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EROSION OF THE TRUST IN HEALTH CARE SYSTEM: DOCTOR'S DUTY OF CARE

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INTRODUCTION

The trust in medical care system is eroding for obvious reasons. Firstly, the state funds allocated to this sector are not sufficient to first, set up and then maintain an efficient health care system, particularly in poor countries, which have limited resources. Secondly, the human factor necessary for a successful health care system is backsliding. The lack of human factor results in apathy and error in diagnosis and treatment, which breads dissatisfaction. In this paper the issue will, therefore, be discussed from two perspectives of resource shortage and medical negligence. Under the first perspective a brief account will be presented of the resource problem of health care system. Under the second perspective a detailed study of medical negligence and its related issues will be undertaken, with a comparative approach of various jurisdictions.

THE PROBLEM OF RESOURCE SHORTAGE

Health Care System encompasses the whole range of activities involved in the process of health care of the people. It would also involve management and control of epidemics that break out occasionally. The normal process of health care commences with the detection of the disease and reporting it to the providers of health care. This is followed by the medical check-up and consultation in order to arrive at a diagnosis. Next is the advice and treatment. In this process a whole lot of infrastructure and manpower is involved. The infrastructure consists of the hospital, the health clinic or medical centers, as the case may be, the equipment and other physical facilities and the medicines available for the patients. On the other hand, manpower consists of the doctors, paramedical staff, administrators and other support staff.

In case all these components are in order, the system works well. Unfortunately, that is not always the position. Many countries today lack one or the other aspect of health care. Moreover, a perfect health care system is not within the reach of every country. It takes huge resources for setting up and maintaining an efficient and effective health care system for all the people. The poor and the underdeveloped countries would not be in a position to bear the burden of modern health care facilities. With their limited resources they cannot aspire for a health care system of international standard for all their people, for, whatever scarce resources they have, much of it is eaten up by their poverty, malnutrition and the epidemics that befall them. It is for these disparities that a uniform and universal standard of health care is not achievable. Each country shall have to pragmatically set its own standard of health care, which is achievable, depending on its resources.

Nonetheless, the ample resources and the proper health care facilities available in some advanced countries, does not mean that everything is fine there. These countries also face problems in the area of health care, relating to medical negligence, informed consent and defensive medicine. These countries also face a burgeoning health care litigation, which has in turn pushed up the cost of medical insurance.

Malaysian Health Care Planning

In Malaysia the budgetary allocation of funds for health care is based on the programmes, which are designed for different health care sectors. The Primary Health Care and the Family Development and Medical Care constitute two main programmes for budgetary purposes. Primary Health Care covers minor ailments, through first examination and treatment in the hospital. It also includes Preventive Health Care in the form of campaigns for hygiene, eye and dental examination camps in schools and other related activities. The doctors in the Primary Health Care organization constitute the bulk of medical practitioners whose services are utilized for the prevention or detection of diseases at early stages, involving an effective but inexpensive treatment

The expenditure for the health facilities in Malaysia is the responsibility of the federal government for which liberal grants are made available to the states. Over the years there has been an increase in the budgetary allocation for medical care. In the 2004 budget, out of a total outlay of RM 112.5 billion a sum of RM 9 billion (8 %) has been allocated for health care. This reflects an increase of 20.5 % from the previous budget for the year 2003. The thrust of the allocation is on the provision of essential medical treatment services, such as dialysis, intensive care and programmes to reduce morbidity and mortality among children. In order to improve and increase the diagnosis and monitoring of infectious diseases, such as SARS, tuberculosis, leprosy and dengue, the Government will provide a sum of RM3 million.

Many hospitals have been built with modern and sophisticated equipment, including the application of ICT for the paperless Total Health Information System (THIS). RM 20 million has been allocated to expedite the setting up of the Centre for Disease Control to combat the spread of diseases. Private Commercial Wings have been set up in Government hospitals, with the dual purpose of meeting the demand for specialist medical care and at the same time enabling serving

doctors to enjoy better remunerations for serving with the Government. It is also aimed at enabling the Government hospitals to be promoted abroad, in line with the objective to encourage health tourism. Other measures underway for the improvement of the health care facilities in the public sector include the government efforts to appoint more doctors in the hospitals and the health care centers so that health care is not denied to people on account of shortage of medical men. Although private sector has been able to provide greener pastures for the medical practitioners but the government is serious to consider revision of salaries for doctors in the public sector as a protection against allurements for them elsewhere. In the past few years there has been some increase in the private medical care centers but the government's efforts to upgrade the facilities and attract best doctors is likely to improve the condition of public sector health care system. At the same time, in order to reduce the increasing financial burden of health care for the Government, the health insurance industry is encouraged to widen its coverage by providing lower premiums affordable to a majority of Malaysians.
The Eighth Malaysian five year plan (2001-2006) envisages Malaysia to be a country of healthy individuals, families and communities through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adoptable and consumer friendly. The emphasis is on equity, innovation, health promotion and respect for human dignity, which promotes individual responsibility and community participation towards an enhanced quality of life[1]. Priority is given to the disadvantaged groups. Quality of the health care services is emphasized with the elements of consumerism, accountability, patient centered care, client satisfaction, efficiency, effectiveness and process control. For accountability and efficiency, it is desired from the health care providers firstly, to share information about their performance with those who have an interest in it; secondly, to develop a work culture with values that are fundamental to the pursuit of quality. The values would include commitment, quality consciousness, timeliness and learning paradigm and thirdly, to have a programme of sustained research in quality in order to measure desired outcomes such as how to help doctors comply with effective strategies or dealing with health problems.

The Human Element

Be that as it may, in each system of health care there is a human element without which it is not possible to achieve the desired standards. Howsoever big or small the health care system may be, its success depends, to a large extent, on the will and commitment of the concerned authorities, especially the government and the human resource group for the system, including doctors and the paramedical staff. The doctors not only have to be qualified but they also need to be dedicated and responsible. They need to realize that the patient, who is generally in a state of distress, submits to the knowledge and experience of the doctor, expecting a speedy cure. This demands utmost care on the part of the doctor in arriving at an accurate diagnosis, proper advice and appropriate treatment for the patient. The doctor should also have regard for his professional obligations and a sense of accountability to the society, as these are not only ethical but also the legal underpinnings on which a sound health care system is based.

It is painful to see that these qualities and qualifications of medical men and the standard of health care system are on a decline. In the wake of commercialization of medical profession, the

[1] Eighth Malaysian Plan, Ch 17, p 509

element of profit making appears to have relegated the patient interest to the background. The situation, in the Indian context, is reflected in the judgment of its Supreme Court when it said:

> [S]uch organizations who in the garb of doing service to humanity have continued commercial activities and have been mercilessly extracting money from helpless patients and their family members and yet do not provide the necessary services[2]

The Apex Court of India outlined the other woes, which a patient has to face. According to the court:

> [I]t is indeed very difficult to raise an action of negligence. Not only that there are practical difficulties in linking the injury sustained with the medical treatment but also it is still more difficult to establish the standard of care in medical negligence of which a complaint can be made. All these factors together with the sheer expense of bringing a legal action and the denial of legal aid to all but the poorest operate to limit medical litigation in this country[3].

Here, we get a glimpse of some of the broader issues in the sphere of medical care. First is the growing apathy on the part of the health-care providers; second, the difficulty in establishing the standard of care for the doctors; third, the requirement to establish causation and lastly the huge legal expenses involved in medical negligence litigation.

This reflection of the state of medical care in India may not be much different from what prevails in other countries of the common law system. The Malaysian consumers also have similar stories to tell about the apathetic and negligent attitude on the part of some doctors. This brings us to the basic question relating to the standard of care expected of a doctor.

THE CONTOURS OF THE STANDARD OF MEDICAL CARE

Law has put the doctor under a duty of care to his patient but the scope and the implications of this duty have undergone great transformation at the hands of judiciary, particularly in the last quarter of the last century. The contours of the duty of care have been reframed. One reason for this change is globalization and transparency resulting in wide spread awareness on medical sciences and the consciousness of the people about their rights. Further, the element of commercialism that has crept into the health care sector in recent years has acted as a catalyst in sensitizing people about their health care issues. The negligence of the doctor is no more a simple matter of fate for the patient to make him complacent. The doctor may have to answer for his callous and negligent conduct if he violates the standard of care.

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[2] *Spring Meadows Hospital v Harjot Ahluwalia* [1998] 4 SCC 39 at 46. In this case, a child with typhoid was admitted to the appellant's hospital where the nurse gave a wrong injection 'Lariago', leading to the immediate collapse of the child who suffered irreparable damage to his brain and could survive as a mere vegetable

[3] Ibid

Position in England

In the United Kingdom, the determination of the standard of care required of a doctor is left to the medical profession. This is vouched by the *locus classicus* on medical negligence laid down in the case of *Bolam v Friern Hopspital Management Committee*[4]. In that case McNair J prescribed the standard of care for the doctors as the standard of the ordinary skilled man, exercising and professing to have that special skill, not necessarily the highest expert skill at the risk of being found negligent. It is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. The standard of ordinary skill was to be laid by the profession itself. According to McNair J:

> The doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a reasonable body of medical men skilled in that particular art…putting in another way around, a man is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion that would hold a contrary view[5].

This judgment laid down the parameters of the standard of care prescribed for a doctor and gave authority to the medical profession to set its standard. According to the court the standard of care prescribed for the doctor was that of an ordinary skilled doctor of his qualification and not that of an expert of higher qualification. Whether in a given case the doctor has observed the standard care, was left for the determination of the reasonable body of medical men.

This reflects medical paternalism, where little is left for the court to decide because in the event of allegation of negligence the doctor is basically subject to a peer judgment in deciding whether he has been negligent or not.

Another important issue in medical care is that of patient's consent for the treatment. Under English law, although a doctor is required to obtain consent from his patient for the proposed treatment, the courts have not recognized the principle of informed consent, under which the doctor is required to give the patient all material information necessary for him to frame a rational consent for or against the proposed treatment. The House of Lords in the case of *Sidaway v Board of Governors of Bethlem Royal Hospital*[6] held that the *Bolam* test of responsible body of medical opinion would apply also in respect of the doctor's duty to warn his patient of the risks inherent in the proposed treatment. Thus, it was left to the doctor to decide whether the risk inherent in the proposed treatment was material to qualify for its disclosure to the patient. An exception was carved in respect of cases where the disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an

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[4] [1957] 1 WLR 582

[5] Ibid at 586. In recent cases the difference of opinion among the medical experts has been viewed seriously. That aspect is discussed at pp 6-7 and 9 infra

[6] [1985] 1 AC 871. *Sidaway* was preceded by the case of *Hills v Potter* [1984] 1 W.L.R 641,652, where it was held that the professional standard of practice applies to a doctor's duty to disclose in the same manner as it applies to duties with respect to diagnosis and treatment. Hirst J felt that the prudent patient test under informed consent would cause formidable problems and potential liabilities for the medical men (at 653)

informed choice that no reasonably prudent doctor would fail to disclose that risk. This attempt of the court to create an exceptional situation, for the obvious risks of serious adverse consequences so as to qualify for disclosure to the patient, could be termed as halfhearted because it made no difference, as the test in such cases was again that of a reasonably prudent doctor. The final judgment was, therefore, once again in the hands of the profession.

The court listed various reasons to give preference to the 'prudent doctor' test over the 'patient autonomy'. Firstly, volunteering unsought information about the risk of failure of the proposed treatment to achieve the result sought, would deter the patient from undergoing the treatment, which in the expert opinion of the doctor is in the patient's interest to undergo. Secondly, the doctrine of informed consent gives insufficient weight to the realities of the doctor/ patient relationship. Thirdly, it is not feasible for the doctor to educate the patient, to his own standard of medical knowledge, of all the relevant factors involved. Fourthly, it would mean that expert medical opinion is no more necessary for the court to arrive at its judgment. Fifthly, the outcome of medico-legal litigation would be unpredictable if judges have to decide what kind of risk a reasonable person in the patient's position would consider significant[7].

These reasons may not be well founded to answer the apprehensions about patient interest, which may be imperiled by the abuse of medical paternalism. There are other common law jurisdictions, which sharply disagree with the English approach. Even in England there is a difference of opinion on this issue. In *Sidaway* too Lord Scarman, in his dissenting judgment, rejected the standard medical opinion as a test in relation to the disclosure of *material risks*. To him, it was for the court to decide whether the doctor is advising the patient in accordance with the requirement of law. Hence, for Lord Scarman, the materiality or otherwise of a risk was to be determined not by the medical opinion but by the court[8]. Lord Bridge and Lord Keith, although they formed a part of the majority in this case, also were not satisfied to accept purely medical expert opinion on a question about which the patient is the only real expert, namely whether the risk in question is worth taking in the light of the physical condition it is meant to alleviate. Lord Bridge made it clear that if an expert witness were to tell the court that the medical profession believed that it was all right not to inform a patient of a gross risk, for example a 10% risk of total paralysis, a judge would be right to ignore the expert and declare the doctor to have been at fault.

Thus, under English law, the doctor's professional actions are scrutinized by medical profession not only in matters of diagnosis and treatment but also in deciding the necessity of disclosing relevant information, the quantum of information to be disclosed and the manner of its disclosure to the patient.

It may however be noted that some recent English cases have caused dents in the absoluteness of the *Bolam* principle. The House of Lords in *Bolitho v City of Hackeney Health Authority*[9] held that, in the event of difference of opinion among the expert doctors, the doctor would be liable for negligence in diagnosis and treatment despite a body of professional opinion sanctioning his

[7] See the judgments of Lord Diplock and Lord Bridge at pp 895 and 899 respectively in *Sidaway*
[8] Id at 876
[9] [1997] 4 All ER 771

conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied upon was *responsible, reasonable and respectable*. The Court of Appeal in the year 2000, further explained the position when in *Penny & Anor v East Kent Health Authority*[10] it held that the two sets of competent experts may genuinely hold differing opinions. The *Bolam* test has no application where what the judge is required to do is to make findings of fact.

Position in Malaysia

In Malaysia, courts have largely followed the British precedent[11]. The preference for medical paternalism in Malaysia is evident from the recent Court of Appeal case of *Dr Soo Fook Mun v Foo Fio Na & Anor*[12]. Although in this case it was the issue of medical negligence in surgical treatment that was in question, the court appears to have followed the English *Bolam* test in all its aspects. Gopal Sri Ram JCA considered the *Bolam* test appropriate for Malaysia for the present. The learned judge abhorred a too interventionist approach of law in the field of medical negligence where:

> For the time being the *Bolam* test maintains a fair balance between the law and medicine. There may perhaps come a time when we will be compelled to lower the intervention threshold if there is a continuing slide in medical standards. But that day has not yet come[13].

It is not known whether the learned judge had the actual data on medical negligence cases in Malaysia before him, in deciding that the time had not come to lower the interventionist threshold. If we go by the recent figures reported in the print media, we may have to take a fresh look on the judicial attitude. The rate of medical negligence in Malaysia has reached a soaring high of 40%. This would certainly include the non-disclosure of risk cases. Every year 2000 to 4000 deaths occur due to some form of medical negligence[14] and a significant number of such cases go unreported either because of the 'out of court settlement', or because the patients accept the incidents as matters of fate, or they are ignorant about their rights, or are too poor to afford litigation. It may be pertinent to note that there is no speedy and inexpensive system of administration of justice in medical negligence cases in Malaysia as envisaged for other consumer cases under the Consumer Protection Act 1999.

In Malaysia, the English precedent has been followed also in respect of informed consent. The duty of the doctor to disclose *material risks* to the patient, in undergoing or foregoing a treatment, has been accepted on the lines of English law. In *Liew Sin Kiong v Dr Sheron OM Paulraj*[15] following *Sidaway*, the duty of disclosure was held to be measurable according to the

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[10] [2000] Lloyd's Rep Med 41

[11] See for example, *Chelliah a/l Manickam & Anor v Kerajaan Malaysia* [1997] 2 AMR 1856; *Kamalam a/pRaman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd* [1996] 4 MLJ 674; *Kow Nam Seng v Nagamah & Ors* [1982] 1 MLJ 128; *Elizabeth Choo v Government of Malaysia* [1968] 2 MLJ 271; *Chin Keow v Government of Malaysia* [1967] 2 MLJ 45; *Inderjeet Singh a/l Piara Singh v Mazlan bin Tasman &Ors* [1995] 2 MLJ 646

[12] [2001] 2 CLJ 4575

[13] Ibid at 4582

[14] See New Straits Times 23-02-2003 at F1-2

[15] [1996] 5 MLJ 193

standard set up by the opinion of a responsible group of doctors. In this case the defendant doctor had explained, to the patient, the risk of infection in the eye that underwent surgery, although he had failed to disclose the risk of danger to the patient's spinal cord. Such non-disclosure was considered to accord with the standard practice of reasonable body of neurosurgical opinion[16].

It is submitted that there are sound reasons to differ from the court's view in these kinds of cases. The risk to the spinal cord is something very grave, which, if it materializes, could cause a grave threat to the patient's life. The patient, therefore, has a right of information about such a risk. Certainly, such risks are *material risks*, which are sure to influence a reasonable patient's decision to undergo or forego the proposed treatment. The court, in the instant case, seems to have taken refuge in the patient's failure to prove on evidence that the surgeon had been in breach of duty by failing to warn him of that risk. The court gave the doctor an overriding power to decide what information should be given to the patient, as also the terms in which the information should be couched, in the 'best interests of the patient'. Thus the clinical judgment of the medical profession prevailed over the concerns of the patient[17]. Nonetheless, in either of the situations, the judgment of the doctor may still be questioned to see whether it was really in the 'best interest of the patient'.

Australian Position

In Australia the courts have refused to toe the *Bolam* line of medical paternalism. In *Rogers v Whitaker*[18] the High Court refused to follow the test of responsible body of medical opinion in as for as the advice part of the medical care is concerned. According to the court in matters of diagnosis and treatment the patient's role is only marginal as his contribution is limited to the narration of symptoms and the relevant history. He does not form a judgment but is merely a recipient of the doctor's expertise. But in relation to the medical treatment, except in cases of emergency and necessity all medical treatment is preceded by the patient's choice to undergo or

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[16] In the English case of *Hills v Potter supra* n 6 also the expert neurosurgeons testified that non-disclosure of the risk of paralysis, in an operation to correct a neck deformity, accorded with the standard medical practice. Consequently the doctor was not held liable for negligence

[17] In the case of *Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd* [1996] 4 MLJ 674, which was decided about the same time by another Malaysian High Court , a departure was made from the *Bolam* standard of medical care when it was held that the standard of care is not determined 'solely' or even 'primarily' by reference to the opinion of the profession but must conform to the standard of reasonable care demanded by law. This could be taken to apply also to the doctor's duty to disclose risks for which the reasonable patient test would apply rather than the peer judgment by the profession. However, this is an isolated case, which has not received any further support from Malaysian judiciary. The *Bolam* approach appears to have been given doctor friendly interpretation in Malaysia in *Payremalu Veerappan v Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380 when mere failure on the part of the doctor to warn the patient of the risk involved in the proposed treatment was not considered negligence *per se*. According to the High Court, in order to constitute negligence, the non-disclosure must relate to a risk, which is real and not farfetched and fanciful.

[18] [1992] 175 CLR 479 at 631

forego it. However the choice is meaningless unless it is made on the basis of relevant information and advice[19]. In the end the court considered the duty of the medical profession to the patients as a 'single comprehensive duty', which encompasses diagnosis, treatment and advice. In matters of diagnosis and treatment the professional opinion is relevant to the court's determination of whether a particular standard of care has been met. However, the professional opinion is never decisive or determinative. On the contrary it remains for the court to make such a decision[20]. In the subsequent case of *Naxakis v Western General Hospital*[21] the court confirmed the rejection of the *Bolam* test in relation to all the three aspects of medical care, viz., diagnosis, advice and treatment. In respect of the professional expert opinion the court said:

> [T]o allow that body of opinion (peer opinion) to be decisive would reintroduce the *Bolam* test into Australian law. In *Rogers v Whitaker* this court rejected the *Bolam* test and held that a medical negligence may be made even though the conduct of the defendant was in accord with a practice accepted at the time as proper by a responsible body of medical opinion…as long as there is evidence that other *respectable practitioners* would have taken a different view[22].

Thus the possibility of bias in the opinion of the responsible professional body of doctors was not ruled out, casting doubts about its reliability.

For an informed consent the doctor is required to reveal *material risks* to the patient and the materiality or otherwise of the risk would be judged from the standard of a reasonable person in a particular patient's position unless the patient, to the doctor's knowledge, would attach unusual significance to it[23]. The Australian courts are of the view that unless there is a particular danger that the disclosure of all relevant information would harm an unusually nervous, disturbed or volatile patient no special medical skill is involved in disclosing the information including the risk attendant on the proposed treatment. The skill is seen to lie in communicating the relevant information to the patient in terms reasonably adequate for that purpose, having regard to the patient's apprehended capacity to understand the information[24].

American Position

In America the patient autonomy is not absolute. The prudent doctor test has an overriding effect in medical decisions. The common law principle that an unauthorized touching constitutes trespass to the person has in principle been accepted. It is also agreed that every human being of adult years and sound mind has a right to determine what shall be done to his body[25] but the last word in medical matters still remains with the doctor. In *Salgo v Leland Stanford Jr. University Board of Trustees*[26], the court recognized the doctor's duty to disclose any facts, which are

[19] Id at 489
[20] Ibid
[21] [1999] 73 ALJR 782
[22] Per Mc Hugh J at 791
[23] *Rogers v Whitaker* [1992] 175 CLR 479 at 631. This has come to be known as prudent patient test
[24] Ibid
[25] Justice Binjamin Cardozo in *Schloendorff v Society of New York Hospital* 105 N.E. 92(N.Y. 1914)
[26] 317 P.2d 1093 (1960).

necessary to form the basis of an *intelligent consent* by the patient to the proposed treatment, but the content of disclosure was held to be a matter of professional medical judgment. This was followed by the Supreme Court of Kansas in *Natanson v Kline*[27], where, following the objective test of a prudent doctor, there was held to be a duty on the doctor to reasonably disclose to the patient the inherent risks in the proposed treatment.

Even in America there is no unanimity on the *prudent doctor* test. The District of Columbia Circuit Court of Appeals in the case of *Canterbury v Spence*[28], held the doctor under a legal duty to disclose all the *material risks* to which the *reasonable patient* would attach significance in deciding whether to undergo or to forgo the proposed treatment. This was subject to the exception of the doctor's therapeutic privilege to withhold information as to the risk if that is known to pose a serious threat of psychological detriment to the patient. Thus, *Canterbury* saw a shift from 'medical paternalism' to 'patient autonomy', upholding the patient's right of informed consent exercised in the light of options available and the attendant risks. The court adopted the prudent patient test enabling the patient to make a fair and informed decision in undergoing or foregoing the proposed treatment, which may be based also on his relevant personal factors such as age, status, outstanding obligations and financial position.

Canadian Approach

In the serene waters of medical paternalism the real turbulence was, however, caused by the Canadian judiciary. The Canadian Supreme Court in *Reibl v Hughes*[29], on the lines of *Canterbury* approach of the North American court, refused to follow the beaten track of the doctor's clinical judgment, in all aspects of medical negligence. This was particularly so in the area of informed consent in as far as the disclosure of risks to the patient was concerned. The court differentiated between the doctor's duty to exercise professional care in the treatment of the patient and his duty to disclose the risks involved in such treatment. The latter could not be left to the judgment of the doctor. In the words of the court:

> To allow medical expert evidence to determine what risks are material, and hence should be disclosed and correlatively what risks are not material, is to hand-over to the medical profession the entire question of the scope of the duty of disclosure including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to risks that reside in or as a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under

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[27] 186 Kan. 393, 350 P.2d 1093 (1960).

[28] 464 F. 2d 772 D C Cir 1972; This case was followed by many other jurisdictions including the Supreme Court of California in *Cobbs v Grant* 104 Cal Rptr. 505 (1972) and the Supreme Court of Rhode in *Wilkinson v Vesey* 110 R.I 606 (1972). However, majority of the jurisdictions in the United States maintain the doctrine of informed consent as regulated by medical experts

[29] [1980] 114 DLR (3rd) 1 (SCC)

> consideration here is the patient's right to know, what risks are involved in undergoing or foregoing certain surgery or other treatment[30].

Thus, the question of determining the materiality or otherwise of the risks involved in the proposed treatment was no more left, solely, to the clinical judgment of the doctor, although the findings about the risks involved could be best left to the medical profession itself. The former are the matters relating to the scope of the duty of disclosure, which, according to the court, can be decided by the court but in which the expert evidence would have relevance. It is for the court to decide whether or not the doctor has discharged the burden of disclosure. Apparently, for the purposes of disclosure, the court made no discrimination between the material and the non-material risks. The doctor was obliged to disclose *all perceivable risks* to the patient, which would have a bearing for him in making a fair judgment.

Hence, what surfaces is that the doctor's duty to inform the patient about his ailment and the risks involved in diagnosis and treatment has turned into a contentious issue in the field of medical negligence. Given the fact that the medical science is an inexact science especially in the area of treatment, whether surgical or medical, a doctor cannot guarantee perfect results. There is always some element of risk involved in the proposed treatment. But this risk cannot be left, solely, to the choice of the doctor, for which, and more importantly, the patient's consent has to be obtained. The patient's preparedness to accept the treatment would depend on many factors including those which are personal to him and which need to be given due consideration. The doctor has to reasonably inform the patient about the nature of the disease, the proposed treatment, the available alternatives and the risks involved in undergoing or foregoing the proposed treatment[31].

It would be pertinent to clarify here that treating a patient without his consent has been held to include continuation of treatment on an unwilling patient. Thus a doctor, who started the treatment with the patient's consent, would be liable for administering the treatment without the patient's consent if the same is continued after the patient desired its discontinuance. In the recent English case of *Re B (adult): refusal of Medical Treatment*[32], a 41 year old woman, suffering from brain hemorrhage, ended up in paralysis. She was kept on a ventilator, which she desired to be taken off. The doctors refused to switch off the ventilator because they did not want to end her life. It was held that the treatment had been continued against the consent of the patient. The court said:

> The right of a competent patient to request the cessation of treatment had to prevail over the natural desire of the medical and nursing profession to try to keep her alive. If mental capacity were not in issue and the patient, having been given relevant information and

[30] Ibid at 13

[31] The word reasonably is used here to acknowledge that a doctor can not be expected to fully educate a patient about all medical knowledge involved in the case

[32] [2002] All ER 449 Fam D

offered the available options, chose to refuse treatment, that decision had to be respected by the doctors[33].

The law is not going to budge even if the doctor has taken the decision solely in the interest of the patient, considering it to be the best option in the given circumstances. Such a decision on the part of the doctor may not always cross the threshold of 'reasonable care' test prescribed by law.

Liability Sans Causation

A doctor cannot be held liable unless it is his negligence that resulted in the patient's damage. Consequently, the doctrine of informed consent cannot be invoked against a doctor in the absence of causation. This means that the doctor's non-disclosure of the risks would implicate him for negligence only when the patient has suffered because of such non-disclosure. There has to be a nexus between the non-disclosure of the risk on the part of the doctor and the damage suffered by the patient. This issue came up before the Supreme Court of Canada in *Reibl v Hughes*[34] , where the plaintiff alleged that he suffered due to the negligence of the doctor in not informing him of the risk involved in undergoing the proposed treatment. The court placed the patient under the onus to establish that he would not have undergone the recommended treatment had he been properly informed about the risks involved. Laskin CJ evolved the test for causation based on a combination of the subjective considerations of the patient and the objective standard of medical profession. Hence, the personal factors having a bearing on the patient's judgment would have to be taken into account in the matter of causation. According to what has come to be known as the *modified objective test* the court should focus on what a reasonable person in the position of the particular patient would have done in those circumstances. Although the fears unrelated to *material risks* would not constitute a causative factor, other ascertainable factors such as age, income and the marital status of the patient, should be taken into account, so too his reasonable beliefs, fears and expectations should be objectively considered.

The modified objective test has been endorsed by the Supreme Court of Canada in *Arndlt v Smith*[35], where Cory J, outlining the benefits of the test, opined that it emphasizes the patient's right to know and ensures that the patient will have the benefit of a high standard of disclosure. At the same time it ensures that our medical system will have some protection in the face of liability claims from patients influenced by unreasonable fears and beliefs while still accommodating all the reasonable concerns and circumstances of the plaintiff[36].

The requirement of causation has been subjected to varying interpretations. In Australia causation has been liberally interpreted. This is explicit in the case of *Chapell v Hart*[37] where the causation aspect of medical negligence has received transformation at the hands of the High Court of Australia, giving it a patient friendly interpretation. The plaintiff in this case, a principle education officer, alleged that the doctor had failed to warn her of the risk of damage to her vocal

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[33] Ibid at 474
[34] Supra n 29
[35] [1997] 148 DLR (4th) 47 SCC
[36] Ibid at 56
[37] [1998] 156 ALR 517

cords, making her lose the chance to defer the operation and have it performed by a more senior and qualified surgeon. The court by a majority of 3:2 held that since the patient was a principle education officer, whose vocation demanded a quality voice, a fact known to the doctor, there was a causal connection between the failure to warn on the part of the doctor and the damage suffered by the patient.

Under English law also the test of causation has been softened for the plaintiff. This is evident from the recent Court of Appeal case of *Chester v Afshar*[38]. In this case the patient, after the removal of her three inter-vertebral discs, suffered nerve damage resulting in paralysis, a very small but known risk of the operation. In establishing causation the patient alleged that had the doctor informed her of the risk she would not have consented to the operation then, but she failed to establish that she would not have the operation done at all. The court, satisfied of the causal connection between the non-disclosure of the risk and the resultant damage, considered it to be a case of negligence and said:

> Where as a result of a doctor's failure to advise a patient about the risks involved in surgical procedure, the patient had an operation which she would not otherwise have had at that time, and the risk materialized and caused her injury, the causal connection between the negligence and the damage was not broken merely because the patient had been unable to show that she would never, at any time in the future, have had the operation of that kind, carrying the same or similar risks. If it were more likely than not that the same danger would not have been suffered, the doctor would have caused the patient to sustain it by causing her to have the operation that day. A conclusion to the contrary would thwart the purpose of the rule that required a doctor to give appropriate information to his patient, namely to enable the patient to decide whether or not to run the risk of having the operation at that time[39].

It is important to note that in an allegation of negligence the contention that the patient would not have had the operation at the time when it was done or by the person by whom it was done, may not be sufficient to establish causation unless the risk was likely to be reduced or abated in postponing the operation. Similarly, the contention that the operation had to be performed sooner or latter is also not sufficient in itself to rebut the causation unless it is proved that the operation would result in the same or similar consequences whether performed at that time or at some future time and whether performed by the same doctor or by any other doctor of his standing.

Conclusion

Determining the liability of a doctor for medical negligence is by no means an easy task, nor has there been unanimity in prescribing the contours of standard of care for the doctors. In two of its aspects viz., diagnosis and treatment the patient may be a mere recipient having no contribution in the process of medical care but in its advice aspect the doctor is under a duty to inform him about the method of the proposed diagnosis and treatment, the likely risks involved in

[38] [2002] 3 All ER 552
[39] Ibid at 552, 572

undergoing or foregoing the proposed treatment, and the alternatives to the proposed treatment known to the medical profession. This information is necessary, in the eyes of law, for the patient to form a rational judgment about his consent for the proposed treatment.

The patient's right to information has been admitted universally but the kind and the quantum of information that the doctor needs to disclose to the patient is still in dispute. English courts leave the judgment, in this regard, in the hands of medical profession as a therapeutic privilege because they consider the doctor as the most competent person to take such a decision. The courts in Canada appear to have taken a contrary view by leaving it for the law to lay down the contours of standard of medical care and decide whether or not the doctor has discharged the duty of disclosure of risks to the patient. For them the medical opinion is relevant to the findings of the risks but it would not be the sole factor in deciding the materiality or otherwise of the risks involved. In Australia too the courts consider the matters of medical negligence to fall within the exclusive competence of law. They have adopted the *prudent patient* approach in determining the materiality or otherwise of the information which a patient has a right to obtain from the doctor. The American medical jurisprudence recognizes the doctor's duty to disclose any facts, which are *necessary* to form the basis of an *intelligent consent* by the patient to the proposed treatment, but the content of disclosure has been considered a matter of professional medical judgment on the principle of *prudent doctor*. The Malaysian courts appear to trust the wisdom of English judiciary and give precedence to the clinical judgment of the doctor in medical matters including the requirement of information that needs to be given by the doctor to the patient.

There appears to be a clash of roles between the doctors and the judges, in these very vital issues of medical negligence. The doctors, apprehending unnecessary intervention on the part of the courts, perceive the judicial approach as confrontationist. Courts on the other hand, with patient's interest in mind, test the doctor's professional conduct on the anvil of law. What is needed is reconciliation. Medical men need to realize that all their clinical judgments may not be correct; that negligence might have crept into their diagnosis and treatment or that the patient ought to have been taken into confidence on matters of risks involved in the treatment. The judges also need to realize that they may not always be qualified in medical matters and that the unbiased expert opinion of medical profession is of great assistance in arriving at the right kind of judgments. Also it needs to be realized that it is not only the factors considered through clinical judgment but also those which are vital from a particular patient's view, that need to be considered in medical decisions, for, after all it is he who has to bear the brunt, monetary, physical, mental or otherwise. It is the interest of the patient that should be the prime consideration for both, medicine and law.