

Abandoning the *Bolam* Principle in Doctor's Duty to Disclose Risks in Malaysia: Are We Heading in the Right Direction?

Puteri Nemie bt Jahn Kassim*

Introduction

The recent Federal Court ruling in *Foo Fio Na v Dr Soo Fook Mun & Anor*¹ abandoned the *Bolam* principle in relation to the doctor's duty to disclose risks in medical treatment. This will strike, and perhaps has struck fear into many medical hearts of potentially escalating medical negligence cases. Since its introduction nearly 50 years ago, the *Bolam* principle had undergone various phases of recognition,² condemnation³ and re-interpretation.⁴ For the medical profession, the *Bolam* principle is no more than simple justice that they, like other professionals, must be judged by their own peers. For the patients, the *Bolam* principle hinders them from getting justice and fair trial. For the courts, abandoning the *Bolam* principle fulfils the community's expectations and indicates that infallibility of medical judgment is a thing of the past.

The *Bolam* principle revisited

When McNair J delivered his judgment in *Bolam v Friern Hospital Management Committee*,⁵ little did he know that part of his judgment would become an integral part of the medical litigation revolution. In his judgment, McNair J formulated a test, later known as the *Bolam* principle or the *Bolam* test, to determine whether the doctor's act falls below the required standard of care:

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art ... in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time ... I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in

1 * Associate Professor, Ahmad Ibrahim Kulliyah of Laws, International Islamic University Malaysia. The author would like to thank Mr PS Ranjan of Messrs PS Ranjan & Co for his generosity, which has motivated the author to write this article. [2007] 1 AMR 621; [2007] 1 MLJ 593.

2 The principle has not only been applied to determine the standard of care in cases of medical negligence but to most cases of professional negligence.

3 The principle has been criticised as being over protective of the medical profession and leaving the standard of care of doctors to medical judgment.

4 The English courts through cases such as *Bolitho v City & Hackney Health Authority* [1997] 4 All ER 771 and *Penny, Palmer and Cannon v East Kent Health Authority* [2000] Lloyd's Rep Med 41, tried to restore the principle to its proper limits and correct the misinterpretation of what was originally intended by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

5 [1957] 1 WLR 582.

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 man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.⁶

This test has been interpreted to mean that a doctor is not negligent if he has acted in accordance with a practice accepted as proper by a body of medical men who possess similar skills. It is immaterial that there exists another body of opinion that would not have adopted the approach taken by the said doctor. As long as there exists a “responsible body of medical opinion” that approves the actions of the doctor, the doctor escapes liability. In other words, the test allows doctors to escape liability by calling experts to testify that the procedure adopted was consistent with practices accepted by a responsible body of medical opinion. Such interpretation of the *Bolam* principle has been re-asserted frequently in determining doctor’s standard of care in medical negligence litigation.⁷

However, little attention was paid to the qualification made by McNair J to the *Bolam* principle when he further added, “At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion.”⁸ McNair J is impliedly suggesting that medical expert evidence that does not really stand up to analysis should be rejected.

Reinterpretation of the *Bolam* principle: *Bolitho v City & Hackney Health Authority*

With the unsatisfactory development of the *Bolam* principle in medical negligence litigation,⁹ the principle was put to rigorous scrutiny in *Bolitho v City & Hackney Health Authority*.¹⁰ Lord Browne-Wilkinson, delivering the judgment in the House of Lords, held that the court is not bound to let a defendant doctor escape liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant’s treatment and diagnosis accorded with sound medical practice. His Lordship held that the word “responsible” used by McNair J in *Bolam* “show[s] that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis.”¹¹ Mere proof that the defendant’s action was supported by expert medical opinion does not automatically exculpate him. The expert medical opinion must have a sufficient logical basis. Lord Browne-Wilkinson then went on to explain that before a judge can accept a body of opinion as being “responsible”, the judge must be satisfied that “... in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a

6 Ibid, at 586-587.

7 See Howie, RBM, “The Standard of Care in Medical Negligence” (1983) Juridical Review 193 and Davies, M, “The New *Bolam*: Another False Dawn for Medical Negligence?” (1996) 12 Professional Negligence 120.

8 [1957] 1 WLR 582 at 587.

9 The judgment of Sachs LJ in the case of *Hucks v Cole* [1993] 4 Med LR 393 very much influenced the change in the English judiciary’s attitude towards delegating the determination of doctor’s liability to the medical profession. *Hucks*’s pragmatic approach held it appropriate for the judge to reject medical expert evidence which does not stand up to analysis.

10 [1997] 4 All ER 771.

11 Ibid, at 778.

defensible conclusion on the matter.”¹² A “responsible” view presupposes that the experts in forming their opinions have weighed the relative risks and benefits. His Lordship further held that “if it can be demonstrated that the expert medical opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not responsible.”¹³ Thus, even though there exists a body of professional opinion sanctioning the defendant’s conduct, the defendant can still be held negligent if the judge is not satisfied that the opinion is reasonable or responsible.

The House of Lords’ decision in *Bolitho* removes the usual “rubber-stamping” of expert medical opinion. Expert opinion now must withstand rigorous scrutiny from the judiciary. Previously, the well-established *Bolam* principle had not given much scope for judicial intervention and had ensured that medical treatment that accorded with a body of professional opinion was not negligent. Presumably, *Bolitho* curbs the power delegated to the medical profession by *Bolam* as there is now no guarantee that expert medical evidence will be accepted. However, before *Bolitho*, the reason for judges not to question the views of the medical profession was due to their insufficient medical knowledge. *Bolitho* has still not changed that position and made them more knowledgeable in medical matters. The decision only allows them to scrutinise medical opinions. To decide whether the expert medical opinion withstands logical analysis, judges have to rely on some evidence. This evidence must be of the same standard or better than the opinion under scrutiny. But where would this evidence come from? From the judge’s own thoughts or independent advisors? How do judges question expert medical opinion when they are experts in law and not in medical science? Even Lord Browne-Wilkinson in *Bolitho* acknowledged that it would be a “rare” or “exceptional” case where judicial intervention will be justified. His Lordship aptly said:

... it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence.¹⁴

Burying *Bolam* down under

The *Bolam* principle is no longer part of Australian law.¹⁵ The Australian judiciary has been quite determined in ensuring that expert evidence is subject to close judicial scrutiny as stated by King CJ in *F v R*¹⁶ that:

... professions may adopt unreasonable practices ... The court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law ... The ultimate question, however, is not whether the defendant’s conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of care demanded by the law. That

12 Ibid.

13 Ibid, at 779.

14 Ibid.

15 Several states in Australia such as New South Wales, Queensland, South and Western Australia have re-introduced the substance of the *Bolam* principle, albeit in a modified form through legislation.

16 (1982) 33 SASR 189 (SC of South Australia).

is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.¹⁷

This view was approved by the High Court of Australia in *Rogers v Whitaker*,¹⁸ which held that the amount of information to be imparted by a doctor cannot be determined by “any profession or group in the community”¹⁹ but upon consideration of complex factors, namely, “the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances.”²⁰ Opinions of medical witnesses should not be decisive. One consequence of the *Bolam* principle is that, “even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion.”²¹ Thus, if the medical profession has already determined what risks should or should not be disclosed to the patient, it would be futile for the patient to ask questions about them. Clearly, the *Bolam* principle pays insufficient regard to questioning by the patient. The High Court further opined that the provision of information merely involves communication skills, which are not exclusive to medical practitioners and therefore, can be judged by non-medical people. The rationale behind the *Bolam* principle that expert matters can only be judged by expert opinion cannot be used to justify its application to determine doctors’ duty to disclose. In such context, the *Bolam* principle serves only to endorse poor communication between doctor and patient and to deprive patients of their ability to make meaningful choices about their treatment. In exceptional cases where the patient seems “unusually nervous, disturbed or volatile”,²² the doctor may exercise clinical judgment on whether to disclose. A doctor does not need special skill to disclose the risks but rather, communicating skill, to enable the patient to apprehend his situation. Information must be given to the patient in a way that it can be digested rationally. The High Court concluded that, with regard to negligence, the scope of a doctor’s duty of disclosure is:

... to warn a patient of a *material risk* inherent in the proposed treatment; a risk is material if, in the circumstances of a particular case, a *reasonable person* in the patient’s position, if warned of the risk, would be *likely to attach significance* to it or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it. This is subject to therapeutic privilege.²³

The decision in *Rogers* emphasises that patients are entitled to make their own decisions about medical procedures and to be given sufficient information to make an informed choice. It is then for the courts,

17 Ibid, at 194.

18 [1993] 4 Med LR 79; (1992) 175 CLR 479.

19 (1982) 33 SASR 189 at 194.

20 Ibid, at 192-193.

21 (1992) 175 CLR 479 at 486-487.

22 Ibid, at 490.

23 (1992) 175 CLR 479 at 490.

having regard to the “paramount consideration” that a person is entitled to make decisions about his own life, to set the appropriate standard of care. This point is the most significant aspect of the case, rendering the standard of care a matter of judicial, not medical opinion.

Rogers merely buried the *Bolam* principle in the realm of doctor’s disclosure of risks. The decision of the Australian High Court in *Naxakis v Western General Hospital*²⁴ rejected the *Bolam* principle in all aspects of medical treatment, including the duty to treat and diagnose. In *Naxakis*, Kirby J and McHugh J opined that it is left to the jury to accept expert opinion of a fellow medical practitioner. Expert opinion of fellow practitioners should not be determinative on the issue of whether or not the defendant is negligent as such evidence may stem “from professional courtesy or collegial sympathy”²⁵ for the defendant. Kirby J reiterated the principle decided in *Rogers* where the court pointed out that the standard of care owed by persons possessing special skills 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.”²⁶ Instead, evidence of acceptable medical practice will only serve as a useful guide for the courts in adjudicating on the appropriate standard of care.

Departing from *Bolam*’s progeny, *Sidaway*: the case of *Chester v Afshar*

The case of *Sidaway v Board Governors of Bethlem Royal Hospital and the Maudsley Hospital*²⁷ staunchly supports the *Bolam* principle, emphasising judicial deference to medical opinion. *Sidaway* rejected the “North American doctrine of informed consent”,²⁸ which is the “the prudent patient” test adopted in *Rogers*. Accordingly, “the law imposes the duty of care; but the standard of care is a matter of medical judgment.”²⁹ However, the ruling by the House of Lords in *Chester v Afshar*³⁰ marked a departure from the strict line followed by *Sidaway* in applying the *Bolam* principle to information disclosure. The case of *Chester v Afshar* involved complex issues of causation in finding the causal link between the breach of duty and the damage caused. The surgical operation was conducted with care and skill and the resultant damage was not due to the doctor’s breach of duty in handling the operation. Instead, the claim was that the doctor breached his duty in failing to warn the patient of the risks, which if properly warned, would have caused her to delay the treatment offered until she received a second or third opinion,³¹ and thus would not have suffered the damage as yet. Relying on Lord Woolf’s observations in the case of *Pearce v*

24 (1999) 73 ALJR 782.

25 *Ibid*, at 797.

26 *Ibid*, at 798, citing *Rogers* at 487.

27 [1985] 1 AC 871; [1985] 2 WLR 480; [1985] 1 All ER 643.

28 Informed consent took a major turnabout in the United States with the introduction of the reasonable prudent patient test in *Canterbury v Spence* 464 F 2d 772 (DC Cir 1972). This test was instrumental in shaping the decision of *Rogers*.

29 [1985] 1 All ER 643 at 649.

30 [2004] UKHL 41; [2005] 1 AC 134; [2004] 4 All ER 587; [2004] 3 WLR 927.

31 See Puteri Nemie, JK, “*Chester v Afshar*: Loosening the Grip on Proving Causation for Failure to Disclose Risks in Medical Treatment” [2004] 5 CLJ i-viii.

*United Bristol Healthcare NHS Trust*³² that “if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk”,³³ Lord Steyn held that:

A surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure. The only qualification is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning. This is, however, irrelevant in the present case. In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.³⁴

His Lordship went on further to state that:

[The] patient’s right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible.

The decision in *Chester* was heavily influenced by the case of *Chappel v Hart*, which was a progeny of *Rogers*. This shows a remarkable departure from the paternalistic and doctor-protective attitudes displayed by the House of Lords in *Sidaway*.

Development of the *Bolam* principle in Malaysia

The *Bolam* principle has been routinely applied by the Malaysian courts³⁵ in determining the doctor’s standard of care. Amongst the earliest Malaysian cases where the *Bolam* principle was applied is *Swamy v Mathews*.³⁶ Different opinions were presented to the court as to the supposed proper treatment and the procedure in giving the treatment to the plaintiff. The majority judgment accepted the testimony of the defendant doctor and his explanation that the prescription and dosage given to the plaintiff, although at variance with the manufacturer’s recommendation, was made based on his personal experience. The emphasis in the majority judgment in discounting the contrary evidence is the classic doctor-centric approach. The court did not examine the reasonableness of the treatment. The court found the medical practitioner not negligent because medical practitioners need not have the highest degree of skill. Ismail Khan J cited *Roe v Minister of Health*³⁷ stating:

But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own

32 (1998) 48 BMLR 118.

33 Ibid, at 124.

34 [2004] 4 All ER 587 at para 16.

35 E.g., *Swamy v Mathews* [1967] 1 MLJ 142; *Mariah bte Mohamad (Administratrix of the estate of Wan Salleh bin Wan Ibrahim, deceased) v Abdullah bin Daud (Dr Lim Kok Eng & Anor, Third Parties)* [1990] 1 MLJ 240; *Inderjeet Singh a/l Piara Singh v Mazlan bin Jasman & Prs* [1995] 3 AMR 2201; [1995] 2 MLJ 646; *Asiah bte Kamsah v Dr Rajinder Singh & Ors* [2002] 1 MLJ 484; *Hor Sai Hong & Anor v University Hospital & Anor* [2002] 5 MLJ 167.

36 [1968] 1 MLJ 138.

37 [1954] 2 WLR 915.

safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.

The Privy Council soon after that applied the *Bolam* principle in *Chin Keow v Government of Malaysia*.³⁸ The trial judge, Ong J, adopted the *Bolam* test of negligence and found the doctor to be negligent for prescribing a penicillin injection as a routine treatment for the patient and that he did so without asking one single perfunctory question to attempt to discover whether she was sensitive to the drug. Such is not considered a practice accepted as proper by a responsible body of medical opinion. The Federal Court, however, rejected Ong J's finding of negligence but on further appeal, the Privy Council adopted Ong J's decision.

In *Elizabeth Choo v Government of Malaysia*,³⁹ several medical experts gave conflicting opinions on whether it was proper for the anaesthetist to perform a sigmoidoscopic examination under general anaesthesia. One expert had expressed the view that it was better to perform sigmoidoscopy without anaesthesia so that the patient could inform the anaesthetist of any pain. The court however, observed that the anaesthetist had previously successfully performed hundreds of sigmoidoscopic examinations under general anaesthesia. This technique was in vogue in his unit since 1956 and had generally not earned the condemnation of medical opinion.⁴⁰ Applying the *Bolam* principle, the court held that the anaesthetist was not negligent as he had followed the general and approved practice. The technique that he adopted was approved by a responsible body of medical men since 1956. It did not matter if there is another body of opinion that would have taken a contrary view. Raja Azlan Shah stated:

The anaesthetist had done hundreds of endoscopic examinations including sigmoidoscopy ... and had encountered no trouble except this particular mishap ... There is evidence that the greatest care is required to ensure free passage when the instrument is introduced in the rectum and the procedure required a high degree of concentration. The anaesthetist said he exercised all care and caution he possessed at the time ... at no time did he lift his sight from the mirror.⁴¹

The judicial decision in *Elizabeth Choo* was further approved in *Kow Nan Seng v Nagamah & Ors*.⁴² There were conflicting opinions on whether a complete plaster cast or a plaster slab was to be used. Again, applying the *Bolam* principle, the court held that there may be differences of opinion as to the types of plaster casts to be applied but this did not mean that choosing a type of plaster cast was in itself negligence. To be negligent, the doctor must have departed from the reasonable standard of care and skill of an ordinary competent doctor.

38 [1967] 2 MLJ 45.

39 [1970] 2 MLJ 171.

40 Ibid, at 172.

41 Ibid, at 173.

42 [1982] 1 MLJ 128.

In *Liew Sin Kiong v Dr Sharon M Paulraj*,⁴³ Ian Chin J applied *Sidaway*, which endorses the *Bolam* principle⁴⁴ and found the defendant not liable as the plaintiff had failed to prove that the defendant had not acted in accordance with the standards of a competent ophthalmologist. The learned judge said that although the consent form did not state that the defendant had informed the plaintiff of the risk of infection, it did not mean that the risk was not explained. Further, the court held that if a doctor was of the view that a patient was in need of an operation then such benefit outweighed a remote risk as the doctor should be allowed the “therapeutic privilege” in deciding whether or not to disclose the risk. It should be noted that although Ian Chin J did not follow *Rogers*, he commented that:

The issue here is not what risks are material for disclosure and therefore it does not call for my decision as to whether to follow *Sidaway* or *Rogers* regarding deferring to medical expert evidence.⁴⁵

However, in 1996, the case of *Hong Chuan Lay v Dr Eddie Soo Fook Mun*⁴⁶ shows the court preferring the Australian decision in *Rogers* and abandoning the *Bolam* test. James Foong J stated that:

For some time, the *Bolam* test i.e., the test expounded by McNair J in *Bolam v Friern Hospital Committee* (supra) was accepted to be applicable to all provisions of a doctor’s duty to his patient. But by a series of cases in the United States of America, Canada and Australia, the *Bolam* test is rejected as regards to the doctor’s duty to disclose information and advice to the patient. In order to explain the arguments against it, and the new test proposed as its substitution, I shall follow the approach adopted by the justices in the High Court of Australia in their judgment of *Christopher Rogers v Maree Lynette Whitaker* (supra). I must proclaim my highest respect to the honourable justices of this Australian High Court for their clarity, conciseness and comprehensibility in explaining the distinction of the *Bolam* test from the new approach.⁴⁷

The rejection of the *Bolam* principle became apparent in *Kamalam a/p Raman & Ors v Eastern Plantation Agency & Anor*.⁴⁸ In *Kamalam*, the defendant doctor failed to diagnose the plaintiff’s ailment, which turned out to be a stroke, thereby causing his death. The court found the doctor had fallen below the standard of care required of him. The court chose to accept the opinion of experts called by the plaintiff who considered that the defendant should have referred the deceased to a hospital because he had manifested symptoms of an impending stroke. The judge did not regard himself bound to find medical practitioners not negligent when there is a body of medical opinion that approved the doctor’s practice. Richard Talalla J stated:

... while due regard will be had to the evidence of medical experts, I do not accept myself as being restricted by the establishment in evidence of a practice accepted as proper by a responsible body of

43 [1996] 2 AMR 1403.

44 Ibid, at 1418-1419.

45 Ibid, at 1420.

46 [1998] 3 AMR 2301; [1998] 5 CLJ 251.

47 Ibid, at 2321 (AMR); 267-268 (CLJ).

48 [1996] 4 MLJ 674.

medical men skilled in that particular art to finding a doctor is not guilty of negligence if he had acted in accordance with that practice. *In short I am not bound by the Bolam principle.*⁴⁹ (Emphasis added).

Further, in *Foo Fio Na v Hospital Assunta & Anor*,⁵⁰ the plaintiff, who suffered total paralysis of the upper and lower limbs, claimed that the defendant failed to inform her of the risk of paralysis inherent in a spinal cord operation. In dealing with this issue, Mokhtar Sidin JCA applied the principles in *Rogers* and considered the risk of paralysis a *material* risk of which the plaintiff should have been warned. According to the evidence, the plaintiff did not know that she consented to a spinal cord operation and was not told it would be a major one, which might lead to paralysis. She was assured by the defendant that the operation was a minor one. The judge commented:

The question of giving proper warning was further emphasised in the Australian case of *Rogers v Whitaker* ... It is clear from the ... principle [in that case] that the court itself has to decide on the doctor's negligence after weighing the standard of skill practised by the relevant profession or trade and also the fact that a person is entitled to make his own decision on his life.⁵¹

However, the judgment by Gopal Sri Ram JCA in *Dr Soo Fook Mun v Foo Fio Na & Anor (and Another Appeal)*⁵² indicates the reluctance of the court in following the developments in Australia and departing from the routine application of the *Bolam* principle. In *Dr Soo*, the judge stated that "the *Bolam* test places a fairly high threshold for a plaintiff to cross in an action for medical negligence ... [and] [i]f the law played too interventionist a role in the field of medical negligence, it will lead to the practice of defensive medicine [and] [t]he cost of medical care for the man on the street would become prohibitive without being necessarily beneficial." Further, his Lordship was of the opinion that allowing doctors to be judged by their own peers would "maintain a fair balance between law and medicine".⁵³

***Bolam* principle in the Federal Court**

In *Foo Fio Na v Dr Soo Fook Mun & Anor*,⁵⁴ Miss Foo Fio Na has made an application for leave to appeal to Federal Court against the decision of the Court of Appeal in *Dr Soo Fook Mun v Foo Fio Na & Anor*.⁵⁵ The main question for which leave was sought was whether the *Bolam* principle in the area of medical negligence should apply in relation to all aspects of medical negligence. The Federal Court held that the question posed and the decision to be made would be to public advantage. In this regard, the Federal

49 Ibid, at 691.

50 [1999] 4 AMR 4494; [1999] 6 MLJ 738.

51 Ibid, at 4523 (AMR); 765 (MLJ).

52 [2001] 2 AMR 2205; [2001] 2 CLJ 457. In this Court of Appeal case, Gopal Sri Ram JCA overruled the decision in the High Court case, *Foo Fio Na v Hospital Assunta & Anor* [1999] 4 AMR 4494; [1999] 6 MLJ 738, by allowing Dr Soo's appeals.

53 Ibid, at 2220 (AMR); 472 (CLJ).

54 [2002] 2 AMR 1524; [2002] 2 MLJ 129.

55 [2001] 2 AMR 2205; [2001] 2 CLJ 457.

Court found it necessary to reconsider whether the *Bolam* principle should apply to all aspects of medical negligence, particularly, in determining the standard of care of medical practitioners in providing advice to patients on the inherent or material risks of the proposed treatment. After four years and seven months, the Federal Court made the long awaited decision that the *Bolam* principle is no longer to be applied to doctor's duty to disclose risks. The test enunciated in *Rogers* would be "a more appropriate and a viable test of this millennium."⁵⁶ The court opined that "the *Bolam* test[/principle] 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. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment."⁵⁷ The court was of the view that "there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations."⁵⁸ The decision of the Federal Court has obviously set a potentially onerous obligation on the medical practitioners, but is nevertheless one which the law considers necessary.

Conclusion

Patient autonomy triumphing over medical paternalism: boon or bane?

It is undeniable that the *Bolam* principle has acted as a gatekeeper to the number of claims against medical practitioners. This has always been seen as necessary to protect the society from unwanted effects of defensive medicine.⁵⁹ The threat of litigation will increase a doctor's malpractice premiums, driving doctors away from high-risk specialties. However, one of the most important ironies of modern health care is that public expectations are rising faster than the ability of health services to meet them. Patients nowadays no longer want to be treated as passive recipients of medical care. They want to be treated as co-producers or partners able to manage their illnesses. A patient's right of self-determination deems the paternalistic approach in the *Bolam* principle outmoded and inappropriate. As reiterated by the Honourable Mr Justice Michael Kirby⁶⁰ that, "... the days of paternalistic medicine are numbered. The

56 [2007] 1 AMR 621, at para 80; [2007] 1 MLJ 593, at para 69.

57 Ibid, at para 40 (AMR); para 36 (MLJ).

58 Ibid, at para 80 (AMR); para 69 (MLJ).

59 Defensive medicine can be positive as well as negative. Positive defensive medicine involves undertaking extra procedures to eliminate any risk inherent in a treatment. For instance, the doctor may subject the patient to additional tests, which in his professional judgment are clinically unnecessary but will ensure that nothing goes wrong. Negative defensive medicine, on the other hand, deprives the patient of treatments that are beneficial to his health as there are some risks attached to the treatment.

60 President of the New South Wales Court of Appeal.

days of unquestioning trust of the patient also appear numbered. The days of complete consent to anything a doctor cared to do appear numbered. Nowadays, doctors out of respect for themselves and their patients must increasingly face the obligation of securing informed consent from the patient for the kind of therapeutic treatment proposed ...". Abandoning the *Bolam* principle may cause medical professionals to tremble, fearing for their professional integrity and independence, but it is a development that will occur sooner or later with increasing public awareness and growth of consumerist attitudes to the provision of medical services. Medical litigation and demands for medical accountability are the trend that will not fade away. Thus, the medical profession needs to change their mindset and be prepared to accept patients as partners and co-producers in decision-making.

A Word of Thanks

On behalf of the Penang Medical Practitioners Society, I wish to take this opportunity to thank the author, Puteri Nemie Bt Jahn Kassim and the Publisher, Sweet & Maxwell Asia of The Thomson Corporation (Malaysia) Sdn. Bhd. for granting PMPS the permission to publish this article, "***Abandoning the Bolam Principle in Doctor's duty to disclose Risk in Malaysia...***" in the Newsletter. Puteri Nemie Bt Jahn Kassim is the Associate Professor, Ahmad Ibrahim Kulliyah of Laws at the International Islamic University of Malaysia. This article highlights the significance of the duty of the doctor to inform and disclose inherent risk of treatment to the patient.

Dr. Patrick Tan,
The Editor.