *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 882.

[78] [2012] SGHC 252.

of GA. On the second, Ang J accepted that the defendant had not advised on the specific risk of neck injury, but accepted that the neck injury was such an uncommon risk that disclosure was unnecessary both under the *Gunapathy* test (which applied) and even under the *Pearce* test (which did not apply).

50 The third aspect of the duty to advise raises an important question as to whether the duty to advise of risks includes a duty to advise of alternative options. *Montgomery* has now answered this

question in the affirmative.[79] In *Joanne Tong*, the two alternatives with respect to anaesthesia were GA and regional anaesthesia ("RA"). The defendant had opted for GA because in his opinion the patient's prior history made GA a safer option. Therefore, he did not discuss the alternative of RA with the patient,[80] even though it was a viable option that would have not carried the risk of neck injury. The plaintiff's expert said that he would have discussed the alternative option with the plaintiff, but the defendant's expert said that he would not. As the defendant's expert's evidence met the *Bolitho*/*Gunapathy* threshold of logic, Ang J held that the defendant could not be found negligent.

51 However, surely information about two viable modes of anaesthesia does not require medical judgment; they are simply different forms of anaesthetic procedures, each carrying different risks and benefits which the plaintiff should have been entitled to consider before making her decision. To defer to medical opinion on such matters is to deny patient autonomy at the most fundamental level. The resistance to patient autonomy and rights in medical negligence cases is not in line with the progressive approach to patient autonomy championed by the medical profession itself, whose Ethical Code and Ethical Guidelines explicitly refers to the patient's right "to information and self-determination".[81] Nor is this in line with Singapore's liberal approach to abortion and end of life matters. Indeed, the Advance Medical Directive Act[91] implicitly recognises the patient's right to make informed decisions:

> **Patient's rights to make informed decisions on his treatment not affected**

[79] *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 at [87].

[80] There was some confusion as to whether the obstetrician had discussed the alternatives with the plaintiff, but that was irrelevant to the outcome.

[81] Singapore Medical Council, Ethical Code and Ethical Guidelines (2002) at para 4.2.4.

[91] Cap 4A, 1997 Rev Ed.

> 12—(1) Section 3 or 10 shall not derogate from any duty of a medical practitioner to inform a patient who is conscious and capable of exercising a rational judgment of all the various forms of treatment that may be available in his particular case so that the patient may make an informed judgment as to whether a particular form of treatment should, or should not, be undertaken.

Perhaps the ideals in the guidelines and statutes do not match practice. A survey of doctors in Singapore found that a significant number of doctors, while acknowledging that patients today are well informed, nevertheless did not believe that patients were capable of making

rational decisions.[82] Based on the responses, the authors of the survey noted that even though doctors claimed to disclose major risks, they may be "paternalistically withholding risk information that they do not consider 'major' even when patients would have considered such information significant for their decision making".[83] Unlike the UK Supreme Court in *Montgomery* which has challenged such a culture, courts in Singapore have chosen not to do so. Indeed, they reflect the prevailing culture, as seen in this observation in *Joanne Tong*:[109]

> That said, it bears emphasising that there must still be a balance between ensuring the disclosure of every conceivable risk, the constraints of time, as well as *the possibility of frightening the patient and inadvertently causing her to come to an unbalanced decision*. [emphasis added]

The *dictum* in *Gunapathy*, noting the difficulties judges face in understanding and making judgments on medical matters, has resulted in a complete hands-off approach. Yet, judges routinely hear and evaluate medical evidence in a plethora of cases and are no less competent in assessing such evidence as they are in assessing other complex expert evidence. It is not disputed, for the reasons set out at the beginning of this paper, that courts should be circumspect when judging doctors sued for negligence. However, the fear of "judges playing doctors" is not a valid reason. The *Gunapathy* approach needs to be reviewed, at least with respect to the duty to inform.

[82] David Chan & Lee Gan Goh, "The Doctor-patient Relationship: A Survey of Attitudes and Practices of Doctors in Singapore" (2000) 14 *Bioethics* 58 at 69.

[83] David Chan & Lee Gan Goh, "The Doctor-patient Relationship: A Survey of Attitudes and Practices of Doctors in Singapore" (2000) 14 *Bioethics* 58 at 70. 109 *Tong Seok May Joanne v Yau Hok Man Gordon* [2012] SGHC 252 at [76].

52 While *Montgomery* has not been considered in Singapore, it has been referred to in a recent medical negligence case where the court left the question open.[84] It bears noting that *Gunapathy* was decided in the wake of the 2001 global health insurance crisis, which may have influenced the court to keep a tight rein on medical liability. Times have changed, and it may now be opportune for the Court of Appeal to reconsider the general principles of medical negligence to bring the law in Singapore in line with contemporary and international standards, as it has recently done in other areas.

53 Singapore's jurisprudence on professional negligence has shown progressive development in the areas of auditor's liability,[85] employer's liability[86] and occupier's liability.[87] The Court of Appeal has emphasised the importance of protecting the vulnerable and developing a framework of negligence law that is based on universal principles rather than pockets of rules. It also recognised the need for legal standards to keep up with scientific knowledge and evolving community expectations.[88] Despite *dicta* in *Gunapathy* that the *Bolam*/*Bolitho* test should not apply to non-medical professionals in Singapore, the Court of Appeal in *JSI Shipping (S) Pte Ltd v Teofoongwonglcloong*[115] ("*JSI*") did apply it. Following a detailed discussion of *Gunapathy* and the *Bolam*/*Bolitho* test of professional negligence, V K Rajah JA stated:[89]

> That said, we are disposed to find that the diametrically opposed reports do, in the ultimate analysis, represent defensible differences of opinion that satisfy the threshold test of logic imposed by the *Bolitho* addendum, as they are largely internally consistent and do not fly in the face of facts relevant to the matter. Bearing in mind the caution expressed in *Gunapathy* ([49] *supra*) at [65], we must reiterate that the review of expert evidence pursuant to the *Bolitho* addendum should not 'unwittingly herald invasive inquiry into the merits of

[84] *Chua Thong Jiang Andrew v Yue Wai Mun* [2015] SGHC 119 at [36]–[37].

[85] *JSI Shipping (S) Pte Ltd v Teofoongwonglcloong* [2007] 4 SLR(R) 460.

[86] *Chandran a/l Subbiah v Dockers Marine Pte Ltd* [2010] 1 SLR 786.

[87] See *Toh Siew Kee v Ho Ah Lam Ferrocement (Pte) Ltd* [2013] 3 SLR 284. Coincidentally, the judgments in these three cases were given by V K Rajah JA.

[88] See, for example, V K Rajah JA's observation in *Chandran a/l Subbiah v Dockers Marine Pte Ltd* [2010] 1 SLR 786 at [16] that legal standards must evolve:

> … in the light of the prevailing regulatory framework, current work safety attitudes, and advances in knowledge and improvements in technology as well as community expectations. 115 [2007] 4 SLR(R) 460.

[89] *JSI Shipping (S) Pte Ltd v Teofoongwonglcloong* [2007] 4 SLR(R) 460 at [64].

> [audit] opinion'. The spotlight will now turn to these differences of opinion.

V K Rajah JA then proceeded to examine the differences of opinion before concluding that the respondent auditor had indeed fallen below the requisite standard of care. *JSI* is a valuable precedent reiterating the fact that ultimately it is the judge's responsibility to decide on what constitutes reasonable care in any given case, and that that responsibility cannot be delegated to the profession.[90] This resonates with the approach to medical negligence in *Rogers*, and is an excellent local illustration of the common law adjudication model. The irrational fear that a rejection of *Bolam* will result in doctors being held liable for medical negligence in unmeritorious claims should not prevent the law from developing along a natural and logical trajectory mirroring scientific progress and community expectations.[91]

## V. Conclusion

54 *Montgomery* provides sound legal and normative reasons for the Singapore Court of Appeal to reconsider the application of *Bolam* to the duty to inform. However, instead of the patient's rights model which was central to *Montgomery*, the better model for Singapore would be the common law adjudication model. The pitfall of the patient's rights model is that it makes patient autonomy the endgame, which, for reasons alluded to in this paper, is not appropriate for the tort of negligence. The common law adjudication model treats patient autonomy not as the endgame, but as a cardinal element that gives content to the duty to inform. It restores the judicial function in medical

[90] *JSI Shipping (S) Pte Ltd v Teofoongwonglcloong* [2007] 4 SLR(R) 460 at [51].

[91] Anecdotally, the jurisprudence in Malaysia after *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593 rejected the *Bolam* test shows that doctors were found not negligent in the majority of the cases applying *Rogers v Whitaker* (1992) 175 CLR 479. The first case applying *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 in the UK resulted in the court finding in favour of the doctor: *Mrs A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038.

negligence cases while ensuring that patient autonomy is given due regard.

55 Refining the *Bolam*/*Gunapathy* test does not mean that judges will routinely ignore medical expert opinion or demand unreasonable standards from doctors. As Gleeson CJ of the Australian High Court noted, while applying *Rogers*: "In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act."[92] *JSI*, applying *Gunapathy* to auditors, should apply in equal fashion to doctors. Judges should be the ultimate arbiters of negligence, and it is not beyond them to apply the law fairly and in a manner sensitive to the unique features of medical practice and the doctor-patient relationship.

[92] *Rosenberg v Percival* (2002) 205 CLR 434 at 439.