MEDICAL NEGLIGENCE LITIGATION IN MALAYSIA: CURRENT TREND AND PROPOSALS FOR REFORM

By

Dr Puteri Nemie bt. Jahn Kassim
Associate Professor
Ahmad Ibrahim Kulliyyah of Laws
International Islamic University Malaysia

Tel: 03-61964229
Fax: 03-61964854
Email: puterinemie@hotmail.com / nemie@iiu.edu.my
Address: Ahmad Ibrahim Kulliyyah of Laws, International Islamic University Malaysia, PO Box 10, 50728, Kuala Lumpur.

1.0 Introduction

Litigation has never been a haven for neither the doctor nor the patient. Although at present, Malaysia is not experiencing the kind of "malpractice crisis"[1] as in the United States[2], Australia[3] and the United Kingdom[4], there is certainly a rise in the number of negligence claims and the size of awards.[5] These factors are sufficient to cause alarm for future implications and generate serious thoughts for reform of the present system. Rising number of medical negligence claims is not considered healthy for a country as it leads to a

[1] A country is said to be experiencing "malpractice crisis" if the number of malpractice cases has risen dramatically in the last 10 to 15 years in terms of medical malpractice suits by the patients. Other symptoms include dramatic rise in medical malpractice insurance premiums, rise in the amount of courts' awards and settlements whether for economic or non-economic damages and greater availability of punitive damages.
[2] Total payments for physicians' malpractice claims in the United States, more than doubled between 1991 to 2003, rising from US$2.12 billion in 1991 to US$4.45 billion in 2003.
[3] In 2002, the main insurer for medical practitioners in Australia, United Medical Protection, collapsed under debts of over AUD$ 1 billion.
[4] In the year 2001, the cost of claims against the National Health Service as estimated at nearly 4 billion pound sterling.
[5] In the year 2000, the amount of compensation paid by the Malaysian government to medico-legal cases was RM219,508 whereas in the year 2001 was RM 430,502, whereas in 2002 was RM951,889. (Source: Medical Practice Division, Ministry of Health Malaysia)

reduction in the amount of money available for patient care. A single large award can distort the amount government or private hospitals can use to enhance healthcare.

2.0 The Tort System

Presently, the tort system is used to regulate medical negligence litigation in Malaysia. Generally, this system provides for compensation only when a doctor or any other medical personnel assisting in the treatment of a patient is negligent. The heart of negligence is the element of fault. However, it can be seen that fault is not a satisfactory criterion for liability due to difficulties of adjudicating on it. Litigation demanding proof of fault is notoriously protracted and complex, particularly, where the behaviour being challenged is that of a professional. Fault-based analysis is not and never was designed to cover the more common cause of personal injury namely accident. The rationale for fault-based analysis that a person that causes harm should pay for its consequences is a myth as personal attribution of fault has little relevance to contemporary life. Most professionals and companies are adequately covered by insurance type schemes and not personally made to pay more than the monthly or annual subscription to them. Award of compensation is to put the person back into the situation he or she would have been but for the fault. However, this would again be unlikely since the compensation awarded is inevitably financial.

3.0 Problems with the Tort System

3.1 Adversarial in nature

The tort system, being adversarial in nature requires the litigating parties to determine the subject matter of the controversy between them and supply the court with the evidence on

which they wish the court to decide. The task of the court is to do justice based on the available evidence and the law. In reality, it sometimes happens that litigation fails to achieve real justice between the opposing parties as a result of inherent weaknesses in the adversarial system and practical disadvantages, which obstruct the proper functioning of such a system. These weaknesses are equally applicable to medical negligence litigation in much the same way as other types of litigation, which include issues of judicial impartiality and competencies, disadvantages of the tactical manoeuvring, partisanship and unreliability of witnesses and the unfairness that can result in such hearings when there is inequality of legal representation.

3.2 The lengthy period in pursuing a claim

The tort compensation system has been known to be cost-inefficient. Administrative costs are high due to the nature of the two principal criteria for compensation, namely, case-by-case determinations of fault and lump sum findings of damages under indeterminate guidelines. The main contributor to the costliness of the tort system is the delay involved in the pursuit of a claim. Delay may occur at different stages in the litigation process and for various reasons. In medical negligence cases, delay occurs for instance, before the plaintiff seeks legal advice, while waiting for information from the opposing side, while the parties wait for experts to investigate and produce their report, while the parties seek and exchange documentary evidence and while waiting for the trial date. These delays clearly contribute to the length of time required for the case to be settled. For instance, in the case of *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals*[6], litigation was initiated on

[6] [1998] 1 MLJ 57.

23 December 1981 whereas the judgment was delivered on 7 November 1997. Altogether, the case took about 16 years to conclude. If the time considered was when the cause of action accrued, that is, 7 January 1976, then the duration would be 21 years. Further, in *Foo Fio Na v Hospital Assunta & Anor*[7], the cause of action accrued on 19 July 1982 whereas judgment by the High Court was given on 8 October 1999[8] whereas the decision of the Court of Appeal[9] was given on the 5th of April 2001. 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*[10] was made in November 2001[11] and the Federal Court finally delivered its judgment on the 29th December 2006, after a delay of over four and a half years from when the application for leave to appeal was made. Thus, the total number of years the case took to conclude from the High Court to the Federal Court was 24 years. It can be seen that the entire litigation process for medical negligence case requires an average of about a minimum period of 15 years, from date of injury to the conclusion of the case.

3.3 Effect of a Medical Negligence Claim on the Defendant Doctor

Doctors not only fear of losing a lawsuit but the lawsuit itself. If the injured patient files a complaint against the doctor, this already has a detrimental effect on the doctor's reputation and practice even if the matter does not go to trial. This is due to the fact that the publicity which a claim entails is sufficient to cause a loss of reputation which might have

[7] [1999] 6 MLJ 738.
[8] 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* [2001] 2 CLJ 457. The Federal Court delivered its judgment on the 29th December 2006, after a delay of over four and a half years.
[9] The judgment can be found in *Dr Soo Fook Mun v Foo Fio Na & Anor* [2001] 2 CLJ 457.
[10] *Ibid.*
[11] This can be found in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2002] 2 MLJ 129.

adverse effects on their practice regardless of whether the doctor wins in court or not. Furthermore, by bringing legal action, the patient assaults the doctor's credibility, insinuating faulty judgment and treatment. Self esteem and status as a successful practitioner may suddenly be jeopardized overnight. In a way, a malpractice suit challenges professional reliability and authority. Such development may not only cause the adoption of defensive medicine but also deter doctors from opting for high-risk specialties. The threat of litigation also subtly changes doctors' relationships with all patients, not just those who initiate claims against them. This is because the threat of malpractice compels the doctor to view his patient as a future adversary in a courtroom proceeding. Even if the negligence claims is settled out of court, there is still an effect on the doctors as settlements out of court leave them with no chance of vindicating themselves. At the end of the day, they still feel that there is a cloud hanging over their head.

3.4 Rise in medical insurance premium rates

Frequency of medical malpractice suits and the amount of awards against doctors can lead to sharp increases in the cost of doctor's liability insurance as has occurred in the United States, Australia and the United Kingdom. Significant increases in subscriptions paid by doctors to the medical defence organisations can have an impact on the patients in the form of increased fees. Ultimately, this may raise the cost of medical attention.

3.5 Defensive medicine

As the pendulum swung towards the plaintiffs in malpractice suits, many doctors have adopted the practice of "defensive medicine". Thus, the litigation system can be said to

have the tendency to develop defensive and confrontational attitudes. In *Whitehouse v Jordan*[12], Lawton J. said that defensive medicine consists of "adopting procedures which are not for the benefit of the patient but safeguards against the possibility of the patient making a claim of negligence."[13]

Defensive medicine can be considered to 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 is clinically unnecessary but necessary to ensure that nothing goes wrong. This procedure is considered to be a waste of time and resources and subjects the patient to unnecessary medical intervention. 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. For instance, a doctor may refuse to carry out a treatment as the risks inherent in the treatment is rather high and therefore, the risk of malpractice litigation if things go wrong is likely to be high too.

3.6 Accountability

Besides their need for compensation, injured victims have also other needs, which the tort system fails to cater. Most medically injured victims are also concerned about obtaining an explanation of why their injury occurred or an apology from the responsible doctor. Furthermore, these victims also place importance on making sure that the mishap does not occur again in the future. A tort action, however, has a limited role as an official and public

[12] [1980] 1 All ER 650.
[13] *Ibid*., at p. 659.

forum in which the defendant's conduct is examined. Moreover, the "real" defendant in a tort action is usually an insurance company any rather than the professional himself.

3.7 Deterrence

The current tort system is ineffective as a deterrent against medical incompetence or malpractice. According to *Brazier*[14], the reason for this ineffectiveness is because an action in negligence focuses on a single incident. As a result, a competent surgeon in a high-risk specialty who makes an unlucky error may be penalised whereas a much less competent doctor in a lower risk specialty will continue to practise unchecked by the courts.[15] The adversarial nature of court proceedings also precludes any proper investigation, either of the incident in question or the practice, which has resulted in the error.[16] Moreover, the amount of damages paid under the existing system is related to the severity of the consequences and not the degree of negligence. This means that a trivial act that has resulted in serious injury will receive larger compensation. For instance, compensation payment for death is generally lower than that of a long impaired life as the amount is related not only to loss of earnings but also the pain and suffering and costs of care. Thus, it seems unfair that the existing system allows a high degree of deterrence for causing expensive injuries but a low degree of deterrence for causing death.

3.8 Compensation

Medical accountability has often been eclipsed by discussion of compensation. The adversarial litigation systems has been said to be unhelpful both to the patients and doctors.

[14] Brazier, M., "Compensation, Competence and Culpability: The Case for a No-Fault Scheme" (Spring 1988) Journal of Medical Defence Union 8, at p. 9.
[15] *Ibid*.
[16] *Id*.

Compensation via negligence is unsatisfactory. In England, the report by the Royal Commission on Civil Liability and Compensation for Personal Injury stated that "[t]he proportion of successful claims for damages in tort is much lower for medical negligence than for all negligence cases..."[17] To assess the present system of compensation, there has to be adequate understanding of the legal requisites of a valid claim and the legal processes involved in bringing an action. As compensation depends upon a successful negligence action, the present system leaves many victims uncompensated for injuries. This is due to the fact that the present system is shaped in such a way that only those that are capable of demonstrating medical negligence can gain monetary compensation. The ones that cannot, will walk away empty-handed. Thus, a situation may exist in which there are two individuals with two identical bad results from their medical treatment but who are treated differently in terms of legal remedy. Such result is clearly at odds with common contemporary notions of fairness. The inequity arising from one individual being denied compensation while another with identical injuries obtains recompense has created an impetus for the courts to find ways of compensating medical accidents.

3.9 The Substantive Law

The tort system is criticised because the plaintiff bears the burden of proving all components of the medical negligence claim. To prove that the doctor had positively breached a standard of care owed in the circumstances to the patient is peculiarly onerous for the plaintiff due to the existence of the *Bolam* principle. The fact that the plaintiff has the burden to prove that the defendant had strayed from the recognized standard of care in

[17] Royal Commission on Civil Liability and Personal Injury, London : HMSO, Vol. 1, Cmnd. 7054, 1978, at paragraph 1337.

the profession imposes upon the plaintiff the burden of establishing first what the professional standard of care is in any given case and then the fact the defendant has departed from it. Generally the only acceptable manner of proof of the standard of care is another doctor's testimony. This often posed an insurmountable obstacle to the victim who routinely has to face the unwillingness of one doctor to provide evidence, which might impose liability on another colleague. What aptly has been dubbed as "conspiracy of silence"[18] has effectively prevented numerous medical accidents from prevailing at trial and deterred others from instituting litigation.

4.0 RECENT TREND - The Decline of Judicial Deference to Medical Opinion

Nevertheless, in recent years, the *Bolam principle* has been subjected to much discussion, not only in the Australian jurisdiction but in its country of origin as well. The problem with the *Bolam principle* is not with the principle itself, but its interpretation and application by courts. Since it was introduced nearly fifty years ago, the *Bolam principle* had undergone various phases of recognition[19], condemnation[20] and re-interpretation.[21] For the medical

[18] The Supreme Court of California in *Salgo v Leland Stanford Jr. Univ. Bd of Trustees* 317 P 2d 1093 (1960) commented:

> "Gradually the courts awoke to the so-called "conspiracy of silence". No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. Not only would the guilty person thereby escape from civil liability from the wrong he had done, but his professional colleagues would take no steps to insure that the same results would not again occur at his hands."

[19] 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.

[20] The principle has been criticised as being over protective of the medical profession and allowing the standard of care of doctors to be a matter of medical judgment.

[21] 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 Law Report (Medical) 41, tried to restore the principle to its proper limits and correct the misinterpretation as what was originally intended by McNair J. in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

profession, the *Bolam principle* has been viewed as no more than simple justice that they, like other professionals, to be judged by their own peers. For the patients, the existence of the *Bolam principle* hinders them from getting justice and the fair trial that they deserve.

4.1 The *Bolam principle*

It is undeniable that the *Bolam principle*[22] has acted as a gatekeeper to the number of claims against medical practitioners as according to this principle, a doctor is not negligent if he has acted with a practice accepted as proper by a responsible body of medical men skilled in that particular art. It is immaterial that there exists another body of opinion that would not have adopted the approach taken by the doctor in question. As long as there exists a "responsible body of medical opinion" that approves of the actions of the doctor, then the doctor escapes liability. The existence of the *Bolam principle* had clearly made it difficult for plaintiff to prove that the doctor had positively breached a standard of care owed in the circumstances. This is due to the fact that the *Bolam principle* has been routinely interpreted by the courts as laying down a principle whereby a court cannot find a defendant negligent as long as there is a common practice or custom that supports the defendant's actions. The "custom test" has been purely descriptive, based on what is

[22] When McNair J. delivered his judgment in *Bolam v Friern Hospital Management Committee* (*supra)*, 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, that later become known as the *Bolam principle* or the *Bolam test*, to determine whether the doctor's act fell 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 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. "

customarily done by the medical practitioners, rather than what ought to be done by the medical practitioners.

4.2 Background of the *Bolam principle*

In order to understand the *Bolam principle,* a short analysis of several cases occurring before the advent of *Bolam* need to be illustrated to understand further the reasons for excessive judicial deference to medical opinion. It can be seen that even before the establishment of the *Bolam principle*, the courts found it difficult to set a standard for the medical profession and majority of them opined that such matter should be left to medical judgments.

In *Mahon v Osborne*[23], the Court of Appeal held that the standard of care is to be measured by expert evidence. Lord Justice Goddard stated that:

> "I would not for a moment attempt to define in vacuo the extent of a surgeon's duty in an operation beyond saying that he must use reasonable care, **nor can I imagine anything more disastrous to the community than to leave it to a jury or to a judge, if sitting alone, to lay down what is proper to do in any particular case without the guidance of witnesses who are qualified to speak on the subject....** As it is the task of the surgeon to put swabs in, so it is his task to take them out, and in that task he must use that degree of care which is reasonable in the circumstances and that must depend on the evidence."[24]

The passage reflects that medicine has always been shrouded with intricacies and technicalities, which may be beyond the comprehension of the judge and jury who have not undergone the rigours of medical training. To reach a just and accurate decision, the matter is best left in the hands of the medical experts who are more capable of analysing

[23] [1939] 2 KB 14.
[24] *Ibid.,* at p. 47.

such complex issues. In other words, the question of whether the doctor is in breach of his duty should be judged by his peers.

In *Roe v Minister for Health*[25], a passage from the judgment of Denning LJ provides a clue to the philosophy of the *Bolam principle*. His Lordship said that:

> "If the anaesthetists had foreseen that the ampoules might get cracked with cracks that could not be detected on inspection, they would no doubt have dyed the phenol a deep blue; and this would expose the contamination. But I do not think that their failure to foresee this was negligence. It is so easy to be wise after the event and to condemn as negligence that which is only a misadventure. We ought always to be on our guard against it, especially in cases against doctors and hospitals. **Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks."**[26]

The passage acknowledges that it is not proper to blame the doctor for everything that has gone wrong. Medicine is clearly an inexact science of which its outcome is rarely predictable. It would be a disservice to the community at large if liability were to be imposed on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken as it would encourage the practice of defensive medicine, which would ultimately not benefit the society as a whole. There must be a proper tool to gauge the standard of care of a doctor in determining his liability.

Further in *Hunter v Hanley*[27], Lord President Clyde stated that:

> "To succeed in an action based on negligence, whether against a doctor or anyone else, it is of course necessary to establish a breach of that duty to take care which the law requires, and the degree of want of care which constitutes negligence must vary

[25] [1954] 2 QB 66.
[26] *Ibid.,* at p. 83.
[27] [1955] SLT 213, [1955] SC 200.

with circumstances ... But where the conduct of a doctor, or indeed of any professional man, is concerned, the circumstances are not so precise and clear cut as in the normal case. **In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis and treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of acting with ordinary care.**" [28]

4.3 Why the excessive judicial deference to medical opinion?

4.3.1 Reluctance in making findings of negligence against members of any honourable profession

Generally, standards of behaviour within all professions were high. The reluctance was not confined to medical profession as they were understandably not comfortable in second-guessing the conduct and opinions of respected professionals practising in their field of expertise.

4.3.2 Difficulties in setting the standard, breach of duty to be judged by his peers.

Judges have difficulties in dealing with cases shrouded with intricacies and technicalities, which may be beyond the comprehension of the judge who has not undergone the rigours of medical training. Medicine being an inexact science may at times produce outcomes that are not predictable. To reach a just and accurate decision, the matter is best left in the hands of the medical experts who are more capable of analysing such complex issues. Thus, the question of whether the doctor is in breach of his duty is to be judged by his peers.

[28] [1955] SLT 213, at p. 217.

4.3.3 Presumption of beneficence

From the time when the Hippocratic Oath was formulated, doctors are generally regarded as having a positive duty to do good, which includes active promotion of good, kindness and charity to help others further their legitimate interests by preventing or removing possible harms. The practice of medicine for quite some time gave rise to little controversy as the medical profession has been trusted to do what's best for their patients.

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

After much dissatisfaction on how the *Bolam principle* has developed in medical negligence litigation[29], the principle was put under rigorous scrutiny in the case of *Bolitho v City & Hackney Health Authority*[30]. Lord Browne-Wilkinson delivering judgment in the House of Lords in *Bolitho* held that the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of 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."[31] This means that merely by showing that the defendant's action was supported by expert medical opinion will not automatically exculpate him. The expert medical opinion in question has to have a sufficient logical basis. Lord Browne-Wilkinson

[29] The judgment of Sachs LJ in the case of *Hucks v Cole* [1993] 4 Med LR 393 was very influential in bringing about the change in attitude by the English judiciary of delegating the determination of doctor's liability to the medical profession. *Hucks* adopted a pragmatic approach to this issue and held that it was appropriate for the judge to reject medical expert evidence if it does not really stand up to analysis.
[30] [1997] 4 All ER 771.
[31] *Ibid*. at p. 778.

then went on to explain that before a judge can accept a body of opinion as being "responsible", the judge will have to 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 defensible conclusion on the matter."[32] Thus, 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."[33] Thus, this would mean that even though there exists a body of professional opinion sanctioning the defendant's conduct, the defendant can still be held negligent if it cannot be demonstrated to the judge's satisfaction that the opinion relied on is reasonable or responsible.

4.5 Burying *Bolam* Down Under

The Australian judiciary has been quite determined in ensuring that expert evidence is subjected to close judicial scrutiny as stated by King C.J in of *F v R*[34] when he said 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 is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community."[35]

This view was approved by the High Court of Australia in *Rogers v Whitaker*[36], where it was accepted that the question of how much information to be departed by a doctor cannot

[32] *Id*.
[33] *Id.* at p. 779.
[34] (1982) 33 SASR 189. (S.C. of South Australia).
[35] *Ibid.*, at p. 194.
[36] [1993] 4 Med LR 79, [1992] 175 CLR 479.

be determined by "any profession or group in the community"[37] but it should be determined 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."[38] Thus, the High Court felt that opinions of medical witnesses should not be decisive at this point. One consequence of the application of the *Bolam principle* to a case involving the provision of advice and information is that, "even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would be 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."[39] 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 doctor's duty of disclosure. 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"[40], then the doctor would be exercising clinical judgment in deciding whether to

[37] (1982) 33 SASR 189, at p. 194.
[38] *Ibid.,* at pp. 192 - 193.
[39] [1992] 175 CLR 479, at pp. 486 - 487.
[40] *Ibid*., at p. 490.

disclose or not. In such a case, the doctor does not need special skill to be able to disclose the risks but rather, communicating skill that will enable the patient to apprehend his situation. Whatever information the patient is given must be given in such a way that the information 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 or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This is subject to therapeutic privilege."[41]

The decision in *Rogers* emphasised that patients are entitled to make their own decisions about medical procedures and to be given sufficient information to make an informed choice. The High Court cautioned that the phrase "informed consent" commonly used by the American counterparts is "apt to mislead as it suggests a test of validity of the patient's consent.... [and] consent is relevant to actions framed in trespass, not in negligence."[42] The court further found that the expression "the right of self determination" is also unsuitable "to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of duty."[43] In determining what information is "material" for a given patient, the needs of each patient must be taken into account. The doctor must consider all that he or she knows about the patient, in order to decide, in the light of those circumstances, what risks the patient would be likely to

[41] [1992] 175 CLR, at p. 490.

[42] *Ibid.*
[43] *Id.*

consider significant. The High Court adopted the views of King C.J. in *F v R*[44], and concurred that the question of how much information to be departed by a doctor cannot be determined by "any profession or group in the community"[45] but it should be determined 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."[46] Thus, the High Court felt that opinions of medical witnesses should not be decisive at this point. In other words, it was for the courts, 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 considered the most significant aspect of the case as this means that the determination of the standard of care is a matter for judicial, not professional opinion.

Rogers had only buried the *Bolam principle* in the realm of doctor's disclosure of risks. However, the decision of Australian High Court in *Naxakis v Western General Hospital*[47] rejected the the *Bolam principle* in all aspects of medical treatment including duty to treat and diagnose. In *Naxakis*, Kirby J. and McHugh J. opined that it was left to the jury to accept expert opinion of a fellow medical practitioner. Expert opinion of fellow practitioner 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"[48] for the defendant. Kirby J. reiterated the principle decided in *Rogers v Whitaker* where the court pointed out that the standard of care owed by persons possessing special skills is not

[44] (1983) 33 SASR 189.
[45] *Ibid.,* at p. 194.
[46] *Id.,* at pp. 192 - 193.
[47] (1999) 73 ALJR 782.
[48] *Ibid*., at p. 797.

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."[49] Instead, evidence of acceptable medical practice will only serve as a useful guide for the courts in adjudicating on the appropriate standard of care.

4.6 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*[50] has been known to be a staunch follower of the *Bolam principle* emphasising judicial deference to medical opinion. *Sidaway* rejected the "North American doctrine of informed consent"[51], 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."[52] However, the ruling by the House of Lords in *Chester v Afshar* [53] 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. As the operation was conducted with care and skill, the damage that resulted from the operation was not due to any breach of duty on the part of the doctor in handling the operation. Instead, the claim was made on the basis that the doctor had breach his duty in failing to warn the patient of the risks, which if properly warned, would have caused her to

[49] *Id*., at p. 798, citing *Rogers* (1992) 175 CLR 479, at p. 487.
[50] [1985] 1 AC 871 ; [1985] 2 WLR 480, [1985] 1 All ER 643.
[51] 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 (D.C.Cir. 1972). This test was instrumental in shaping the decision of *Rogers v Whitaker*.

[52] [1985] 1 All ER 643, at p. 649.
[53] [2004] UKHL 41, [2005] 1 AC 134, [2004] 4 All ER 587, [2004] 3 WLR 927.

delay the treatment offered until she receives a second or third opinion[54], and she would not have suffered the damage as yet. Relying on Lord Woolf's observations in the case of *Pearce v United Bristol Healthcare NHS Trust* [55] 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"[56], 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."[57]

His Lordship went on to further to state that:

> "…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*[58]*,* which was a progeny of *Rogers v Whitaker*. This shows a remarkable departure from the paternalistic and doctor-protective attitudes displayed by the House of Lords in *Sidaway.*

4.7 The Development of the *Bolam principle* in Malaysia

The *Bolam principle* so formulated has been routinely applied by the Malaysian courts to the relevant cases[59] in determining the doctor's standard of care. Amongst the earliest case

[54] See Puteri Nemie, J.K., *Chester v Afshar : Loosening the grip on proving causation for failure to disclose risks in medical treatment* [2004] 5 Current Law Journal I - viii.
[55] (1998) 48 BMLR 118.
[56] *Ibid.* at p. 124.
[57] [2004] 4 All ER 587, at paragraph 16.
[58] (1998) 156 ALR 517.
[59] E.g.s,. *Swamy v Matthews* [1967] 1 MLJ 142; *Mariah bte Mohamad (Administratix of the estate of Wan Salleh bin Wan Ibrahim, deceased) v Abdullah bin Daud (Dr Lim Kok Eng & Anor, Third Parties)* [1990] 1

in the Malaysian jurisdiction wherein the *Bolam* principle was applied is *Swamy v Mathews*[60]. There were different opinions presented to the court in this case as to what was supposed to be the proper treatment and the procedure in giving such treatment to the plaintiff. The majority judgment accepted the testimony of the defendant doctor and his explanation that the prescription and the dosage given to the plaintiff, although at variance with the manufacturer's recommendation, was made based on is 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. Mr Justice Ismail Khan cited *Roe v Minister of Health*[61] 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 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."

Further his Lordship stated what was uttered 130 years ago by Tindal J in *Hancke v. Hooper*[62] whereby:

> "A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge of his profession. If from some accident, or some variation in the frame of a particular individuals, an injury happens, it is not a fault in the medical man ... The plaintiff must show that the injury was attributable to want of skill; you are not to infer it."

MLJ 240 ; *Inderjeet Singh a/l Piara Singh v Mazlan bin Jasman & Prs* [1995] 2 MLJ 646.
[60] [1968] 1 MLJ 138.
[61] [1954] 2 WLR 915.
[62] [1835] 7 C & P 82.

The Privy Council had soon after that applied the *Bolam* principle in *Chin Keow v Government of Malaysia*[63]. 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 as 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*[64], several medical experts gave conflicting opinions on whether it was proper for the anaesthetist to perform sigmoidoscopic examination under general anaesthesia. One expert had expressed the view that it is better to perform sigmoidoscopy without anaesthesia as the patient could be forewarn 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 is in vogue in his unit since 1956 and the technique had not earned the condemnation of medical opinion generally.[65] Thus, applying the *Bolam principle* to this issue, the court held that the anaesthetist is not negligent as he had followed the general and approved practice in the situation, which he was facing. The technique that he adopted was approved by a responsible body of medical men since 1956. Therefore, it did not matter if there is another body of opinion that would have taken a contrary view. Raja Azlan Shah stated:

[63] [1967] 2 MLJ 45.
[64] [1970] 2 MLJ 171.
[65] *Ibid*. at p. 172.

> "The anaesthetist had done hundreds of endoscopic examinations including sigmoisdoscopy…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…. The principle of law is well established that a practitioner cannot be held negligent if he treads the well-worn path; he cannot be held negligent if he follows what is the general and approved practice in the situation with which he is faced."[66]

The judicial decision in *Elizabeth Choo* was further approved in *Kow Nan Seng v Nagamah & Ors* [67]. There were conflicting opinions on whether a complete plaster cast or a plaster slab is 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 in the treatment but this does not mean that choosing a type of plaster cast is in itself negligence. To be negligent, the doctor must have departed from the reasonable standard of care and skill of an ordinary competent doctor.

In *Liew Sin Kiong v Dr Sharon M Paulraj*[68], Ian Chin J. applied *Sidaway,* which endorses the *Bolam principle*[69] 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

[66] *Id.* at p. 173.
[67] [1982] 1 MLJ 128.
[68] [1996] 2 AMR 1403.
[69] *Ibid.,* at pp. 1418 - 1419.

risk. However, it should be noted that even though Ian Chin J. did not follow the principles established in *Rogers v Whitaker*, he commented that:

> "[t]he 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."[70]

Further, in *Chelliah a/l Manickam & Anor v Kerajaan Malaysia*[71], the High Court held that the defendant was vicariously liable for the acts of the doctors at Penang General Hospital. The doctors involved had wrongly diagnosed an acute perforated appendicitis. The treatment for pancreatitis and appendicitis are different, namely in the case of acute appendicitis the treatment is surgical intervention whereas for acute pancreatitis is conservative treatment. Jeffrey Tan JC stated that:

> "Doctors and members of other professions and callings must, therefore, exercise the standard of skill which is usual in their profession or calling, and it is no defence that they acted to the best of their skill if that falls below the required standard….The obligation to exercise that skill is based on the ground that a reasonable man who owes a duty of care would exercise the care of a skilled man in doing the operation in those circumstances."[72]

In *Chin Yoon Hiap, Dr v Ng Eu Khoon & 2 Ors*[73]*,* Abdul Malik Ahmad JCA referred to *Maynard v. West Midlands Regional Health Authority* [74] and held that it had to be recognised that differences of opinion and practice existed in the medical profession and that there was seldom any one answer exclusive of all others to problems of professional judgment. Although the court might prefer one body of opinion to the other, that was not a basis for a conclusion that there had been negligence on the part of the defendant doctor. On a similar note, PS Gill J. in *Dr KS Sivanathan v The Government of Malaysia* [75] held

[70] *Id*., at p. 1420.
[71] (1997) 2 AMR 1856.
[72] *Ibid*., at p. 1859.
[73] [1997] 4 AMR 4204.
[74] [1985] 1 All ER 635.
[75] [2001] 1 MLJ 25.

that it is not sufficient to establish negligence for the plaintiff to show that there was a body of competent professional opinion that considered the decision was wrong. As there were differences of opinion by the expert witnesses as to the correct type of fixation that should have been done, there is a body of professional opinion, equally competent, that supported the decision as having been reasonable in the circumstances. In *Payremalu Veerappan v Dr Amarjeet Kaur & Ors*[76], VT Singham JC, referring to the judgment by his Lordship S. Krishnan Unni in *M Shoba v. Dr. Mrs Rajakumari Unnithan & Others*[77] said that:

> "A doctor is never presumed to be infallible. He is also not obliged to achieve triumph in every clinical case that he treats. Doctor cannot be held negligent simply because something goes wrong. Doctor can be found guilty only if he falls short of standard of reasonable skilful medical practice. The true test, therefore, to hold a medical practitioner guilty of negligence is to have a positive finding of such failure on his part as no doctor of ordinary skill would be guilty of acting with reasonable and ordinary care."

The judgment given by Gopal Sri Ram JCA in *Dr Soo Fook Mun v Foo Fio Na & Anor and Another Appeal*[78] had also indicated 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

[76] [2001] 3 MLJ 725.
[77] [1999] AIR Kerala 149.
[78] [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] 6 MLJ 738, by allowing Dr Soo's appeals.

opinion that allowing doctors to be judged by their own peers would "maintain a fair balance between law and medicine"[79].

In *Asiah bte Kamsah v Dr Rajinder Singh & Ors*[80], the plaintiff underwent lower section caesarian operation due to suspicion of fetus distress. She was put under general anaesthesia. Unfortunately, she did not recover from operation and later, suffered permanent irreversible brain damage. In deciding whether the doctor and the anaesthetist were negligent, the court made a straightforward application of the *Bolam principle.* Mr James Foong stated:

> "I find no evidence to support a finding that this doctor was negligent in this surgery by the test set out in the established case of *Bolam v Friern Hospital Management* Committee…. I find that the second defendant is guilty of negligence since he did not act in accordance with the practice accepted as proper by a responsible body of medical men skilled in this particular art – a test as set forth in Bolam's case." [81]

Similarly, in *Hor Sai Hong & Anor v University Hospital & Anor*[82], the court applied the *Bolam principle* in determining whether the doctor was negligent in handling the birth of the second plaintiff's child. The child or the first plaintiff suffered brain damage after the birth by operation and the court held that the defendants fell below the standard required by them in this area. Justice Rahmah Hussain, in applying *Bolam* stated that:

> " In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man ..... But where you get a situation, which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on top of Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill."

[79] *Ibid.*, at p. 472.
[80] [2002] 1 MLJ 484.
[81] *Ibid.* at p. 492.
[82] [2002] 5 MLJ 167.

Further, in *Foong Yeen Keng v Assunta Hospital (M) Sdn Bhd & Anor*[83], the patient suffered severe abdominal pain and had her ruptured ovarian cyst as well as the appendicitis removed in the first operation. After the operation, the patient was still suffering tremendous pain. At this point, the patient was attended to by another doctor as the doctor who conducted the first operation was on leave. The patient underwent a second operation to clear the pus found in the right paracolic gutter. The patient claimed that the first doctor had failed to ensure immediate administration of correct and adequate antibiotics after the operation, which resulted in the infection and the necessity for a second operation. Although the notes were incomplete[84], there was ample evidence supporting the hospital's contention that the antibiotic prescribed had been dispensed sufficiently.[85] The choice of antibiotics is dependant on clinical judgment of the doctor and there is even a body of opinion, which supports the view that there is no necessity to give antibiotics for the kind of operation undergone by patient.[86] The patient further claimed that the delay in the second operation was a contributory factor for her internal injuries, pain and suffering. The delay was due to the conservative treatment undertaken by the second doctor. However, the court held that the conservative treatment, the timing of the second operation and the early laparatomy involved clinical judgment. The hospital cannot be faulted where there are differences of opinion as to the treatment of a patient. This does not make a doctor negligent merely because his opinion leading to his diagnosis differs from that of other doctors. What is important is he acts with the ordinary care and skill of a

[83] [2006] 5 MLJ 94, at paragraph 62, which stated that "… the maxim of *res ipsa loquitor* does not apply in this case. .. the fact that the patient came out of a hospital in a worse condition before admittance does not constitute proof of negligence by the hospital staff. One must be able to accept that medical treatment carries the risk and the occurrence of injury is not necessarily evidence of lack of reasonable care."

[84] This merely indicates carelessness of the nurses. *Ibid.,*at paragraph 49.
[85] *Id*, at paragraph 100.
[86] *Id.,* at paragrapgh 40 (iv).

doctor with his qualification.[87]

In *Tan Eng Siew & Anor v Dr Jagjit Singh Sidhu & Anor*[88], the court applied the *Bolam principle* and found the defendant doctor negligent in treating, managing and caring for the patient, who suffered from a fractured the neck of her left femur and a crack fracture of her tibia. The defendant did not use cement to secure the prosthesis in the femur. The use of bone cement for such operation, according the expert witness in the case, is common among the surgeon he worked with.

4.8 The Departures

The first decision in which the court refused to apply the *Bolam principle* and instead adopted the principles set forth in *Rogers v Whitaker* had been *Kamalam a/p & Ors v Eastern Plantation Agency & Anor*[89]. In this case, the defendant doctor failed to diagnose the plaintiff's ailment, which turned out to be a stroke. The court found that the doctor had fallen below the standard of care required of him in failing to admit the plaintiff into the hospital and thereby, causing his death. 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 manifested symptoms of an impending stroke. The trial judge did not regard himself as being bound not to find medical practitioners negligent if there is a body of medical opinion that approved the doctor's practice. Richard Talalla J. stated:

[87] *Id*., at paragraphs 57 and 59; Lord Denning 's judgment in *Hucks v Cole* [1968] 112 SJ 483 applied in which his Lordship stated that "…a doctor was not to be held negligent simply because something went wrong. He was not liable for mischance or misadventure, nor for error of judgment. He was only liable if he fell below the standards of a reasonable competent practitioner in his field, so much so that his conduct was deserving of censure or inexcusable."

[88] [2006] 1 MLJ 57.

[89] [1996] 4 MLJ 674.

> "…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 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*."

Kamalam was soon followed by *Tan Ah Kau v Government of Malaysia*[90]. Applying *Rogers v Whitaker*, the court held that it is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant .... In the instant case, where the risk of paralysis was very real, more so when the tumour was intramedullary, it is absolutely essential for the attending surgeon or any doctor assisting him to warn the patient of the foreseeable risk of even a finding of intramedullary tumour.

Similarly, in *Foo Fio Na v Hospital Assunta & Anor* [91], the court applied the principles in *Rogers v Whitaker* in deciding whether the defendant was negligent in failing to inform the plaintiff of the risk of paralysis that is inherent in a spinal cord operation. The court found that the risk of paralysis was considered to be a material risk of which the plaintiff should have been warned. Mokhtar Sidin JCA stated:

> "The question of giving proper warning was further emphasized 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 practiced by the relevant profession or trade and also the fact that a person is entitled to make his own decision on his life."[92]

Further, in *Hong Chuan Lay v Dr Eddie Soo Fook Mun*[93], the defendant doctor was found not liable for the injuries suffered by the plaintiff, as there was no evidence adduced as to which aspect of the surgery the defendant was incompetent. The defendant was at all

[90] [1997] 2 AMR 1382.
[91] [1999] 6 MLJ 738.
[92] *Ibid.*
[93] [1998] 5 CLJ 251.

material times a qualified and experienced orthopaedic surgeon and the method and procedure adopted by him were accepted in the medical field for operations of this nature.[94] In dealing with this claim, the court abandoned the *Bolam test* and applied the approach used by the Australian courts in *Rogers v Whitaker*. Mr Justice Foong stated that:

> "For sometime, 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."[95]

4.9 *Bolam principle* in the Federal Court

The recent ruling of the Federal Court of Malaysia in *Foo Foo Fio Na v Dr Soo Fook Mun & Anor*[96] abandoned the *Bolam principle* in relation to doctor's duty to disclose risks in medical treatment. In this case, 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*[97]. The main question for which leave is sought is 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

[94] The plaintiff appealed to the Court of Appeal in *Hong Chuan Lay v Dr Eddie Soo Fook Mun* [2006] 2 MLJ 218 but his appeal was dismissed due to the inconsistencies in the evidence given by him. The inconsistencies had affected his credibility as a witness and the Court was of the opinion that "cases of medical negligence are, in the main, fact sensitive…. in a case of this sort where everything turns upon the credibility of witnesses about what was said or not said or done or not done, the view formed by the primary trier of fact is entitled to great weight and we as a Court of Appeal are not entitled to differ save in an exceptional case…. [a]nd this not an exceptional case." (paragraph 4).

[95] [1998] 5 CLJ, at pp. 267 - 268.

[96] [2007] 1 MLJ 593.

[97] [2001] 2 CLJ 457.

made would be to public advantage. In this regard, the Federal 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 have made the long awaiting decision by deciding that the *Bolam principle* is no longer to be applied to doctor's duty to disclose risks. The test enunciated in *Rogers v Whitaker* [98] would be "a more appropriate and a viable test of this millennium."[99] 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."[100] 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."[101] The decision of the Federal Court has obviously put a potentially onerous task for the medical practitioners, but is nevertheless one, which the law considers as necessary.

---

[98] *Supra*.
[99] [2007] 1 MLJ 593, at paragraph 69.
[100] *Ibid*., at paragraph 36.
[101] *Id*., at paragraph 69.

5.0 Some discussions on the decision by the Federal Court

5.1 The Procedural Issues

Procedurally, a number of jurisdictional issues give rise to concern. The most significant of these is that the Court upheld the trial judge's findings of fact, and made them the basis for reinstating the orders of the High Court, when these findings had been specifically rejected by the Court of Appeal. Under sections 69 and 96 of the Courts of Judicature Act 1964, the Court of Appeal is the only Malaysian appellate court with the power in civil matters to re-hear cases, draw inferences of fact and make orders similar to those of the High Court. This certainly suggests that the Federal Court exceeded its jurisdiction in this respect. Other issues include the Court's characterization of disputed matters as having been undisputed at trial, and the lapse of almost twenty-five years between the conduct complained of and the final disposition of the appeal. This extreme delay is of particular concern given the complexity of the medical evidence involved. Moreover, the fact that the Federal Court itself took over four and a half years to deliver its judgment also made it difficult for the Court to deal disinterestedly with the negative observations made by the Court of Appeal about the procedural delays which had occurred in the High Court.

5.2 The Substantive Issues

Substantively, the decision displays a rather confusing conflation of the various aspects of medical negligence. In examining the English cases, which have demonstrated a more relaxed approach to the *Bolam test*, the Court may have overestimated the significance of *Bolitho*, a decision which, with the benefit of hindsight, most commentators now recognize

to have had a limited impact on judicial attitudes to negligent treatment. On the other hand, in the area of informed consent, the Court seems, in relying on Lord Scarman's dissenting judgment in *Sidaway*, rather than on more recent cases, to have understated the degree to which the courts have moved away from *Bolam*. There is for example, no reference in the decision to Lord Woolf's judgment in *Pearce v. United Bristol Healthcare NHS Trust (supra)*, or, more significantly, to the 2005 decision of the House of Lords in *Chester v Afshar (supra)*. Although *Chester* (which closely resembled the High Court of Australia's decision in *Chappel v Hart (supra)* was decided on the issue of causation, it is generally regarded as having heralded a more patient-friendly approach to the duty to inform, based on normative values and the vindication of rights, in general, a patient's right to autonomy, and more specifically, the right not to be subjected to an undisclosed risk.

With respect to Australian law, the Federal Court's decision offers a strong analysis of both *Rogers* and *Naxakis*. However, it does not refer to the warning of the Chief Justice of the High Court of Australia in *Rosenberg v. Percival* that "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." More importantly, it fails to allude to the recommendations of the Ipp Committee, which, in 2002, suggested the adoption of a test for establishing negligence in cases of medical treatment, which was far closer to *Bolam/Bolitho* than to *Rogers/Naxakis*. Nor does it acknowledge the fact that the various Australian states have, in the wake of the Ipp Committee's report, enacted legislation to limit litigation and cap damages in general, and to restrict professional negligence actions

and re-impose a modified version of the *Bolam test* in particular.[102] In light of these omissions, the Federal Court's picture of Australian medical negligence law can hardly be described as entirely accurate or fully comprehensive.

5.3 Anticipated Implications of the Federal Court ruling

5.3.1 Escalating claims in future?

At present, there is no empirical evidence that adoption of a *Rogers* approach in Malaysia will necessarily lead to numerous claims or excessive awards. So far, it is undeniable that "civil litigation founded upon medical negligence are few and far apart in Malaysia"[103] compared to the Western countries such as United Kingdom, Australia and the United States. However, the adoption of *Rogers* test is not without any limitation. The test set forth by the case of *Rogers v Whitaker* specifically mentioned about the "exception of therapeutic privilege". This exception allows the doctor to withhold information from his patient concerning risks of proposed treatment if it can be established by means of medical evidence that disclosure of this information would pose a serious threat of psychological harm to the patient. However, the privilege operates only when the communication of information to the patient, based on sound medical judgment, would cause the patient to become distraught that he would not be able to make a rational decision. Thus, the impact of *Rogers* would be significant in cases of *elective* surgeries such as cosmetic surgeries and not in *therapeutic* surgeries where the doctor is able to invoke the defence of therapeutic privilege in not informing the risks to the patient. But in elective surgeries such as the

[102] Legislative changes in Australia were precipitated primarily by the collapse of a major medical indemnity provider in 2001. It has since become clear that this was by no means solely attributable to an overly litigious post-Rogers culture, and the legislation has been criticized for being introduced too hastily and without full consideration.

[103] Words of Low Hop Bing J in the case of *Tan Ah Kau v Government of Malaysia* [1997] 2 AMR 1382.

cosmetic ones, the doctor will be required to address the concerns of the patient fully and the test of "material risks" is dependent on the type of patient involved.

5.3.2 Abandonment was only restricted to doctor's duty to disclose risks

By adopting the test set forth in *Rogers*, the Federal Court had clearly only abandoned the *Bolam principle* to doctor's duty to disclose and not to doctor's duty to treat and diagnose. This is because the case of *Rogers v Whitaker* had only abandoned the *Bolam principle* to doctor's duty to disclose and it was not until 7 years later in the case of *Naxakis (supra)* that there was total abandonment of the *Bolam principle* to duty to diagnose and treat. Although *Naxakis* was discussed at length by the Federal Court, the court failed to highlight this point. Thus, it can be concluded that the higher standard of care as adopted in the case of *Rogers* is only applicable to doctor's duty to disclose in Malaysia and not applicable to duty to treat and diagnose. In the realm of diagnosis and treatment, the *Bolam principle* still reigns in determining the standard of care in medical negligence cases in Malaysia.

5.3.3 *Rogers* did not deny the relevance of medical opinion but only denied its conclusiveness

The High court in *Rogers* held that while evidence of medical practice is a useful guide to the courts, it is ultimately for the court to adjudicate on the appropriate standard of care. It is acknowledged that the medical practice of informing or not informing certain risks is a useful guide in determining whether those risks are material. The rejection of the *Bolam principle* means that evidence of medical practice is just another factor that the courts

should take into account in determining the scope of "material risks". Others factors that will be taken into account are the likelihood and gravity of risk, the desire of the patient for information, the mental and physical health of the patient, the need for treatment and alternatives available, medical practice at that time and whether the nature of procedure is routine or complex. Thus, by the adoption of the test set forth in *Rogers*, professional practice and opinion will still be relevant and not denied in setting the standard of care. What will be denied is its conclusiveness. Thus, medical opinion will be ***one*** of the factors to be taken into account in determining the standard of care for doctor's duty to disclose, it will no longer be the ***only*** factor.

5.3.4 Significance of the application of *Bolitho v City & Hackney Health Authority*

The application of the case of *Bolitho* in the Federal Court appears to do away with the usual "rubber-stamping" of expert medical opinion. Expert opinion now has to withstand rigorous scrutiny from the judiciary. Previously, the well established *Bolam principle* had not given much scope to the judiciary to intervene and had ensured that any medical treatment that accords with a body of professional opinion is not negligent. On the surface, it appears that *Bolitho* has curbed the power delegated to the medical profession by *Bolam* as now there is no guarantee that expert medical evidence will be accepted even if provided. However, even before *Bolitho,* the reason for judges not to question the views of medical profession was because they themselves do not have sufficient understanding of medical matters. *Bolitho* has still not changed that position and judges have not been made more knowledgeable in medical matters through the outcome of the case. The decision only allows them to scrutinise medical opinions. In order to find that the expert medical

opinion does not withstand logical analysis, judges have to rely on some sort of evidence. The evidence used to denounce the expert medical opinion must be of the same standard, if not, better. But where would this evidence come from? From his own thoughts or independent advisors? How is it possible for judges to question expert medical opinion when they are the 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:

> "...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."

5.3.5 Patient autonomy triumphing over medical paternalism: Boon or bane?

Judicial deference to medical opinion has always been seen as necessary to protect the society from unwanted effects of defensive medicine. The threat of litigation will cause an increase in doctor's malpractice premiums and this has the effect of 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. Instead, they want to be treated as co-producers or partners able to manage their illnesses. As respect for patient's right to determine his own destiny be given due consideration, such paternalistic approach in using the *Bolam principle* has been considered to be outmoded and inappropriate. As reiterated by the Honourable Mr Justice Michael Kirby[104] that, "… the days of paternalistic medicine are numbered. The days of unquestioning trust of the patient also appear numbered. The days of complete consent to anything a doctor cared to

[104] President of the New South Wales Court of Appeal.

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* in doctor's duty to disclose risks may caused medical professionals to tremble, fearing for their professional integrity and independence. But such development 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 is the current trend and will not fade away. What the medical profession needs is to change their mindset and be prepared to accept patients as partners and co-producers in this process of shared decision-making. For the Malaysian society, the time may well have come to recognize that *Bolam* is already fifty years old and belongs to a less sophisticated and more paternalistic era. Where doctors were once accorded an unparalleled level of deference, society now expects a more egalitarian approach to all professions.

5.3.6 Creating awareness about legal issues amongst the medical professionals

With the growing demands of accountability by the society, it is imperative that medical service providers creates a variety of settings to ensure that those involve in medical practice will be made knowledgeable about the legal issues affecting them in their daily practice. It can be seen that one of the implication of the Federal Court ruling would be to put an onerous task on medical service providers to ensure that they are geared to meet the level of standard demanded by law.

6.0 PROPOSALS FOR REFORMS

In order to have a satisfactory system, all of the needs of parties involved in medical negligence must be taken into account. This will ensure that neither patients nor doctors suffer as a result of the reform. The problem must be looked at from all angles, not simply from the point of view of compensation while other issues are ignored. What is needed is an improved system for ensuring accountability of doctors as well as compensation. Vision for reform is to try to widen the provision of compensation, to enhance accountability and improve the standard of care without promoting defensive medicine. In any case, a system resolving disputes about medical treatment must be designed to meet the needs of patients as well as doctors.

Litigation often starts because the patient cannot get the information he is seeking, explanation or apology from the appropriate persons. Not all patients want to obtain financial compensation, some merely want to ensure that there is no repetition of the mishap that had occurred and to receive an apology for what had happened**. Lord Woolf MR** in an interim report on his **Access to Justice Inquiry** in June 1995 identified the needs of patients as wanting "impartial information and advice, including an independent medical assessment, fair compensation for losses suffered, a limited financial commitment, a speedy resolution of the dispute, a fair and independent adjudication; and (sometimes) a day in court."[105] Doctors, on the other hand, want "a discreet, private adjudication, which some would prefer to be by a medical rather than legal tribunal, an expert of their own or their solicitor's choice and an economical system."[106] Legal proceedings should be treated

[105] Lord Woolf MR, *Access to Justice: The Final Report to the Lord Chancellor on the Civil Justice System in England and Wales,* London: HMSO, 1996, at paragraph 18.
[106] *Ibid*., at paragraph 19.

as a last resort and to be used only when other means of resolving disputes have been exhausted. It is vital to find out what the aggrieved patient wishes to achieve.

Implicit in any criticism of the current fault-based system for compensation is that any satisfactory compensation system should meet certain objectives. *Keeton*[107] suggests eight principles for judging the effectiveness and fairness of a compensation system. He thinks that a satisfactory system should be "equitable as between those who receive its benefits [and] those who bear its costs..."[108] The system should not only "contribute to the protection, enhancement and appropriate allocation of human and economic resources"[109] but also "compensate promptly, be reliable, predictable, distribute losses and be efficient in minimising waste and cost."[110] Further, if feasible, the system should "provide deterrence, avoid inducements and minimise risk of exaggeration, fraud and opportunity for profit from such conduct."[111] However, it has to be noted that how far these principles ought to be built in a compensation system of a society depends on what principles and priorities inherent in the particular society.

6.1 Moving to a "No-fault" System

A radical solution to the problem is to move away from the current tort or fault-based system towards a "no-fault" based system of liability for medical negligence. Such system provides compensation without the need to prove fault. In other words, this system provides awards to injured patients irrespective of the requirement of proving fault on the

[107] Keeton, R.E., "Compensation for Medical Accidents", *University of Pennsylvania Law Review*. 121: 590-617.
[108] *Ibid*., at p. 603.
[109] *Ibid*.
[110] *Id.*
[111] *Id*.

part of the medical personnel. Under no-fault principles, anyone who has become injured in a mishap should receive compensation for their injuries irrespective of the cause of their accident. Those who injure themselves through their own fault, those who are injured by the fault of others and those who are injured through no-one's fault will all be in the same position. Their entitlement will depend solely on the fact that they suffered an injury. The level of compensation payable will depend on the nature of their injuries and amounts provided under a no-fault compensation scheme. Usually, some form of fund is established which disburses compensation once the eligibility criteria have been met.

The arguments in support of a no-fault system are clearly attractive, but emotive. On the positive side, the system would enable victims of medical negligence to be compensated quickly and at little administrative cost. Legal fees are eliminated and the adversarial features of the tort system are avoided. Claimants do not have to find a skilled lawyer to act on their behalf. As a consequence, it is possible to provide compensation to a larger number of people than under tort law. Thus, the bulk of the expenditure involved goes directly to the claimants.

There is no doubt that introducing a no-fault compensation scheme would overcome many of the shortcomings such as the expense and time in pursuing a tort claim, the unpredictability and the tendency to award disproportionate compensation to similar situated plaintiffs. However, it is not easy to design a no-fault scheme for medical accidents which is simple to run, straight forward in operation and acceptable in costs.

Many lessons can be learned from the New Zealand and Swedish schemes.[112] On the positive side, the scheme provides universal entitlement for victims of accidents who come within the scope of the scheme. Claims are settled quickly and at little administrative cost. The adversarial features of the tort system are avoided and those injured do not have to meet legal expenses.

However, can Malaysia adopt a no-fault compensation scheme? Although theoretically appealing, it seems unlikely that Malaysia is suited to the development of an extensive social safety net for its population. There are fundamental issues, which prevent the no-fault system from being the elixir to the medical malpractice problems in Malaysia. The main problem would be the size of the population in Malaysia, which is considerably larger of nearly 27 million[113], as compared with New Zealand or Sweden. The adoption of a no-fault compensation scheme as that, which exists in New Zealand or Sweden, designed to deal with a substantially larger population of 27 million is financially not viable. As mentioned earlier, the welfare scene in New Zealand and Sweden has enjoyed generous social security benefits as compared to Malaysia.[114] For a system not based on fault to be truly comprehensive and for it genuinely to meet needs, not only the political will but also the financial commitment has to be available. New Zealand is an egalitarian society[115],

[112] In 1974, the tort or fault-based system in New Zealand was abandoned and replaced by a no-fault compensation scheme through the operation of the relevant parts of the Accident Compensation Act 1972. In Sweden, the Patient Insurance Scheme was introduced in January 1975 to provide patients with private insurance coverage for treatment injuries. This coverage provides patient who has suffered injury with the right to indemnity from the insurance directly and independently regardless of whether the injury has been caused by negligence or not.

[113] http://www.statistics.gov.my/ (accessed on 12th February 2007)

[114] For instance, in the year 2001, New Zealand spends 6.45% of her Gross Domestic Product (GDP) on health expenditure whereas Sweden's was 4.8% and Malaysia spends 2.59% of her Gross Domestic Product (GDP) on healthcare. (SeeTable 2.2, Economic Report 2000/2001, Ministry of Finance, Kuala Lumpur, at p. xi.)

[115] *Ibid.*

with a fairly narrow range of incomes, which has made it easier for Parliament to fix ceilings for earnings-related compensation under the new schemes. However, the disparity of income is wide in Malaysia and this causes difficulty for Parliament to offer a viable level of compensation that suits the need of the whole population.

6.2 Reforming the existing system

The difficulties in implementing a no-fault compensation scheme suggests that policymakers should look to sustainable and incremental reform of the tort based system rather than pursuing the implementation of a full fledged no-fault system. The tort system, despite its demerits, has the unique feature of presenting the victim of negligence with a financial incentive to pursue a claim against the person believed to be responsible. The present system is useful in making large institutions more publicly accountable for their actions. Public interest is also served by issues of poor care being discussed in open court and court decisions can have positive effect on standard of care. The fear of litigation may encourage doctors and health authorities to take greater care and help reduce the number of accidents by raising quality of treatment. Thus, the tort system of civil liability has a role to play in signaling the social costs of resource allocation decisions to policy-makers in the health sector. If the tort system is not seen as purely compensatory but as a mechanism for creating an incentive to provide high quality service, the case for its abandonment is less clear-cut.

Nevertheless, if the present system is to be retained, some changes have clearly to be made.

6.2.1 Legislating the principles of law

Medical negligence law has so far been handled traditionally by court mainly through the principles made by common law. However, there are clear advantages of constructing legislations that are able to clarify the law, particularly on the changes made in establishing the standard of care in medical negligence litigation. This will provide doctors with greater certainty as to what is expected of them by law, particularly, on the difference in the standard of care demanded by them in relation to duty to disclose risks and duty to treat and diagnose. Another important part which legislation can play a vital role is to put a limit on the amount that could be awarded in medical negligence suits. These statutory limits are also known as "caps". Legislative caps will be able to restrict the size of awards in malpractice suits, particularly, in non-economic damages. Further, the requirements needed to qualify as an expert witness can also be put in statutory provisions.

6.2.2 Setting up effective patient complaint mechanisms

Medical negligence claims often starts when a patient is unable to get the appropriate information, explanation or apology from the relevant persons. These claims can be defused at an early stage if the patients received the appropriate information. To some patients, monetary compensation alone may not be the answer to their grievances. Most of the time, they want to know what actually happened, why it happened and be assured that it will not happen again in the future. They need an avenue where their complaints can be channelled expediently and taken seriously. In recent years, there has been increasing public concern on the effectiveness and credibility of the existing patient complaint mechanisms in Malaysia. These concerns have culminated into demands for a redress of

the existing mechanisms that will be able to deal with complaints expeditiously, sympathetically and comprehensively.

The right to complain is considered as an invaluable right in ensuring the quality in health care delivery systems. In order to meet the patients' demands for sufficient information and support within health care, there is a need to have an effective complaint mechanism, which possess criteria such as openness, speed and impartiality.

6.2.2.1 Channels for Complaints in Malaysia's Health Sector

At present, there are a number of channels for patient to make complaints in Malaysia. Some of these channels belong to the core regulatory institutions of the government[116], some belong to the professional self-regulatory bodies[117] and the third category consists of non-governmental organizational bodies involved directly with the health sector.[118] For the purpose of this paper, only the Malaysian Medical Council will be discussed.

6.2.2.2 The Malaysian Medical Council (MMC)

The MMC is established under the provisions of section 3 of the Medical Act 1971.[119] Although the Council is a body corporate, it gets its financial and administrative manpower

[116] These include bodies such as the Malaysian Medical Council, Malaysian Optical Council, Malaysian Dental Council, Nursing Board Malaysia, Midwives Board Malaysia and Medical Assistants Board.
[117] Examples of such bodies include the Malaysian Medical Association, Malaysian Dental Association and Federation of Private Medical Practitioners Association.
[118] Examples would include Federation of Malaysian Consumers Association (FOMCA), Trade Union Congress (MTUC) and Aliran.
[119] The Medical Act approved on 27 September 1971 and gazetted on 30 September 1971. Being provided with a legal framework and governed by the Medical Act 1971 and Medical Regulations 1974, the MMC is the core regulatory body of the medical profession. The main office of the Council is situated in Putrajaya while there is an office branch, which deals specifically with disciplinary complaints or enquiry only at the Ministry of Health, Kuala Lumpur.

support from the Ministry of Health. The functions of the MMC are to maintain a register of medical practitioners in Malaysia, to promote and maintain standards of practice of medical practitioners and to investigate complaints made against practitioners and administration of disciplinary provisions. The members of the MMC are drawn from three main sources, namely, nomination by universities, election by registered medical practitioners from East and West Malaysia, and appointed members from the public services[120]. The members shall hold office for not more than three years[121]. In the year 2005, there were 33 members of the Council. Section 19(2) of the Medical Act 1971 empowers the Council to exercise disciplinary jurisdiction over medical practitioners who is convicted of a punishable offence with imprisonment, found guilty of "infamous conduct in any professional respect"[122], obtained registration through fraudulent means and has breached the code of professional conduct. The punishments that the Council may impose on the medical practitioners found guilty are striking them off the register, suspension for a certain period they deem fit or reprimand.[123]

Any members of the public who wish to lodge a complaint against a doctor is to submit in writing to the President of the MMC, giving particulars such as the name of the practitioner, the place of practice, nature and details of complaint and documents and evidence in support of the complaint.[124] An investigation shall then be made by one of the

[120] Section 3 (1) of the Medical Act 1971.
[121] Section 3 (6) of the Medical Act 1971.
[122] The phrase "infamous conduct in a professional respect" was defined in 1894 by Lord Justice Lopez in *Allinson v The General Council of Medical Education and Registration* [1894] 1 QB 750 as follows:
"If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect."
[123] Section 30 of the Medical Act 1971.
[124] The procedures of disciplinary enquiries are outlined in Regulations 26 to 33 of the Medical Regulations 1974 and guided by the Code of Professional Conduct.

three Preliminary Investigation Committees (PICs) set up by MMC.[125] Through PICs, MMC holds a tribunal or a kind of court to inquire into the complaints about medical professionals and whether there is a prima facie case against them. One of the PICs is specifically assigned to look into matters pertaining to advertisement whereas the other two look into matters of ethics and conduct.[126] PICs can summarily dismiss an allegation if it is found to be unsustainable.[127] However, if PICs find there are grounds to support a charge, they may recommend an inquiry by the MMC[128]. If a doctor is found guilty of "infamous conduct in a professional respect"[129] during the inquiry, MMC may take disciplinary action.[130] If a person is not satisfied with the decision of the MMC in the exercise of its disciplinary jurisdiction, he or she may appeal to the High Court.[131]

Presently, the Malaysian Medical Council (MMC) has been labeled as not being effective and lacks "teeth" that it requires in a patient complaint mechanism.[132] This could be due to

---

[125] The Council may establish one or more committees and may delegate to them some of the Council's function as the Council thinks fit. This is provided under the First Schedule of the Medical Act 1971. The committees currently established by the Council are:

a) The Evaluation Committee
b) The Ethics Committee
c) The Committee to Review the Code of Professional Conduct
d) The Medical Act and Regulations Amendment Committee
e) The Preliminary Investigation Committees
f) The Editorial Committee
g) The Medical Review Panel.

[126] Nik Rosnah Wan Abdullah, *Regulating the Private Health Sector in Malaysia*, 2005, University of Malaya Press: Kuala Lumpur, at p. 129.

[127] Regulation 28 of the Medical Regulations 1974.

[128] Regulation 29 of the Medical Regulations 1974.

[129] Forms of infamous conduct which may lead to disciplinary proceedings is found in the Code of Professional Conduct which , the members of the medical profession are expected to abide apart from the provisions under the Medical Act 1971 and the Medical Regulations 1974.

[130] According to the powers given by section 30 of the Medical Act 1971.

[131] Section 31(1) of the Medical Act 1971.

[132] See *Kumaraguru*, Comment made to the Malaysian Bar's website on *Patient-protection mechanisms should be strengthened*, Monday, 10 April 2006, http://www.malaysianbar.org.my/content/view/2732/2/.

the fact that the members of Preliminary Investigation Committees (PICS) are medical professionals and by virtue section 3(1)(a) of the Medical Act 1971, the Director General of Health is also the ex-officio President of the Medical Council. Furthermore, the expenditure of the Council is also paid out of the annual budget of the Ministry of Health. The composition of the PICs suggests that the viewpoints of doctors and their interests have an important influence and this would clearly lead to possibilities of prejudice and biasness. As all complaints to the MMC are vetted through PICs, their decision on whether there is a prima facie case of professional misconduct is of crucial importance. Further, it is very rare for recommendations by PICs be overturned by MMC. The MMC usually goes by the decision of the PIC. Although the complainant may appeal against the decision of MMC to the High Court, it would be extremely difficult to set aside the findings or decision of the tribunal unless it can be shown that there is a substantial error of law or procedure or the findings are inconsistent with the evidence. Another problem, which contributes to the criticisms of MMC being ineffective, is the backlog of cases. Although PICS hold around 80 meetings per year[133] to investigate complaints, there is still a backlog of cases that have accrued from 1986, which have yet to be settled.[134] In 2005, there are 189 outstanding cases as compared to 100 of settled ones.[135] Such figure is considered worrying as it reflects PICs as being inefficient in conducting their investigations and that there has to be a major revamp on the whole system of hearing complaints and conducting investigations. MMC has further been criticized for not being effective because of its limited jurisdiction to hear ordinary negligence cases. The Council claimed that they are

[133] Nik Rosnah Wan Abdullah, *Regulating the Private Health Sector in* Malaysia, Kuala Lumpur: University Malaya Press, 2005, at p. 136.
[134] See, *ibid*.
[135] MMC Annual Report 2005.

not concerned with cases of negligence that can give rise to actions in civil courts.[136] The reason being that it is not the Council's duty to act as a court to decide whether there was negligence or not. That is for the court to decide. However, the Council do not have problem in looking at matters of gross negligence, as it would be a clear-cut case just as applying the doctrine of *res ipsa loquitor*.[137] Further, there is also no fixed time frame for the investigation to be settled by MMC and for the complainant to know the outcome of the case. As a result, the investigation process for some cases take longer time than others.

Consumer complaints are a unique source of information for health care services on why adverse events occur and how to prevent them. While poor complaints management can be damaging, good complaints management systems help to improve the safety and quality of the service.[138] Thus, effective complaint procedures are capable of being an alternative or way of avoiding civil litigation. To be effective, complaints mechanisms should be totally unbiased and without prejudice in order to maintain public confidence. Thus, there should be an independent panel comprising of "not only doctors" overseeing complaints against doctors.[139] This would clearly provide a fair and independent assessment of the complaints made. The panel should incorporate members from the legal profession with medical negligence specialty, the medical profession, representatives from medical organizations, academicians and laypersons to ensure the element of neutrality. Once the panel has

[136] Section 1.1 of the MMC Code of Professional Conduct states that: "The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence".

[137] This maxim means that "the thing speak for itself." In legal terms, it means that the fact of the accident by itself is sufficient (in the absence of an explanation by the defendant) to justify the conclusion that most probably the defendant was negligent and that his negligence caused the plaintiff's injury.

[138] See *Complaints Management Handbook for Healthcare Services*, published by Australian Council for safety and Quality in Health Care, July 2005.

[139] Proposed idea by *S.M. Mohamed Idris*, President of Consumers' Association Penang in New Straits Times, 3rd March 2006 – letters.

completed its investigations and made written reports, the matter can be referred to the Malaysian Medical Council if there is a need for further disciplinary action. In this way, complainants can be confident that the hearing of their complaints will be genuinely independent.

Further, the Medical Act 1971 and Medical Regulations 1974 should be amended to cover instances of medical negligence. At the moment, based on section 1.1 of the MMC Code of Professional Conduct, MMC is not "ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters, which give rise to action in the civil courts for negligence". The fact that MMC disregard complaints on medical errors in diagnosis or treatment clearly goes against its "primary duty is to protect the public" and fails to become an "effective disciplinary mechanism to safeguard the public."[140] Further, there should be effective complaints unit placed in public and private hospital. Although there is no provision in statutory law that demands setting up of a complaint unit in public hospitals, the Private Healthcare Facilities and Services Act 1998 enforced in May 2006 has made it mandatory for private hospitals to have a patient grievance mechanism plan.[141] This plan requires the hospital to appoint a patient relations officer to serve as a liaison between the patient and the private healthcare facility.[142] The plan also requires all complaints to be documented and detailed grievance procedure is laid down under section 40 of the 1998 Act. Amongst the list of procedures in ensuring effective complaint management is that the result of the investigation must be produced within ten working

[140] Kumaraguru, Comment made to the Malaysian Bar's website on *Patient-protection mechanisms should be strengthened*, Monday, 10 April 2006, http://www.malaysianbar.org.my/content/view/2732/2/.
[141] Section 39 of the Private Healthcare Facilities and Services Act 1998.
[142] Section 39(a) of the Private Healthcare Facilities and Services Act 1998.

days after the complaint had been received.[143] Such patient grievance mechanism plan should also be implemented in public hospital, particularly, in ensuring the designation of patient relations officer that will attend to complaints on the spot and if necessary, refer the matter for investigation as soon as possible. Strict adherence to the grievance procedures outlined in the plan will avoid backlog of cases that clearly contributes to the ineffectiveness of the system. Complaint procedures should also be well publicised and available to patients. It must also be made as easy as possible for complainants to make their views known. At the point of lodging the complaint, complainants should be provided with the necessary support and assistance to help clarify the objective of their complaint with a view of mediation, if considered appropriate. Guidance on recourse to the appropriate complaint channel should be offered to patients to minimize the chance of the case being misdirected to an inappropriate channel. All these could improve the transparency, accessibility and user-friendliness of the whole complaint system.

6.2.3 Introducing pre-action protocols

The Malaysian civil justice system is lacking of procedures that are able to encourage settlement at the earliest appropriate stage. Before the parties decide whether to bring the matter to court, it would be vital to have procedures that are able to resolve the dispute without resorting to legal action. This will instill a more co-operative culture amongst the health providers, medical professionals and patients to adopt a more constructive approach to the claims and allegations made. **Lord Woolf** in his **Access to Justice Report** *(supra)*[144] recommended that patients, their advisers and healthcare providers should work more

[143] Section 40(4) of the Private Healthcare Facilities and Services Act 1998.

[144] http://www.dca.gov.uk/civil/final/sec3a.htm#c10.

closely together to try to resolve the disputes co-operatively without resorting to litigation. **Lord Woolf** specifically recommended pre-action protocol for medical negligence cases. These are intended to build on and increase the benefits of early but well-informed settlements, which genuinely satisfy both parties to a dispute. The purposes of such protocols are:

- To focus the attention of litigants on the desirability of resolving disputes without litigation;
- To enable them to obtain the information they reasonably need in order to enter into an appropriate settlement or;
- To make an appropriate offer (of a kind which can have costs consequences if litigation ensues); and
- If a pre-action settlement is not achievable, to lay the ground for expeditious conduct of proceedings.

What is needed crucially in the Malaysian civil justice system are procedures that enables the parties to a dispute to embark on meaningful negotiation as soon as the possibility of litigation is identified, and ensures as early as possible for them to have the relevant information to define their claims and make realistic offers to settle. This can only be achieved if the court itself takes more account of pre-litigation activity than has traditionally been the case. Once a protocol has been adopted, the parties' compliance or failure to comply with it will be taken into account when the court is dealing with the future conduct of the case. In particular, if one party has unreasonably refused to accept a pre-action offer to settle, this will have consequences in costs once litigation has started.

Pre-action protocols should be made an important part of our civil justice system. They are not only intended to provide a comprehensive code for all pre-litigation behaviour, but will also be able to deal with specific problems in specific areas. They will set out codes of sensible practice which parties are expected to follow when they are faced with the prospect of litigation in an area to which a protocol applies. Protocols will make it easier for parties to obtain the information they need, by the use of standard forms and questionnaires wherever possible. Protocols will also be an important means of promoting economy in the use of expert evidence, in particular by encouraging the parties to use a single expert wherever possible. In addition, protocols will encourage the use of any appropriate alternative mechanisms for the resolution of disputes.

Recently, the Singaporean Subordinate Courts Practice Direction 3 of 2006 has introduced pre-action protocol for medical negligence cases, which takes effect on 2nd January 2007. Under the protocol, patients will have the opportunity to seek explanations or discuss their cases with doctors and hospitals without having to file a writ to get their attention. This will encourage early communication between the parties so as to ensure that any appropriate apology or explanation is offered at the earliest instance. The ultimate aim of the protocol is to advance the interest of justice by facilitating early settlement of meritorious claims and discouraging claims which are frivolous or devoid of merit. According to Judge Ng Peng Hong, director of the Primary Dispute Resolution Centre of the Subcourts, the initiative was a collaboration between the Ministry of Health, the medical fraternity, the judiciary and the Law Society. The protocol will apply from the time a potential claimant

contemplates filing a medical negligence claim in court. The first step is for the claimant to request a medical report from the doctor or hospital. This should be provided within six weeks upon payment of the requisite fee. The claimant will then write a letter of request for discussion, to which the hospital or doctor must respond within 14 days, proposing a meeting, which should be held within two months from the date of the letter. If the discussions fail to produce a resolution, the claimant must give 10 clear days' notice by letter to the potential defendants of his intention to proceed with a writ. He must also provide each potential defendant, to the best of his knowledge, with the names of all the parties he is contemplating suing. Parties who do not abide by the protocol may have to bear more of the costs and damages resulting from subsequent court action.

6.2.4 Setting up a Medical Review Bureau

There is a need to establish a system to co-exist with the courts, which can set a proper balance between doctor and patient. The Medical Review Bureau would be the starting point of entry to provide a forum outside the courtroom in which the problem may be solved without the expense, publicity and the difficulty of court proceedings. This Bureau should aim at providing a framework to resolve disputes by offering an independent, accessible and impartial alternative to the courts. It is important that the Bureau is not adversarial or disciplinary in character in order to promote co-operation amongst parties. Its principal role would be to scrutinise the medical conduct referred to it, to provide an explanation and apology and to report its findings quickly. The Bureau is to oversee its own investigations through an informal, inquisitorial procedure rather than adversarial.[145]

[145] The advantage of it being inquisitorial rather than adversarial is that parties involved are no longer opponents of each other. They will no longer be contesting with each other on who will win the case. Instead, they will be subjected to investigative methods of acquiring information.

There should be submission of written reports, which then could be referred to the Malaysian Medical Council for further action. However, the Bureau should avoid making recommendations about disciplinary action. The Bureau should not operate in a confrontational or legalistic way, as the process is intended to be questioning rather than adversarial. The composition of the Bureau should incorporate several independent assessors. These assessors should be drawn from the legal profession with medical negligence specialty, from the medical profession, from medical and law academicians and representatives from medical organisations and laypersons to ensure the element of neutrality. If specialist advice is needed, then he can be appointed temporarily or co-opted to the panel. If more than one specialty is involved, one of the assessors should represent each specialty.

When a patient wishes to bring an action against the doctor, he submits a written request to the Bureau to consider the claim. When the affected parties meet the panel members of the Bureau, no legal representation from both sides should be allowed. However, claimants may be accompanied by any member of their family or advisor.[146] Similarly, doctors may be accompanied by representatives from their professional organisation or their colleagues. Claimants should be encouraged to speak openly and freely about their concerns during interviews with the panel. Claimants must agree to give written authorization to the Bureau for access to all his medical and hospital records and allow themselves to be examined by disinterested physician. The doctor involved will then be invited to comment on the substance of the complaint. After hearing explanations from both sides, the initial

[146] This person can be anyone that the claimant trusts and has been his or her confidante throughout the ordeal. The person can even be another doctor who has been advising the claimant on the matter.

investigation should be taken up by members of the Bureau who are from the medical profession. They would be supplied with all the hospital records and the record of investigations, which has been carried out at the hospital. They should have full investigative and inquisitorial powers, with a view to identifying issues and establishing as far as possible the probable facts. Their findings would be recorded and presented to other members of the Bureau for further discussion. The Bureau must emphasise the confidentiality of the proceedings.

Once the issues have been explored, there should be a full and positive response aimed at satisfying the claimant that his or her concerns have been taken seriously. An apology and expression of genuine sincere regret should be given but it should be noted that apologising should not be mistaken for admission of liability. There should be some assurance given to the claimant that his or her grievances will be attended to as soon as possible. There should be a time limit set for the panel to complete their report, for instance, three months from the date of the complaint. It is important that the time limit set is not too long as there should not be lengthy delays for the claimant to receive information on the outcome of the investigations. Once the report has been finalised, the parties are free to accept or reject the findings of the Bureau. They can then decide to sue or settle.

6.2.5 Developing effective pre-trial procedures

The Rules of High Court set out steps that a party to a court action must take before the matter is fixed for hearing. Pre-trial procedure begins immediately after the close of pleadings and its purpose is generally to get the case ready for trial by each party

disclosing to the other in some detail the nature of his case so that the other party may know before-hand the case he has to meet at the hearing. This also helps to narrow the issues in the case and save expenses in proving admitted facts. At the moment, the pre-trial steps that are available in the Malaysian courts are discovery of documents[147], interrogatories[148], summons of directions[149] and setting down for trial[150]. It is proposed that a pre-trial procedure known as pre-trial conference be introduced at the stage when summons of directions are applied for at which the court will take a more pro-active interventionist role in setting the time frame and reviewing the procedure to be followed before trial. Pre-trial conferences involve positive intervention by the court on a pro-active basis to ensure timely disposition of the cases and the efficient utilisation of judicial time and court resources. It helps to reduce the amount of time to be spent for the trial, reduce the likelihood of cases being adjourned after hearing dates have been allocated and facilitate the fixing of the cases. The main objectives of the pre-trial conference are:

- To bring the parties together to consider the possibility of settlement;
- To assist the parties in narrowing the disputes;
- To determine the readiness of the parties to proceed to trial and make further directions as necessary to get the parties ready for trial;
- To assess the amount of time required by each party at trial.

Thus, the pre-trial conference aims at strategically monitoring events at the pre-trial stage. It will, thus allow an early opportunity for the court to review with the parties and

[147] Order 24 of the Rules of High Court 1980.
[148] Order 26 of the Rules of High Court 1980.

[149] Order 24 of the Rules of High Court 1980.
[150]Order 34 of the Rules of High Court 1980.

their lawyers on the progress of their preparation for trial, the prospect of settlement and to ensure that overall time line integrity is maintained. Close monitoring of all cases filed at an early stage and provisions made for easy transferability of cases between Subordinate and High Courts as may be deemed appropriate having regard to financial weight, complexity, importance and the capacity of the courts.

6.2.6 Implementing effective case management

Order 34[151] of the Rules of High Court 1980 sets out the steps that a party to a court action must comply with before the matter is fixed for hearing. This pre-trial case management procedure begins immediately after the close of pleadings. The objectives of this procedure is to encourage parties to co-operate with each other by disclosing some information on the nature of his case so that they can narrow down the issues at an early stage. In actions begun by writ[152], the judge to whom the action has been assigned shall order the parties to take several pre-trial steps, which are stated in Order 34 rule 4. One example include discovery of documents as required under Order 24 of the Rules of High Court 1980. However, in order for the pre trial case management to be effective, the judge has to play a proactive role in implementing the procedures stated in Order 34 rule 4. **Lord Woolf** made some recommendations on implementing effective case management in his interim report on civil justice reforms[153]. His Lordship recommended that "the courts should take over responsibility for effective and efficient case management in all cases to ensure that cases proceeded according to strict-imposed timetables and the costs generated by the litigation

[151] Order 34 was substituted by the Rules of the High Court 2000 (PU(A) 342/2000) para 15.
[152] Order 34, rule 1 of the Rules of High Court 1980.
[153] Access to Justice: Reform of Civil Procedure 1995 - http://www.law.woolf/report/recom.htm

were proportionate to the issues and the amount involved."[154] His Lordship was also of the opinion that it is imperative that during this pre-trial stage, the courts actively manage the cases by encouraging parties to cooperate with each other in identifying issues early, discussing with the parties on whether settlements through various methods of alternative dispute resolution have been exhausted and considering whether the likely benefits of taking a particular step justify the cost of taking it.[155] The court should also set a timetable, which is geared specifically to each claim to ensure that parties worked in a discipline manner and penalise parties that are delaying in settling claims in an unreasonable manner.

6.2.7 Promoting Alternative Dispute Resolution

If the present tort system is to be retained, there is a need for alternative dispute resolution to be an integral part of the litigation process. Alternative dispute resolution methods have the advantage of preserving doctor-patient relationship and offer an alternative for those who lack the stamina to see through the litigation process.

6.2.7.1 Mediation

Compared to other methods of alternative dispute resolution, mediation seems to offer a costless process of integrative bargaining. It does not emphasize on who should win or lose, who is right or wrong. Rather, it focuses on goals of reconciliation and personal transformation. In mediation, parties participate directly in what is thought to be an informal and voluntary dispute resolution process that may offer a novel and promising approach in resolving claims. The author strongly suggests that mediation be used as the

[154] *Ibid*.
[155] *Id.*

main form of dispute resolution as it provides speedy, economical and trauma-free alternative to litigation. **Lord Woolf** in his ***Access to Justice Final Report 1996*** has singled out medical negligence as requiring special attention because it has become increasingly obvious that it was in the area of medical negligence, that the civil justice system was failing most conspicuously to meet the needs of litigants in a number of respects. His Lordship further recommended alternative dispute resolution mechanisms, particularly mediation, to be used for medical negligence claims, which may be better suited than litigation to the needs of both patients and doctors.

For successful mediation, the role of the mediator must be clearly defined. The mediator is not to make a decision, as that is the function of the judge or the arbitrator. The role of the mediator is simply to establish an atmosphere in which the parties work to settle a situation themselves. The good mediator constantly points out to the parties the practicalities of negotiations and the advantages and disadvantages of various approaches. Necessarily, mediators should have fair knowledge of the subject matter. This can be achieved by having independent scientific experts advising mediators on aspects of medical issues. With sufficient knowledge, mediators should be able to propose settlement terms, with compensation being assessed for losses or previous temporary impairment and loss of income suffered and the effects of continuing impairment. By probing strengths and weaknesses of each side, the mediator can facilitate settlement or help to narrow the issues in dispute. The strength of evidence on one side can be brought to the attention of the other side at an early stage and this may prompt early settlement. Substantial costs and expenses can be saved. The appointment of the mediator should be at the discretion of both parties.

Impartiality should be the main assessing criteria in choosing the mediators. Mediation should be conducted on without prejudice and the mediator should have the power to choose the procedure, which he thinks fits and considered to be the most efficient, speedy and cost effective. The mediator cannot be called upon to act as an advocate adviser or witness to a litigation proceeding or be in a position that requires him to disclose information about any matter arising from the mediation. This is to ensure the confidentiality of the proceedings. The parties should bear their own costs of mediation and pay half of the mediator's fee regardless of the outcome.

Mediation also provides an early opportunity for patients' needs to be reviewed and addressed in a positive light. Unlike arbitration or court litigation, no resolution can be reached save by the consent of the parties and mediator's decision is not binding. All discussions are without prejudice and parties can walk away at any stage. In other words, the parties should be free to continue or opt out. Settlement achieved should be on terms acceptable to all parties after each side assesses and balances the risks involved. If after a session of information-sharing and good faith negotiations the parties cannot agree, settlement will not and should not result. Levels of compensation offered must be realistic. It must be a structured settlement and the complainant is to be told what is the adequate award for their type of injury and structured specifically for them.

The recent announcement by the Malaysian judiciary[156] that there is a proposal for a Mediation Act to allow for court-annexed mediation is very much welcome. Court-

[156] See Prime News in News Straits Times, Monday, June 18, 2007, at p. 6.

annexed mediation is when a judge refers the matter to a mediator with or without the consent of the parties involved. This will ensure speedy disposal of all pending civil cases as of July last year, there were 319,862 civil cases pending in the high courts and the subordinate courts which were registered from 1st January 2000. The Supreme Court of Australia has successfully tackled backlogs in civil cases between 1992-1993 by implementing mandatory mediation in this way.[157] If mandatory mediation is to be implemented during pre-litigation stage, claimants should file a written request for mediation within two to three weeks of filing their malpractice claim. Mediation panel should consist of three members; a lawyer who chairs the panel, a doctor or health professional with some expertise in the area of the claim and a layperson. It does not matter if they do not have previous experience but some brief mediation training may be required. The lawyer is to assume the role of a legal expert, the doctor as a neutral medical expert and lay member as an advisor. Panels are to meet within the prescribed period for mediation and parties involved must attend the mediation session. These sessions are to be informal and non-binding. No records are to be kept and nothing said in a session is admissible in a subsequent court action. In theory, panels do not render decisions but if mediation does not produce agreement, panel members are then free to advise parties on their projections of the likely outcome should the case proceed to trial. This will enable them to initiate the processing and settlement of small claims that might not otherwise be able to proceed because of the high transaction costs of litigation. In this way, unmeritorious claims can be removed from the courts as soon as possible.

6.2.7.2 Arbitration

[157] Bartlett, C., "Mediation in the Spring Offensive 1992" (1993) 67 Law Institute Journal 232.

Arbitration may be defined as settling a dispute through appointing a third party, chosen by the disputants, whose decision will be binding on them. In Malaysia, the Arbitration Act 2005 lays down the general procedure to be followed in an arbitration proceeding. According to section 9 of the Arbitration Act 2005, "arbitration agreement" means an agreement by the parties to submit to arbitration all or certain disputes which have arisen or which may arise between them in respect of a defined legal relationship, whether contractual or not. The arbitrator is usually a person who is an expert in the relevant field, which is the subject matter of the dispute. Arbitration agreements usually unequivocally waive their rights to trial or judicial oversight of their disputes.

There are many advantages in arbitration proceedings compared to court proceedings. The procedure involved in arbitration proceedings is less formal and simpler. For instance, arbitration proceedings require less discovery and strict rules of evidence are relaxed. This means that arbitration proceedings would solve many problems created by complex medical negligence cases such as difficulty in finding expert medical witness. Coincidentally, the costs of litigation would be less to pursue and resolution can be reached faster. There is no time constraint on the parties as the proceedings can take place at any time according to the availability of the parties. Further, arbitration forums are private and not for public viewing. This would mean that none of the parties run the risk of publicity that may be damaging to their reputations. Thus, by arbitrating, the possibility of maintaining a positive relationship between doctor and patient is favourable compared the tense relationship they have to bear in court proceedings. However, the written agreements between the parties in arbitration proceedings have no precedential value. Thus, disputes

proceeding to resolution in arbitration are not integrated into the dynamic process of creating case law.[158] This may create unnecessary hardship for medical negligence cases as these cases usually involve the complexity of medical jargons. Thus, where the facts of the cases are similar, reference would be denied, as precedents are irrelevant in arbitration proceedings.

7.0 Conclusion

There has certainly been a recent tenfold increase in the number of medical negligence claims mounted in the courts in Malaysia. With the current problems affecting medical negligence litigation, it would appear that the no-fault compensation scheme could provide a tempting solution. However, even with its merits, the scheme may not provide a real solution because the benefit must be weighed against the fact that it will do away with the deterrent effect. Funding the scheme is still a problem and the fact that it relinquishes the rights to civil action has to be given a thorough consideration. Other alternatives to the litigation process such as various methods of alternative dispute resolution merit consideration. Litigation has proved to be a destroyer of relationships and the cause of emotional turmoil's for the parties affected. Amicable and peaceful way of solving disputes should be promoted. In the words of *Abraham Lincoln*:

> "Discourage litigation, persuade your neighbours to compromise whenever you can. Point out to them how the nominal winner is often a loser in fees, expenses and cost of time."

Nevertheless, there is no easy answer to the problems arising in medical negligence litigation. Opinions may differ on what is the best method to be used to resolve this

[158] Rolph, E., Moller, E., & Rolph, J.E., "Arbitration Agreements in Health Care: Myths and Reality" (Winter 1997) 60 Law & Contemporary Problems 153, at p. 156.

conflict. But there is widespread consensus that continuing with the present system unaltered is clearly an unsatisfactory policy option. As Lord Justice Otton aptly said:

> "The question that need to be asked is as a civilised society, are we content with a system where a person who has by ill-fortune suffered grievous injury as a result of medical treatment can be denied all form of compensation due to the failure to establish negligence? The present system requires...serious thought. It is time that society, government, doctors, judges and academics, and in particular members of this prestigious and influential society considered the possibility of thoroughgoing change."[159]

[159] Lord Justice Otton, "Medical Negligence - Is there something wrong? [2001] 69 Medico-Legal Journal 72, at p. 75.