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JUDGING DOCTORS AND DIAGNOSING THE LAW: *BOLAM* RULES IN SINGAPORE AND MALAYSIA

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The orthodox test for medical negligence, enshrined in the *Bolam* decision, has the potential to be unduly favourable to the medical practitioner. The doctor–centric approach it engenders is particularly troubling with respect to the duty to inform and does not bode well for a healthy balance in the doctor–patient relationship. It is argued that the *Bolam* test as currently applied is inappropriate and that courts have a responsibility to reassert their role as the final arbiters in determining medical negligence. This article seeks to strike a balance between the interests of medical practitioners and patients; the former should not be vilified for human errors that include negligence while the latter should not be deprived of fair compensation and certain fundamental rights.

I. INTRODUCTION

In July 2001, the Singapore High Court handed down a medical negligence decision that captured popular interest in an unprecedented manner. The decision prompted a full page report in the national daily under the headlines "When Medical Experts No Longer Hold Sway",[1] and inspired a public debate through a mini torrent of letters to the newspaper. The medical fraternity was terrified not only at the prospect of a shift in the law, but also by the size of the payout of S$2.5 million (approximately US$1.4 million), which by Singapore standards was an astronomical sum. The case was appealed and in May 2002, the Court of Appeal overturned the High Court decision. In a powerful judgment, it reaffirmed—and strengthened—the orthodox approach to medical negligence, where the standard of care and breach thereof is to be determined by the medical profession itself.

> Beyond [the *Bolam* test], neither this court nor any other should have any business vindicating or vilifying the acts of medical practitioners. It would be pure humbug for a judge, in the rarefied atmosphere of the

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1 H.T. Liang, *The Straits Times* (21 July 2001) H12-3.

> courtroom and with the benefit of hindsight, to substitute his opinion for that of the doctor in the consultation room or operating chamber. We often enough tell doctors not to play God; it seems only fair that, similarly, judges and lawyers should not play at being doctors.[2]

The issue of medical negligence has been a burning one in recent times not only in Singapore, but also in Malaysia,[3] the United States,[4] the United Kingdom[5] and Australia.[6] At heart is the difficult question of judging medical standards. The orthodox approach of leaving the determination of negligence to the profession risks medical paternalism and raises concerns that the medical profession is a law unto itself. The alternative approach, adopted in varying degrees in several jurisdictions, including the United States, Canada and Australia, is to permit the court to go beyond medical opinion and decide for itself—based on medical evidence—whether or not the defendant medical practitioner has been negligent. The concern with this approach is that courts may demand unrealistic standards and force the medical profession into unhealthy defensive practices.

The medical duty of care is a comprehensive one that includes all aspects of the medical practitioner's relationship with the patient, covering diagnosis, treatment, care, information and advice. A practical distinction sometimes arises between the duty with regard to diagnosis, treatment and care on the one hand and information and advice on the other.[7] There are cogent reasons to adopt a more patient–centric approach, at least with respect

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2 *Dr Khoo James & Anor v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414 at 419 *per* Yong Pung How C.J [*Gunapathy*].

3 The Federal Court of Malaysia has given leave to appeal a medical negligence case for the purpose of determining whether or not, and to what extent, the *Bolam* test should continue to apply in Malaysia given the developments in other Commonwealth jurisdictions. *Foo Fio Na v. Dr Soo Fook Mun & Ors* [2002] 2 M.L.J. 129.

4 First Common Good Forum, "Beyond Patients' Rights: Do We Need a New System of Medical Justice?" (24 April 2002) AEI/Brookings Joint Center for Regulatory Studies, Washington D.C. A commentator at the forum described the medical justice system in the United States as "legal terrorism", online: Common Good <http://ourcommongood.com/medicine/>.

5 The medical malpractice crisis in the United Kingdom has prompted calls for reform of the law. See report by National Audit Office (UK), *Handling Clinical Negligence Claims in England* (May 2001); Department of Health (UK), *Clinical Negligence: What are the Issues and Options for Reform?* online: UK Department of Health <http://www.doh.gov.uk/clinicalnegligencereform/>.

6 On 1 May 2002, United Medical Protection, the leading health insurer in Australia, collapsed under massive debt, sending the medical profession and healthcare into a state of crisis. The Federal Government was forced to intervene and act as guarantor for all medical procedures. Legislation has been introduced to reduce medical negligence and general negligence claims—for example, *Health Care Liability Act 2001* (N.S.W.), *Civil Liability Act 2002* (N.S.W.).

7 *Sidaway v. Governors of Bethlem Royal Hospital* [1985] 1 A.C. 871; *Reibl v. Hughes* [1980] 2 S.C.R. 880; *Rogers v. Whitaker* (1992) 195 C.L.R. 479.

to the duty to inform. Failure to demand high standards from the medical profession, at least in terms of respecting patient's rights and autonomy, will ultimately lead to lack of confidence in the profession. The recent scandal in Singapore where a medical research team tested 127 patients without their consent is but one extreme example.[8]

The choice that presents itself, expressed in a simplistic manner, is that between the English approach enshrined in *Bolam v. Friern Hospital Management Committee*[9] and the Australian approach as stated in *Rogers v. Whitaker*.[10] In recent years, there has been an uncharacteristic number of medical negligence cases in the Singaporean and Malaysian courts seeking guidance on which approach to adopt. The Singapore Court of Appeal has now authoritatively stated the law,[11] and the Malaysian Federal Court has granted leave to appeal a medical negligence case to consider whether the Australian developments should be preferred in Malaysia.[12] In addition to the comparative analysis, this article will also draw out some ancillary factors that have shaped the law of medical negligence in general, namely the subtle influence of judicial attitudes, the persuasion of rhetoric and the impact of inapt empirical evidence.

II. The Common Law of Medical Negligence

The medical profession has always enjoyed a unique position, which discourages judges from independently determining whether or not there is a breach of duty. This uniqueness exists at two levels. First, medical practice is regarded as a specific science and there is a view that, therefore, only medical practitioners are qualified to adjudicate upon the standard of care that can be expected in any given circumstance. This attitude is actually of relatively recent vintage, having been enshrined in the law only in the mid-1950s.[13] Nearly a hundred years earlier, an English judge had stated quite unambiguously that medical negligence was a matter for the jury, not the expert medical witness to decide: "A medical man . . . was bound to have that degree of skill which could not be defined, but which, in the opinion of the jury, was a competent degree of skill and knowledge. What that was the jury were to judge."[14]

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8 See Z. Ibrahim, "$10m Research was 'Unethical and Uncivilised"' *The Straits Times* (4 April 2003) 3; Chong Ai Lien, "A Tangled Web of Lies and Risky Shortcuts" *The Straits Times* (5 April 2003) H4.

9 [1957] 1 W.L.R. 582 [*Bolam*].

10 [1992] 195 C.L.R. 479 [*Rogers*].

11 *Gunapathy*, *supra* note 2.

12 *Foo Fio Na v. Dr Soo Fook Mun & Ors* [2002] 2 M.L.J. 129.

13 *Roe v. Minister of Health* [1954] 2 Q.B. 66 [*Roe*]; *Hatcher v. Black* [1954] C.L.Y. 2289 [*Hatcher*]; *Bolam*, *supra* note 9.

14 *Rich v. Pierpoint* (1862) 176 E.R. 16 at 18–9 *per* Erle C.J [*Rich*].

Secondly, there is a special status that is accorded to medical practitioners that is not accorded to other professionals or experts. This is partly due to the "noble calling" that has historically characterised the profession; an idea that is now perhaps more romantic than realistic.[15] This is not to be disrespectful to medical practitioners, but merely to state a reality that applies to other traditionally "venerable" vocations, including academia. Interested parties have been adept at combining rhetoric with the universal fear of rising medical costs and access to health, in order to preserve this judicial deference to the medical profession.[16] The judicial sentiments of senior judges also can significantly influence the law and litigation practices. Lord Denning, as a High Court judge in the 1950s and through his term as Master of the Rolls until 1982, consistently displayed a doctor–centric approach to medical negligence.[17] Commenting on Lord Denning's impact on medical negligence, Harvey Teff wrote: "Since several of these judgments were delivered when he presided over the Court of Appeal, they had the dual effect of discouraging medical litigation and inhibiting the development of legal principle in the sphere of medical liability."[18]

The oft-cited test for medical negligence is found not in an appellate decision, let alone a House of Lords decision, but in a trial decision of 1957. The case of *Bolam v. Friern Hospital Management Committee*[19] involved a voluntary patient at a mental hospital who was subjected to a form of treatment known as electro-convulsive therapy (ECT), which involved passing an electric current through the plaintiff's brain. The procedure involved the risk of excessive convulsions, which could result in injury to the patient. The treatment was carried out without relaxant drugs and without adequate restraints. The plaintiff suffered a fracture during convulsions. The plaintiff alleged that the defendant was negligent in treatment and in failing to warn him of the risk of fracture. It was accepted that there were

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15 See A. Ho, "Doctor, Can I Really Trust You?" *The Straits Times* (19 January 2003) H33, who cites empirical evidence highlighting the conflict between the medical practitioner's ethical duties and financial interests.

16 The present Lord Chief Justice of England and Wales has recently reflected on the judicial deference to the medical profession. Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1.

17 *Roe, supra* note 13; *Hatcher*, *supra* note 13; *Davidson v. Lloyd Aircraft Services* [1974] 1 W.L.R. 1042; *Whitehouse v. Jordan* [1981] 1 W.L.R. 246; *Hyde v. Tameside Area Health Authority* [1986] 2 P.N. 26. This period coincided with the onset of U.S. style litigation in the United Kingdom, and arguably Lord Denning's conservative judgments were an attempt to protect the medical profession from the possible onslaught of litigation.

18 H. Teff, *Reasonable Care: Legal Perspectives on the Doctor Patient Relationship* (Oxford: Clarendon Press, 1994) at 30 [Teff]. See also, J. Mason, "Master of the Balancers; Non-Voluntary Therapy under the Mantle of Lord Donaldson" [1993] Juridical Review 115 at 115: "[I]ndividual senior judges may exert an apparently disproportionate influence on the relationship between the law and medical practice during their limited terms of high office."

19 *Bolam*, *supra* note 9.

two schools of thought on whether restraints should have been used when ECT was administered without drugs, and whether such risks should have been disclosed.

McNair J.'s direction to the jury on medical negligence has become the classic statement of the test: "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."[20]

The jury were therefore not allowed to prefer one school of medical thought to another.[21] The problem with *Bolam* lies principally with its subsequent interpretation and application. The *Bolam* ruling is seen as laying down a test that prohibits a court from independently determining whether or not a defendant medical practitioner is negligent as long as there is evidence of a common practice or custom that supports the defendant. This has the potential of reducing medical negligence to being determined by the lowest standard of care (accepted by the medical profession) rather than reasonable contemporary standards (expected by the community). The courts have not given due regard to the normative dimension of the test; the reference to a *responsible* body of medical practitioners seems to have been lost. It has also been held that the evidence of a *single* defence witness can be representative of a *body* of medical professionals.[22] In many instances the *Bolam* test has been uncritically applied and the court effectively tied its hands in assessing the negligence of the defendant.[23] For example, in *Maynard v. West Midlands Regional Health Authority*,[24] the trial judge had clearly preferred the evidence of the plaintiff's experts to the defendant's and had found for the plaintiff, but the case was overturned on appeal on the basis that a court did not have the right to choose between conflicting medical opinion. As Lord Scarman put it:

> It is not enough to show that there is a body of competent professional opinion which considers that theirs [the defendant's] was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the

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20 *Ibid*. at 587. Similar statements of the test had been uttered in earlier decisions with respect to diagnosis and treatment (*Hunter v. Hanley* [1955] S.L.T. 213 [*Hunter*]) and provision of information (*Hatcher*, *supra* note 13).

21 *C.f. Rich*, *supra* note 14.

22 *Gerrard & Anor v. Royal Infirmary of Edinburgh NHS Trust* [2002] ScotC.S. 11 at [89] *per* Lady Paton, citing with approval *Hunter, supra* note 20.

23 *Maynard v. West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 [*Maynard*]; *Gold v. Haringey Health Authority* [1988] 1 Q.B. 481; *Blyth v. Bloomsbury Health Authority* (1993) 4 Medical Law Reporter 151; *Defreitas v. O'Brien* [1995] 6 Medical Law Reporter 108.

24 *Maynard*, *ibid*. 23.

> circumstances . . . A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence.[25]

Three broad criticisms can be levelled at the *Bolam* approach to medical negligence. First, it perpetuates medical paternalism. This is the notion that the doctor knows best and the patient inevitably is forced to sacrifice or compromise some degree of personal autonomy. This issue is particularly relevant to the duty to inform and advise, and it is in this area that *Bolam* has received its severest challenge. Because the duty to inform directly impacts on the autonomy of the patient and shades into trespass,[26] the *Bolam* approach may be inappropriate.

Secondly, *Bolam* has some inherent practical and conceptual difficulties because it forces the medical profession to regulate itself. Self-regulation may be appropriate in some contexts, but it is arguably inappropriate when it comes to determining acceptable standards of practice. Without external evaluation, internal industry or professional norms become the accepted standard; and instead of self-regulation, we find ourselves in the realms of self-adjudication.[27]

Thirdly, *Bolam* carries the occasional risk of abdication of judicial responsibility. The standard of care and the determination of negligence are matters for judges to decide, but *Bolam* takes that decision-making power away from the judges. As Lord Scarman said in *Sidaway v. Governors of Bethlem Royal Hospital*: "In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment."[28] This statement is sometimes used to defend a strict application of *Bolam*; in light of Lord Scarman's earlier view in *Maynard*, this may be fair. However, it should be noted that Lord Scarman in fact made the *Sidaway* statement in the context of his dissenting judgment where he argued strongly against the application of the *Bolam* test to the medical practitioner's duty to inform. He followed the above statement with this observation: "The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors."[29]

Leaving the standard of care to be determined solely by medical experts carries certain inherent risks. There is always a danger that experts may be biased; this is clearly evidenced by the fact that two diametrically opposing "objective expert opinions" are often put in court. It has been said that

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25 *Ibid.* at 638.

26 See K.F. Tan, "Failure of Medical Advice: Trespass or Negligence?" (1987) 7 Legal Studies 149.

27 As one Malaysian High Court judge observed extra-judicially, ". . .the courts in the United Kingdom have allowed the medical profession to be the judge and the jury." Dato' R.K. Nathan, "Medical Negligence in Malaysia" [2000] 1 MLJ i at vii.

28 *Sidaway v. Governors of Bethlem Royal Hospital* [1985] 1 AC 871 at 881 [*Sidaway*].

29 *Sidaway, supra* note 28 at 882.

"*Bolam* will only work fairly if the use of hired hands as defence medical experts is eliminated. It would then be possible to talk of a responsible body of medical opinion."[30] In some cases, the eminence of an expert sometimes unduly influences the court, which uncritically accepts the expert's views.[31] The Lord Chief Justice of England and Wales has recently warned against this abdication of judicial responsibility:

> The problem with *Bolam* is that it inhibited the courts exercising a restraining influence. The courts must recognise that theirs is essentially a regulatory role and they should not interfere unless interference is justified. But when interference is justified they must not be deterred from doing so by any principle such as the fact that what has been done is in accord with a practice approved of by a respectable body of medical opinion.[32]

The *Bolam* test is a particularly inappropriate test to determine negligence with respect to the duty to inform. A challenge in this context reached the House of Lords in 1985 in the case of *Sidaway*. The plaintiff sued the defendant, alleging negligence in failing to disclose a 1–2% risk of damage to the spinal cord. By a majority, the House of Lords confirmed that *Bolam* applied to the duty to inform. However, only Lord Diplock fully supported the *Bolam* approach. The other Lords expressed some reservation; Lords Bridge, Templeman and Keith applied *Bolam*, but stated that there might be cases where the risk was sufficiently grave that the court should decide for itself whether the failure to disclose was negligent. In such cases, the Lords were prepared to go beyond the *Bolam* test. Lord Scarman, in his famous dissent, argued fervently against the application of *Bolam* to the duty to inform. Adopting the American approach in *Canterbury v. Spence*,[33] Lord Scarman rejected *Bolam* and firmly supported the patient's right to self-determination and informed consent:

> In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and

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30 N. Harris, *Solicitors Journal* (Supplement) 25 July 1997, as cited in H. Teff, "The Standard of Care in Medical Negligence—Moving on from *Bolam*?" (1998) 18 Oxford Journal of Legal Studies 473 at 482.

31 "In any event . . . Mr Sheperd strongly supported the defendant's decision to carry out the operation. Since Mr Shepherd is acknowledged to be a very experienced and distinguished surgeon, *it seems to me quite impossible to conclude that the defendant fell below the ordinary skill of a surgeon in this field* [my emphasis]." *Abbas v. Kenney* [1996] 7 Medical Law Reporter 47 at 57.

32 Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1 at 15.

33 464 F2d 772 (1972). For earlier U.S. development in this area, see *Salgo v. Leland Stanford* 154 Cal. App. 2d 560 (1957); *Natanson v. Kline* 186 Kan. 393 (1960).

> competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.[34]

The next House of Lords challenge to *Bolam*, albeit indirectly, was the case of *Bolitho v. City & Hackney Health Authority*.[35] The plaintiff was a child who had suffered a cardiac arrest and brain damage following a respiratory failure. The doctor had negligently failed to respond to repeated calls by the nurse. The question was whether that failure to attend had caused the child's injury. The only way the injury could have been prevented was to have intubated the child. The doctor testified that even if she had attended, she would not have intubated the child, thus her failure to attend was not causative of the injury. This line of defence necessitated an inquiry into whether or not the decision not to intubate would have been held to be negligent, and it was with respect to this inquiry that the *Bolam* test was applied.

The trial judge in *Bolitho* preferred the plaintiff's expert witnesses, as their views appealed to his common sense, but he found for the defendants on the ground that there was a body of medical opinion that supported the defendant. As a result of *Bolam*, the judge was prevented from using his own common sense to resolve the issue, as that could be construed as a substitution of his views for those of the medical experts. The Court of Appeal dismissed the plaintiff's appeal but two judges held that the reasoning in *Hucks v. Cole*[36] was to be preferred over that in *Bolam*; that ultimately a court, not a medical practitioner, should decide on the issue of negligence.[37] The House of Lords retracted slightly from the position of the Court of Appeal, holding that *Bolam* applies unless "in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, [then] the judge is entitled to hold that the body of opinion is not reasonable or responsible."[38]

The *Bolitho* decisions gave hope that *Bolam* would be curtailed and judges would reassert the ultimate adjudicative function in medical negligence. The Court of Appeal decision, in particular, resulted in several first instance

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34 *Sidaway, supra* note 28 at 876.

35 [1998] A.C. 232.

36 (1968) 112 S.J. 483 (C.A.), reported in [1993] 4 Medical Law Reports 393 (C.A.).

37 Dillon and Farquharson L.J. were the two judges who commented on *Bolam*. The third judge, Simon Brown L.J. did not offer any views.

38 [1998] A.C. 232 at 243.

judgments where courts were more willing to challenge medical opinion.[39] This development was short-lived, as Lord Browne–Wilkinson's opinion in the House of Lords was a clear warning that courts should not deviate from *Bolam* except in the most exceptional of circumstances. At the end of the day, *Bolitho* has hardly changed the law in England and *Bolam* lives on. As the Lord Chancellor of England and Wales stated, in response to suggestions that *Bolitho* had signalled the end of *Bolam*, "I am not convinced that, by itself, *Bolitho* heralds such a change."[40]

While *Bolitho* may not have been a medical negligence revolution,[41] it is a pivotal case in the gradual evolution of medical negligence. Judges are now more circumspect in their evaluation of medical opinion,[42] and in cases of duty to inform are perhaps more willing to go beyond a strict *Bolamite* approach to determining negligence. For example, in *Pearce v. United Bristol Healthcare NHS Trust*, Lord Woolf stated:

> [I]f 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, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.

The *Pearce* approach has faint echoes of the Australian position on medical negligence, which has its modern roots in *Rogers*. *Rogers* concerned a medical practitioner's duty to inform the patient. The High Court of Australia rejected *Bolam* and adopted instead the dissenting judgment of Lord Scarman in *Sidaway*, shades of which were already existent in the earlier South Australian case of *F v. R*.[43] The *Rogers* court approved of the material risk test enunciated in the American decision in *Canterbury* and held:

> The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the

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[39] See for example, *McAllister v. Lewisham and North Southwark Health Authority* (1994) 5 Medical Law Reporter 343; *Smith v. Tunbridge Wells Health Authority* (1994) 5 Medical Law Reports 334; *Gascoine v. Ian Sheridan & Co v Latham* (1994) 5 Medical Law Reports 437; *Newell & Newell v. Goldenberg* (1995) 6 Medical Law Reports 437; *Lybert v. Warrington Health Authority* (1996) 7 Medical Law Reports 71; *Wisniewski (A Minor) v. Central Manchester Health Authority* [1998] Lloyd's Medical Law Reports 223.

[40] Lord Irvine, "The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties" (1999) 7 Medical Law Review 255.

[41] *Cf.* M. Brazier and J. Miola, "Bye-Bye *Bolam*: A Medical Revolution?" (2000) 8 Medical Law Review 85.

[42] See for example, *Penney and Others v. East Kent Health Authority* [1999] 7 Medical Law Reports 343; *Marriot v. West Midlands Health Authority* [1999] Lloyd's Medical Law Reports 23.

[43] (1983) 33 S.A.S.R. 189.

> circumstances of the 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 the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.[44]

The *Bolam* test, which was initially rejected with respect to the duty to inform, has been held to have been rejected with respect to all aspects of the medical practitioner's duty of care.[45] The clearest statement of this is the 1999 High Court decision of *Naxakis v. Western General Hospital*.[46] This case concerned a young boy who had suffered head injuries and was misdiagnosed by the defendant neurosurgeon, who failed to order an angiogram to check for the possibility of a burst aneurysm. The child suffered from a burst aneurysm and was left seriously disabled. The overwhelming medical evidence was in favour of the defendant. At trial, there was no medical witness that challenged the defendant's decision and therefore the trial judge held that there was no case to answer and refused to allow the case to be put to the jury.

On appeal to the High Court, it was held that the standard of care was a matter to be determined by the court or the jury, and not by the medical practitioner. Therefore, even though the medical opinion was unanimously in favour of the defendant, the case still had to be put to the jury because the jury was the ultimate arbiter of medical negligence. Gaudron J. stated the position without any ambiguity:

> The *Bolam* rule, which allows that the standard of care owed by a doctor to his or her patient is 'a matter of medical judgment', was rejected by this Court in *Rogers v. Whitaker*. In that case it was pointed out that, in Australia, the standard of care owed by persons possessing special skills is that of 'the ordinary skilled person exercising and professing to have that special skill [in question]'. In that context, it was held that 'that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade'.[47]

The Australian position therefore is that, while medical opinion is extremely important, ultimately it is the court's duty to determine whether or not the medical practitioner in question has fallen below the standard of care reasonably expected of him or her. This has been reaffirmed time

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44 *Rogers, supra* note 10 at 490.

45 *Lowns v. Woods* (1996) Australian Torts Reports 81-376 (N.S.W.C.A.).

46 (1999) 197 C.L.R. 269 at 275.

47 *Naxakis v. Western General Hospital* (1999) 197 C.L.R. 269 at 275 (footnotes omitted) [*Naxakis*].

and again by the High Court of Australia,[48] most recently in the case of *Rosenberg v. Percival*.[49]

III. Singapore and Malaysia

Courts in Singapore and Malaysia are not bound by English decisions, although these decisions are highly persuasive.[50] Despite the strong influence of English law, there has been, in line with global patterns, a growing trend of adopting a more comparative approach to the development of domestic common law. The courts in both countries have regularly looked to the jurisprudence in other Commonwealth jurisdictions, in particular Australia. Both Singapore and Malaysia have accepted and applied the *Bolam* rule to medical negligence; but in recent years, following *Rogers* in Australia and *Bolitho* in the United Kingdom, cracks have begun to appear in the *Bolam* rule in both jurisdictions. A flurry of cases testing the law on medical negligence have occupied the courts in the last two or three years.

Inevitably, the final appellate court in the respective countries confronted the issue and took on the task of authoritatively stating the law in this area. The Singapore Court of Appeal has already done so in *Dr Khoo James & Anor v. Gunapathy d/o Muniandy*,[51] while the Malaysian Federal Court, which gave leave to appeal the decision of *Foo Fio Na v. Dr Soo Fook Mun & Ors*[52] in 2001, is poised to do likewise. The parallels in both cases are striking. In each, a young woman was rendered wheelchair-bound as a result of medical negligence; in each, the trial judge found for the plaintiff and awarded what would have been a record amount in damages.

A. *Singapore*

The Court of Appeal in *Gunapathy* declared its intention to comprehensively review the law of medical negligence and authoritatively state the position for Singapore.[53] However, the Court surprisingly does not refer

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48 *Breen v. Williams* (1996) 186 C.L.R. 1; *Chappel v. Hart* (1998) 195 C.L.R. 232; *Naxakis, supra* note 47.

49 (2002) 205 C.L.R. 434.

50 *Pang Koi Fa v. Lim Djoe Phing* [1993] 3 S.L.R. 317 at 323 *per* Amarjeet Singh J.C.: "The courts in Singapore are not strictly bound by decisions of the English courts in that the courts in England are not part of the hierarchy of courts in Singapore . . . nonetheless, in respect of decisions in common law, particularly in the areas of tort in general and negligence in particular, decisions of the highest court in England should be highly persuasive if not practically binding."

51 *Gunapathy, supra* note 2.

52 [2002] 2 M.L.J. 129.

53 *Gunapathy, supra* note 2 at 429 *per* Yong Pung How C.J.

to the significant jurisprudence of Australia, which has adopted a position contrary to the English, and thus would have provided valuable comparative material for analysis. The Court has in earlier decisions not hesitated to look beyond England for guidance. The most notable cases where the Court has rejected a conservative English approach in favour of a more liberal Australian approach are, in fact, negligence cases.[54] It is disappointing that the Australian jurisprudence on medical negligence, so highly regarded in other common law countries, including the United Kingdom and Canada, was ignored.

While the Singapore line of authority on medical negligence is preponderantly in favour of the *Bolam* test,[55] a chink had appeared soon after the *Bolitho* decision. The first indication of a possible shift away from *Bolam* was the unreported decision of *Jason Carlos Francisco v. Dr L M Thng & Anor*.[56] Judith Prakash J., in reviewing the law of medical negligence, referred to *Bolitho* and stated: "Whilst I accept the above formulation of the law I also recognise that the judge has to exercise his own critical faculties and not simply be swept along by the opinion of the medical experts."[57] This is a clear statement that the determination of medical negligence is a matter for the courts and not the medical practitioners. However, the case attracted little attention because the court ultimately found for the defendants. It was the subsequent decision of *Gunapathy* where the trial judge found for the plaintiff and awarded a record sum that brought the issue of medical negligence to the fore, and ironically resulted in a reversal of any shift towards a more patient-oriented test of medical negligence.

The plaintiff in *Gunapathy* had been treated for a brain tumour by the defendant. The defendant had performed brain surgery to remove a benign neurocytoma and during post-operative treatment an MRI scan revealed a lesion in the region where the neurocytoma had been removed. The radiologist reported that this lesion was probably a scar and recommended no

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54 *RSP Architects Planners & Engineers v. Ocean Front Pte. Ltd.* [1996] 1 S.L.R. 113; *RSP Architects Planners & Engineers (Raglan Squire & Partners FE) v. Management Corporation Strata Title Plan No. 1075 & Anor* [1999] 2 S.L.R. 449. The Court of Appeal in these cases rejected the English approach to economic loss and defective buildings as stated in *Murphy v. Brentwood District Council* [1991] 1 A.C. 398, preferring instead the Australian approach in *Bryan v. Maloney* (1995) 182 C.L.R. 609. See D. Ong, "Defects in Property Causing Pure Economic Loss" [1995] Singapore Journal of Legal Studies 256; D. Ong, "Defects in Property Causing Pure Economic Loss: The Resurrection of *Junior Books* and *Anns*" [1996] Singapore Journal of Legal Studies 257.

55 *Gunapathy, supra* note 2; *Supuletchimi d/o Rajoogopal v. Tay Boon Keng & Ors*, Suit No. 210 of 2000Y (unreported, 22 February 2002, Lee Seiu Kin J.C.); *Vasuhi d/o Ramasamypillai v. Tan Tock Seng Hospital Pte. Ltd.* [2001] 2 S.L.R. 165; *Yeo Peng Hock Henry v. Pai Lily* [2001] 4 S.L.R. 571; *Denis Matthew Harte v. Dr Tan Hun Hoe*, Suit No. 1691 of 1999 (unreported, 24 November 1999, Chan Seng Onn J.C.).

56 Suit No. 573/1998 (unreported, 6 August 1999, Judith Prakash J.).

57 *Ibid*. at [109].

further action. The defendant took a different view, diagnosing the lesion as a remnant tumour. He recommended radiosurgery, which involved the application of a high dose of radiation to destroy the tumour cells. This procedure carried an inherent risk of radionecrosis, which could result in cerebral oedema. The surgery was performed with disastrous consequences. It was alleged, *inter alia*, that the defendant had been negligent in carrying out the process by using too high a dose of radiation and had failed to inform the plaintiff of the attendant risks.

Selvam J. applied the House of Lords' dicta in *Bolitho* and found in favour of the plaintiff. He held that determining whether the lesion was a scar or a tumour was a finding of fact that was not governed by the *Bolam* test.[58] Therefore, he was not bound by medical opinion but could, based on the evidence, decide for himself whether the lesion was in fact a scar or a tumour. Selvam J. was also less than impressed by the credibility of the defendant's expert witnesses and held that the opinion proffered failed the *Bolitho* threshold test of logical defensibility. The trial decision gave the impression that the Singapore courts were loosening up on medical negligence, and it was perhaps this impression that prompted the Court of Appeal, in its reversal of the decision, to preface its judgement with the candid statement that "the cart must be put before the horse"[59] to prevent the law from deviating from the correct path.

The law on medical negligence now stands as stated in the *Gunapathy* appeal. The *Bolam/Bolitho* test has been given a very narrow interpretation. Judges are not permitted to determine the reasonableness of the medical opinion; otherwise, "[a] doctor would . . . be liable when his view, as represented by the defence experts, was found by the court to be unreasonable."[60] All that a court is permitted to do is determine whether the expert witnesses of the defence have come to a logically defensible conclusion. A medical practitioner thus cannot be found liable even if the court believes the medical practice to be wholly unreasonable and even if it is shown that the medical practice is wrong. Indeed, in a High Court decision handed down in early 2002 (after the trial decision in *Gunapathy* but before the appeal), it was held that where "there are differing opinions on the part of the experts the defendant would not be in breach of the duty of care if his position is accepted by a responsible body of medical professionals in that area *even if the diagnosis or treatment were wrong*."[61] An English commentator, criticising the conservative application of the *Bolitho* test in *Newbury v. Bath*

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58 *Cf. Penney and Others v. East Kent Health Authority* [1999] 7 Medical Law Review 327.

59 *Gunapathy, supra* note 2 at 419 *per* Yong Pung How C.J.

60 *Gunapathy, supra* note 2 at 433.

61 *Supuletchimi d/o Rajoogopal v. Tay Boon Keng & Ors*, Suit No 210 of 2000Y (unreported, 22 February 2002, Lee Seiu Kin J.C.) at [101]. Strangely, the *Gunapathy* trial judgment, despite the considerable public attention it attracted, was not referred to [my emphasis].

District Health Authority,[62] a case which has many parallels with *Gunapathy*, observed, "[o]ne might be forgiven for wondering when *Bolitho* would bite if not in a case such as this."[63] The same may be said in the Singapore context.

The Court of Appeal in *Gunapathy* was ambiguous as to whether and to what extent *Bolam* applied to the duty to inform. Although the court stated that it was not making any pronouncement on the doctrine of informed consent,[64] it confirmed that the *Bolam* test applied to the issue of advice.[65] Given *Gunapathy's* restrictive interpretation of the *Bolam* test, there are cogent reasons for the court to reconsider the application of *Bolam* to the duty to inform and advise if the occasion ever arose. The *Gunapathy* approach could unfairly distort the balance in the doctor–patient relationship and compromise even a modicum of patient autonomy. Empirical evidence also suggests that good communication results in less litigation.[66] A high proportion of litigation against medical practitioners is by patients or their families who did not receive sufficient information. Raising the standard of care with respect to the duty to inform creates an incentive for good communication and this will be beneficial as it improves the doctor–patient relationship and mitigates against unnecessary litigation.

There are several related points with respect to the patient autonomy argument that deserve elaboration. First, individuals have a right to decide on how to manage their own health and should be provided with all information that they would reasonably require to make informed decisions. That right is not respected if medical practitioners can withhold information that the patient reasonably requires. Secondly, the doctor–patient relationship is evolving. Patients today are generally more informed and savvy about their rights and choices; there is an expectation that they be involved in the management of their health. Denial of information results in frustration and is detrimental to the doctor–patient relationship, and eventually to the patient's health. Thirdly, the patient is ultimately responsible for the best management of his or her health. The health and illness belongs to the patient, not the doctor. Patients should not be disempowered by doctors on the basis that "doctor knows best"; rather, they should be empowered so that they understand the illness and how best to manage it.[67]

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62 (1998) 47 B.M.L.R. 138.

63 A. Maclean, "Beyond *Bolam* and *Bolitho*" (2002) 5 Medical Law International 205 at 217.

64 *Gunapathy, supra* note 2 at 453.

65 *Gunapathy, supra* note 2 at 454.

66 See C. Vincent, M. Young and A. Phillips, "Why do People Sue Doctors?" (1994) 343 The Lancet 1609, cited in P. Niselle, "Managing Risk in Medical Practice" (2000) 7 Journal of Law and Medicine" 130 at 131.

67 See Teff, *supra* note 18, especially chapter 6, which discusses collaborative autonomy.

A final observation needs to be made of *Gunapathy*. The Court of Appeal, despite acknowledging that both *Bolam* and *Bolitho* made clear that the test applied to all professionals in general, held that in Singapore only medical professionals were to be governed by a narrow application of *Bolam*. The courts are therefore not similarly fettered with respect to other professionals:

> [T]he willingness of the court to adjudicate over differing opinions in other professions should not be transposed to the medical context. While judges are eminently equipped to deal with the practice and standards of, for example, the legal profession, the same cannot be said with the intricacies of medical science. The fact that *Edward Wong* . . . was cited in *Bolitho* should not therefore be treated as an invitation to merge the treatment of expert medical evidence with that of other expert evidence.[68]

This clearly is at odds with the position in the United Kingdom and Australia, where in theory at least, all professionals are governed by the same test for professional negligence.[69] Lawyers, who used to enjoy special treatment when it came to negligence, are no longer treated differently from other professionals, even in Singapore.[70] Is it really necessary to treat medical practitioners so differently?

B. *Malaysia*

The Malaysian courts have been less consistent than their Singaporean counterparts and there have been several decisions preferring the *Rogers* approach to *Bolam's*.[71] The first Federal Court decision on medical negligence in Malaysia was *Government of Malaysia & Anor v. Chin Keow*,[72] in which the court did not refer to *Bolam* but instead based its decision on *Marshall v.*

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[68] *Gunapathy, supra* note 2 at 435. *Edward Wong* is a reference to *Edward Wong Finance Co. v. Johnson Stokes & Master* [1984] A.C. 296, in which the Privy Council held that the common practice of solicitors was itself negligent and therefore the defendant could not escape liability by showing adherence to a common practice.

[69] See W.V.H. Rogers, *Winfield & Jolowicz on Torts*, 16th ed., (London: Sweet & Maxwell, 2002) at 197. The *Bolam/Bolitho* test has been applied to professionals in a variety of areas: for example, *Patel v. Daybells* [2001] E.W.C.A. Civ. 1229 (conveyancing solicitors); *Calvers v. Westwood Veterinary Group* [2001] Lloyd's Medical Law Reports 20 (veterinary surgeons); *Michael Hyde & Associates Ltd v. J.D. Williams & Co. Ltd.* [2000] E.W.C.A. Civ. 211 (architects); *Adams & Anor v. Rhymney Valley District Council* [1999] E.W.C.A. Civ. 1257 (local council—window design); *Izzard & Anor v. Palmers & Ors* [1999] E.W.C.A. Civ. 2045 (property surveyors).

[70] *Arthur J.S. Hall & Co. v. Simons* [2000] 3 W.L.R. 543; *Chong Yeo & Partners & Anor v. Guan Ming Hardware & Engineering Pte. Ltd.* [1997] 2 S.L.R. 729.

[71] See cases cited, *infra* note 90.

[72] [1965] 2 M.L.J. 91.

Lindsey Country Council[73] and *Roe v. Minister of Health*.[74] The defendant in *Chin Keow* had given the plaintiff's daughter a penicillin injection without checking for any possible allergy. The patient died within minutes. The trial judge found for the plaintiff. On appeal to the Federal Court, it was held that the defendant could not be found negligent because there was a common practice at that time of giving penicillin injections without checking for allergies.

The Privy Council, in reversing the decision,[75] held that the trial judge had correctly applied *Bolam*. Arguably, the case could have been decided without recourse to the *Bolam* test for medical negligence, given that the defendant had himself admitted that he was aware of the risks of penicillin allergy and it had been noted clearly in bold type on the patient's records. Knowing the risk and failing to check the out-patient card, let alone failing to make inquiries of the patient, was clearly negligent. *Chin Keow* therefore did not call for any peculiarly "medical" standard; it was a matter that could be resolved with common sense. Lord Wooding, in holding that the defendant had been negligent under the *Bolam* test was perhaps suggesting that the common practice itself was negligent. It is likely that his Lordship was influenced by evidence given at trial that British medical practitioners always made inquiries about allergies before administering penicillin injections. This raises two questions: first, is it fair to transpose the standards of common practice in a more developed country to a less developed country;[76] and secondly, is this a correct application of *Bolam*? The answer to both is in the negative.

Recently, an English court had to determine the standard of care that applied to practitioners of alternative medicine. In *Shakoor v. Situ*,[77] the defendant, who was a practitioner of traditional Chinese herbal medicine, had given the plaintiff's husband some herbs which eventually destroyed his liver and killed him. The court had to state the test to be applied in deciding whether or not the defendant was negligent and the question turned on whether the defendant ought to be judged by the standard of a practitioner of Chinese herbal medicine or the standard of the orthodox medical practitioner in England.[78] There was concern that a straightforward application of *Bolam* could result in the common practice of the particular regime of alternative

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73 [1935] 1 K.B. 516.

74 *Roe, supra* note 13.

75 *Chin Keow v. Government of Malaysia & Anor* [1967] 2 M.L.J. 45.

76 *Cf. Whiteford v. Hunter* (1950) 94 Sol. Jo. 758 where the House of Lords applied British medical standards to find in favour of an English specialist, although evidence of common practice in the United States suggested that the English specialist was negligent. See R. Balkin & J. Davis, *Law of Torts*, 2nd ed. (Sydney: Butterworths, 1996) at 280–1.

77 [2001] 1 W.L.R. 410.

78 *Ibid.* at 414 *per* Bernard Livesey Q.C.

medicine in question being determinative of reasonable standards. This was unpalatable. The court thus, paradoxically, relied on *Bolitho* to hold that judges were entitled to go beyond the common practice of a particular speciality to determine negligence. In this case, the court ultimately used the standard of orthodox medical practice as a benchmark to determine whether or not the Chinese herbalist was negligent.[79]

The second Federal Court decision on medical negligence was *Swamy v. Matthews & Anor*,[80] handed down in 1968. However, neither *Bolam* nor *Chin Keow* was cited and the court found against the plaintiff by a majority of 2-1. *Bolam* was applied in Malaysia in the 1970 decision of *Elizabeth Choo v. Government of Malaysia & Anor*[81] by Raja Azlan Shah J., who later went on to become the Lord President of Malaysia. While endorsing the *Bolam* test, the judge also opined that "the true test was . . . expressed by Erle CJ in *Rich v Pierpoint*."[82] That case, of course, clearly stated that it was the jury—not the medical profession—that had the final say in determining the standard of care. The judicial sentiment in *Elizabeth Choo* was also quite the opposite to the pro-doctor sentiments expressed by McNair J. and Lord Denning in the English cases of the 1950s. Raja Azlan Shah J. stated, in response to the plaintiff's counsel's suggestion that courts rarely find for the plaintiff:

> With respect that proposition cannot be true. To say the least I am not an advocate of the right of medical men occupying a position of privilege. *They stand in the same position as any other man*. Their acts cannot be free from restraint; where they are wrongfully exercised by commission or default, *it becomes the duty of the courts to intervene*.[83]

The Federal Court's third medical negligence case was *Kow Nan Seng v. Nagamah & Ors*,[84] decided in 1982. The plaintiff had been injured in a road accident and had his leg put in a complete plaster cast. The cast was put too tightly, resulting in gangrene and amputation of the leg. The trial judge found that that the doctor had not been negligent. The Federal Court, instead of referring to its earlier decisions in *Chin Keow* and *Swamy*, relied instead

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79 It should be noted that the court was sensitive to the legitimacy of alternative medical practices and attempted to accommodate such practices within the orthodox scheme, but it is fair to say that at the end of the day, the assessment of medical negligence was based on the reasonable general practitioner standard. See M. Fordham, "The Standard of Care Applicable to Practitioners of Alternative Medicine" [2001] Singapore Journal of Legal Studies 1 for a review of this case.

80 [1968] 1 M.L.J. 138.

81 [1970] 2 M.L.J. 171.

82 *Ibid.* at 172. See text accompanying footnote 14.

83 *Ibid.* at 172 [my emphasis].

84 [1982] 1 M.L.J. 128.

on the interpretation of *Bolam* in *Elizabeth Choo*; judges should not be constrained from deciding for themselves whether or not a medical practitioner was negligent. According to *Kow Nan Seng*, "[a] doctor's duty towards his patient is that he has to exercise a fair and reasonable standard of care and skill, *i.e.*, the skill of an ordinarily competent medical practitioner."[85] While expert evidence was relevant, it was not conclusive. With respect to certain acts of medical negligence, even a "layman"[86] could assess whether a fair and reasonable standard of care and skill had been exercised.

Given the Malaysian courts' early ambivalence towards *Bolam*, and less deferential attitude to medical professionals, it is not surprising that the Malaysian jurisprudence in this area is inconsistent, with some recent cases following *Bolam*,[87] and others preferring *Rogers*.[88] In a recent issue of the Malayan Law Journal, two judges publicly aired their opposing views on *Bolam* and medical negligence.[89] Hopefully, the uncertainty will be resolved when the Federal Court hands down its decision in the *Foo Fio Na* appeal. While it is impossible to predict how the court will ultimately decide, there is a possibility that the Malaysian Federal Court may adopt the *Rogers* approach to medical negligence, at least with respect to the duty to inform. Even in the Court of Appeal, Sri Ram J.C.A. did admit to an attraction to the *Rogers* approach, but felt compelled to preserve *Bolam* because of precedent and for its inherent practical appeal.[90] The Federal Court, in granting leave to appeal has clearly indicated the need to reconsider *Bolam*:

> The question posed was one of importance upon which further argument and a decision of this court would be to public advantage. In this regard, the court's attention had been drawn to later case jurisprudence from Australian and other Commonwealth countries, which it was contended,

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85 [1982] 1 M.L.J. 128 at 129 *per* Salleh Abbas F.J., who, like Raja Azlan Shah J., also went on to become Lord President.

86 *Ibid.* at 131 *per* Salleh Abbas F.J.

87 See, for example, *Asiah bte Kamsah v. Dr Rajinder Singh & Ors* [2002] 1 M.L.J. 484; *Dr Soo Fook Mun v. Foo Fio Na & Anor* [2001] 2 M.L.J. 193; *Payremalu a/l Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 3 M.L.J. 725; *Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors* [1998] 1 M.L.J. 57; *Liew Sin Kiong v. Dr Sharon DM Paulraj* [1996] 5 M.L.J. 193; *Inderjeet Singh a/l Piara Singh v. Mazlan bin Jasman & Ors* [1995] 2 M.L.J. 646.

88 See, for example, High Court decisions such as *Dr KS Sivananthan v. The Government of Malaysia & Anor* [2001] 1 M.L.J. 35; *Foo Fio Na v. Hospital Asunta & Anor* [1999] 6 MLJ 738; *Hong Chuan Lay v. Dr Eddie So Fook Mun* [1998] 7 M.L.J. 481; *Kamalam a/p Raman & Ors v. Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor* [1996] 4 M.L.J. 674.

89 Dato' R.K. Nathan, "Medical Negligence in Malaysia" [2000] 1 Malayan Law Journal i; Dato' G. Sri Ram, "The Standard of Care: Is the *Bolam* Principle Still the Law?" [2000] 3 Malayan Law Journal lxxxi.

90 *Dr Soo Fook Mun & Ors v. Foo Fio Na* [2001] 2 M.L.J. 193 at 207–8.

had refined the *Bolam* test to such an extent that it may now be necessary for this court to reconsider it.[91]

C. *Illusive Spectres; Elusive Rhetoric?*

The rhetorical defence of *Bolam* exhibits a two-pronged strategy, alternately manipulating society's basic emotions of fear and sympathy. The dangers of unrealistic premiums depriving ordinary people of adequate health care is coupled with the distressing effects that allegations of negligence will have on medical practitioners. There is no doubt that there is a crisis in some countries, but it is unclear whether there is a crisis in Singapore or Malaysia. The protagonists have yet to offer empirical evidence based on data in the respective jurisdictions. What is convenient—and effective—is to point to the rise of defensive medicine and the medical malpractice crises elsewhere. Such rhetoric does little to add to informed debate.

The spectre of defensive medicine is constantly raised to preserve the *Bolam* test. However, the examples given are based on U.S., U.K. and Australian statistics, where the culture of litigation, the magnitude of awards and the doctor–patient relationship are vastly different. To put it in perspective, the record award for damages in medical negligence in Malaysia and Singapore respectively are about R500,000 (approximately US$131, 000)[92] and S$356,000 (approximately US$200, 000).[93] In contrast, the record Australian payout is A$14.2 million (approximately US$7.7 million)[94] and the English, £12 million (approximately US$18.6 million).[95] The American records need not be mentioned![96] It has been asserted by a Malaysian lawyer that the average insurance premium for an obstetrician in Florida (U.S.A.) had risen to US$203,000 in 1993 and that the rate of increase in

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91 *Foo Fio Na v. Dr Soo Fook Mun & Ors* [2002] 2 M.L.J. 129 at 130.

92 *Dr Soo Fook Mun & Ors v. Foo Fio Na* [2001] 2 M.L.J. 193 at 207-8. Note that this case is currently being appealed.

93 *Denis Matthew Harte v. Dr Tan Hun Hoe* [2001] 4 S.L.R. 317. Note: The trial judge in *Gunapathy* had awarded S$2.5 million (approximately US$1.4 million) but the decision was overturned.

94 *Simpson v. Diamond & Anor [No 2]* [2001] N.S.W.S.C. 1048.

95 Anon, "£19 Million for Dancer Paralysed by Hospital's Blunder" *The Times* (15 October 2002), online: The Times <http://www.timesonline.co.uk/printFriendly/0,,1-2-447116,00.html>. The media reports bandy a figure between £19 and £20 million, but that assumes the plaintiff lives out the remainder of her life and continues to collect the annual £250,000. The actual amount given to the plaintiff was £7 million plus £5 million put in trust to generate the annual £250,000, as part of the settlement.

96 It should be noted that reforms in California have had some measure of success in curbing the cost of medical liability insurance. However, it should also be noted that these reforms were in tandem with other wide ranging reforms in the insurance industry.

premiums over the preceding ten-year period was 1745%.[97] At that rate, the current premium in Florida should be in the region of US$3.5 million per annum! A Singaporean doctor has also quoted the similar US$200,000 figure for premiums in Florida,[98] but apparently treats it as the current rate. This figure is used as fact to argue for a conservative approach to medical negligence.

With respect, it is inappropriate to use the statistics of a foreign jurisdiction where the legal, medical and economic substrata are wholly different to the domestic. It is even more inappropriate when these figures are not conclusive. If true, then since the Malaysian writer used that figure for the rate in the year 1993 and the Singapore writer used that figure for the year 2002, it suggests that premiums in Florida, although exorbitant, have in fact remained stable for the last ten years, and not risen at the purported rate of 1745%. The President of the American Medical Association, in a statement on 25 September 2002, put the premiums for obstetricians in Florida in the region of US$100,000.[99] In contrast, the insurance premium in Singapore for the highest risk category of medical practice, which includes obstetrics, is in the region of S$9,500 (approximately US$5,400)[100] and in Malaysia, the highest risk premiums are in the region of R3,200 (approximately US$840).[101]

Instead of resorting to fear politics, it is better to recognize that medical practice involves risks, that medical practitioners will occasionally be negligent and that there is a cost to all of this, which simply has to be factored in through adequate insurance. This may well mean higher premiums, but perhaps that is the inevitable cost of moving from third world to first. All first world countries have far higher medical indemnity and general insurance costs, as well as higher compensatory awards. We cannot have our cake

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97 See S. Radakrishnan, "Medical Negligence Litigation: Defensive Medicine Now the Norm?" [1999] 4 Malayan Law Journal cxcvi at cxcvii. Unfortunately, the source for these alarming figures is not provided.

98 L.G. Goh, "What Can Be Done to Unsustainable Malpractice Payouts?" (2002) 34(6) Singapore Medical Association News 7.

99 Y.D. Coble Jr., "AMA Calls on House of Representatives to Pass Liability Reforms for All America's Patients", online: American Medical Association <http://www.ama-assn.org/ama/pub/article/1617-6766.html>. The current premium in Nevada is approximately US$80,000, which is still prohibitively high.

100 See website of National Trades Union Congress for examples of premiums in Singapore, at http://www.income.com.sg/insurance/medical/premium.asp. The limit of the cover is S$5 million (approximately US$2.78 million). It was reported in *The Straits Times* on 5 February 2003 at 1 that the United Kingdom-based United Medical Protection was set to increase the premiums for obstetricians in Singapore to over S$15,000.

101 See website of Malaysian Medical Association Indemnity Scheme for examples of premiums in Malaysia, at <http://www.mma.org.my/insuran/mmi.htm>. The limit of the cover is R2 million (approximately US$526,000).

and eat it; the move to first world status also means embracing an advanced citizenry that is aware of its rights and desires to assert them.

The second prong of the strategy is to paint medical practitioners as victims of unfair allegations who will suffer irreparable damage. The colourful description by a former Lord President of Malaysia, likening an allegation of negligence to a dastardly attack with a dagger from behind, remains a powerful rhetorical weapon:

> [I]t would be wrong and bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community. It would mean that a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be for ever looking over his shoulders to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body—perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body.[102]

Allegations of medical negligence may be damaging, but this is mainly—perhaps only—because of the unfortunate conflation of civil fault and criminal blameworthiness. The concept of fault in the tort of negligence serves the function of shifting the loss from one party to another. It is designed to hold one party responsible for the cost of the loss; it should not be seen as labelling the party morally culpable. The failure to distinguish between civil responsibility and criminal blameworthiness is regrettable. "Negligence" in the context of the tort of negligence should not be viewed as conduct "deserving of censure".[103] Contrary to Lord Radcliffe's view in the classic case of *Bolton v. Stone*,[104] negligence should not be "concerned less with what is fair than with what is culpable;"[105] the reverse should be true. The focus should be on the fair allocation of loss, not the moral culpability of the defendant. This is not only common sense but logical too; otherwise, the distinction between compensatory and punitive damages disappears.

To deny recovery to deserving claimants merely because the law—and a section of both the medical and legal professions—have engendered a misconception of negligence is unfair. Instead of playing the blame game in medical negligence cases, a more sensible approach is to acknowledge that doctors are not infallible; that like any other human being they are also prone to occasional negligence. Rather than being trapped in a culture of

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[102] *Swamy v. Matthews & Anor* [1968] 1 M.L.J. 138 at 139–40 *per* Syed Agil Barakbhar L.P.
[103] *Ibid.* at 140 *per* Syed Agil Barakbhar L.P.
[104] [1951] A.C. 850.
[105] *Ibid.* at 868.

infallibility, it is better to recall Alexander Pope's famous observation that "to err is human."[106] Finding a doctor liable in negligence need not be a dagger in his or her back.

IV. Conclusion

The medical negligence jurisprudence based on *Bolam* is unnecessarily conservative. *Bolam* was decided in post-War Britain when there was a pressing need to protect hospitals from the litigation explosion that was occurring in the United States.[107] Today, even Britain is relaxing the *Bolam* approach to medical negligence. Australia has relegated the *Bolam* test to its appropriate place as a matter of evidential rather than substantive law. This has yet to occur in Singapore and Malaysia, largely due to the fear that any relaxation of *Bolam* will result in a medical malpractice and healthcare crisis that is occurring elsewhere. Unnecessary litigation can be avoided by promoting a culture of collaborative autonomy where patients are properly informed and actively involved in the process; the empirical evidence shows that well informed patients are less likely to sue even when they have a good claim. Preventing genuine claims and disempowering patients will entrench a culture of distrust and shift the locus of the doctor–patient relationship from the clinic to the courtroom, a sure way of inviting a medical malpractice crisis.

The law on medical negligence has been captured by incomprehensible rhetoric and fear politics, one effect of which is to have rendered the standard of care sacrosanct. The *Bolam/Bolitho* test of "logical defensibility" or "irrationality" has a Janus-like quality. It acknowledges that judges have the final power and responsibility to determine reasonable standards in medical negligence, but in the same breath says that judges are only allowed to test the logical defensibility of the medical experts' views as to what constitutes reasonable practice. This is clearly a test that is designed to fetter judicial power, and for that reason alone, should be rejected. Ultimately, it is the judge's responsibility, under the law of negligence, to determine reasonable standards and—in the absence of a jury—to apply them to the facts. Judges are trusted to do this with respect to all other cases of negligence, including professional negligence; they should be trusted to do likewise with respect to medical negligence.

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[106] A. Pope, *An Essay on Criticism*, 1711.

[107] Lord Woolf, "Are Courts Excessively Deferential to the Medical Profession?" (2001) 9 Medical Law Review 1 at 2.