Singapore Journal of Legal Studies
[2009] 182–210

ROGERS v. WHITAKER LANDS ON MALAYSIAN SHORES—IS THERE NOW A PATIENT'S RIGHT TO KNOW IN MALAYSIA?

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In *Foo Fio Na v. Dr. Soo Fook Mun* [2007] 1 M.L.J. 593 ('*Foo Fio Na*'), the Federal Court of Malaysia rejected the *Bolam* test in duty of disclosure of risks cases and endorsed the patient-centred approach in *Rogers v. Whitaker* (1992) 175 C.L.R. 479 ('*Rogers*'). This article examines the common law developments in England and Australia as well as recent developments in Malaysia in relation to this duty and argues that the decision in *Foo Fio Na* falls short of its apparent promise of a patient-centred approach. The author proposes that a more appropriate framework to safeguard patient autonomy in Malaysia is required—one that allows for the convergence of the legal and ethical principles relating to a patient's right to know about material risks and one that recognises this right as an extension of the right to life guaranteed by the Malaysian Federal Constitution.

I. INTRODUCTION

On 29 December 2006, the Federal Court of Malaysia[1] delivered its long awaited judgment in *Foo Fio Na v. Dr. Soo Fook Mun*.[2] At first glance, this case marks the turning point in Malaysian medical negligence law. In deliberating the question as to whether to depart from the *Bolam* test[3] in relation to the duty and standard of care in disclosure of risks cases, the Federal Court of Malaysia held that "the *Rogers*

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1 The highest court in Malaysia.

2 [2007] 1 M.L.J. 593 [*Foo Fio Na*]. This decision was delivered four and a half years after the Federal Court of Malaysia heard the appeal in May 2002.

3 The test enunciated in *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 582 at 586-7 (McNair J.) [*Bolam*]. This test is two-fold: first, in determining the standard of care to be followed by medical practitioners, "the test is the standard of the ordinary skilled man exercising and professing to have that special skill", and second, the medical practitioner "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" even if there is a body of opinion who would take a contrary view.

v. Whitaker test would be a more appropriate and viable test of this millennium then [than] the *Bolam* test."[4]

The decision in *Foo Fio Na* represents a departure from the deference that the judiciary in Malaysia,[5] like other common law jurisdictions,[6] has accorded to the medical profession in the past. In departing from the *Bolam* test, the Federal Court of Malaysia in *Foo Fio Na* relied heavily on the Australian and English developments in this area of medical negligence.

This article examines the decision in *Foo Fio Na* in light of the common law developments in England and Australia in relation to *one* aspect of the duty of care of medical practitioners—namely, the duty of disclosure of risks. The article argues that the decision in *Foo Fio Na*, whilst a step in the right direction, falls short of its apparent promise of a patient-centred approach to the duty to disclose risks.

As such, this article proposes that a more appropriate framework in Malaysia for the duty of disclosure of risks is required—one that takes into consideration the convergence of the legal and ethical principles relating to this duty, and that recognises a patient's right to know and to make informed decisions about the patient's health as a fundamental right protected by the *Federal Constitution of Malaysia* ("*Malaysian Constitution*").

This article concludes that there is need for greater clarity and room for further judicial activism in this area to ensure the recognition and protection of patient autonomy in Malaysia.

II. A Patient's Right to Know at Common Law

A. *The Duty of Disclosure of Risks*

A patient's right to know about the implications and risks involved in a proposed treatment, so as to give proper consideration to the issues involved and to make

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4 *Foo Fio Na*, *supra* note 2 at 611 (Yaakob F.C.J. who delivered the judgment on behalf of the Federal Court pursuant to section 78(1) of the *Courts of Judicature Act 1964* (Malaysia) due to the retirement of the then Chief Justice of the Federal Court, Dzaiddin F.C.J.), approving the decision of the Australian High Court in *Rogers v. Whitaker* (1992) 175 C.L.R. 479 [*Rogers*].

5 See *Swamy v. Mathews* [1967] 1 M.L.J. 142 [*Swamy*], where at first instance, the High Court cited with approval Lord Denning's caution in *Roe v. Minister of Health* [1954] 2 Q.B. 66 [*Roe*] that medical practitioners should not be blamed for every misadventure that occurs or for every medical injury suffered by patients. See also *Swamy v. Mathews* [1968] 1 M.L.J. 138 (Privy Council), *Chin Keow v. Government of Malaysia* [1967] 2 M.L.J. 45, and *Kow Nan Seng v. Nagamah* [1982] 1 M.L.J. 128 in which the courts applied the *Bolam* test.

6 See for example, the judgment of Lord Denning in *Roe*, *supra* note 5 at 83 and at 86-7, in which he stated that:

> [I]t is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks… But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiatives would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point but we must not condemn as negligence that which is only a misadventure.

an informed decision, is at common law founded upon and subsumed within the medical practitioner's duty of care to the patient.[7] The current legal position taken by the courts in England and Australia (and likewise in Malaysia) is that a medical practitioner's failure to disclose risks will give rise to an action in negligence by the patient. In an action for negligence for failure to disclose risks, the patient must not only prove the breach of the duty to disclose risks, but also establish a causal link between that failure and the harm suffered.[8]

It is this duty as defined above that is the subject matter of consideration in this article.

B. *A 'Doctor Knows Best' Approach in England*

The *locus classicus* in the discussion of the standard of care in the context of the duty of disclosure of risks is the decision of McNair J. in *Bolam.*[9] McNair J. directed the jury that, first, in determining the standard of care to be followed by medical practitioners, "the test is the standard of the ordinary skilled man exercising and professing to have that special skill",[10] and second, the medical practitioner "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"[11] even if there is a body of opinion who would take a contrary view.

The above pronouncement, now commonly referred to as the *Bolam* test, reflects a paternalistic approach to doctor-patient relationships. This test establishes that the standard of disclosure of risks and the amount of information to be disclosed remain the preserve and prerogative of the medical profession,[12] whether as a class or a small number of that class.[13]

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7 In *Rogers*, *supra* note 4 at 483, the High Court of Australia determined that the medical practitioner's duty of care in giving information is part of the general duty to take reasonable care in looking after a patient which is a single comprehensive duty founded in negligence and not in trespass.

8 The patient would therefore have to show that if the patient had been properly informed about the risks inherent in the intended treatment, the patient would not have chosen to have or would have delayed that treatment and therefore not suffered damage.

9 *Supra* note 3. In this case, the plaintiff was advised to undergo electro-convulsive therapy but was not warned of the risk of fracture involved, which was one in 10,000. There were different views amongst the experts for both parties as to whether a patient should be expressly warned of the risk of fracture before being treated.

10 *Ibid*. at 586-7.

11 *Ibid*. at 587. In his direction to the jury, McNair J. continued that, "Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view … it is not essential for you to decide which of two practices is the better practice, as long as you accept that what the defendants did was in accordance with a practice accepted by responsible persons": *ibid.* at 588. The jury found the defendants not guilty of negligence.

12 This test has been criticised by Lord Scarman in *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] 1 A.C. 871 at 881 [*Sidaway*], as giving rise to a situation where "the law imposes the duty of care; but the standard of care is a matter of medical judgment".

13 Lord Irvine (Lord Chancellor), "The Patient, the Doctor, their Lawyers and the Judge" (1999) 7 Med. L. Rev. 255 at 257.

Of course, as a result of the *Bolam* test, the content of the duty of disclosure of risks will depend on what a reasonable body of medical opinion thinks is appropriate for the patient to know, given that this is seen as the appropriate standard of disclosure.

The House of Lords in *Sidaway*[14] by majority applied the *Bolam* test, despite a strong dissent from Lord Scarman.[15] The House of Lords in this case felt that what risks were to be disclosed to the patient was as much an exercise of professional skill and judgment as any other part of the medical practitioner's comprehensive duty of care to the patient.[16] Conversely, by formulating a standard of disclosure premised on the patient's right to know what the treatment entails and to be able to make an informed choice, Lord Scarman in *Sidaway*[17] expressed the content of the duty of disclosure of risks as being confined to whether, in the circumstances of the particular case, the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk.[18]

Notwithstanding Lord Scarman's strong dissent in *Sidaway*, the *Bolam* test still remains the law in England save to the extent that it has now been modified by the decisions in *Bolitho (administratrix of the estate of Bolitho (deceased)) v. City of Hackney Health Authority*[19] and in *Pearce v. United Bristol Healthcare NHS Trust*.[20]

According to the approach taken by the House of Lords in *Bolitho*,[21] the standard of care is determinable by a body of responsible medical opinion, unless in a rare case, it is demonstrated to the court's satisfaction that this medical opinion is not "responsible, reasonable and respectable", and thus not capable of "withstanding logical analysis".[22] The modified *Bolam* test in *Bolitho* was held by the

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14 *Supra* note 12.

15 Lord Scarman in his dissenting judgment sought to adopt the American doctrine of informed consent as developed in *Canterbury v. Spence*, 464 F. 2d 772 (D.C. 1972), in which Robinson J. said that "respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves" (at 784). Lord Scarman took the view that it would be inconsistent for the courts to permit doctors to determine whether and in what circumstances a duty to disclose risks arises, particularly when the courts also recognised a patient's right to make decisions about the patient's health. His Lordship opined that the medical practitioner's duty of care extended not only to the health and well-being of the patient but also to a proper respect for the patient's right to make his or her own decision as to whether to undergo the proposed treatment. As such, Lord Scarman concluded that the duty to warn formed part of the medical practitioner's duty of care: *Sidaway*, *supra* note 12 at 876–90.

16 *Sidaway*, *supra* note 12 at 895 (Lord Diplock).

17 *Ibid*. at 889-90 (Lord Scarman).

18 *Ibid*. at 889-90.

19 [1997] 4 All E.R. 771 (Lord Browne-Wilkinson) [*Bolitho*].

20 [1999] P.L.Q.R. 53 (Lord Woolf M.R.) [*Pearce*].

21 *Supra* note 19.

22 *Ibid.* at 779 (Lord Browne-Wilkinson). In arriving at this decision, Lord Browne-Wilkinson went on to add in parenthesis, "I am not here considering questions of disclosure of risk." This raises the issue of how the *Bolam* test would apply in disclosure of risks cases. If the *Bolam* test were to apply in its original form to disclosure of risks cases, this would seem irrational and illogical given the way the *Bolam* test was applied in a modified form to diagnosis and treatment in the instant case. It is possible that Lord Browne-Wilkinson's exclusion of disclosure of risks from his reasoning was simply because the issue of non-disclosure of risks did not arise in this case.

Court of Appeal in *Pearce*[23] as being applicable to cases involving the disclosure of risks.

More recently, the House of Lords in *Chester v. Afshar*[24] indicated a further departure away from the *Bolam* test. The House of Lords in this case took the view that the surgeon owed a duty to the patient to inform of risks that were inherent in the proposed surgery, including the risk of cauda equina syndrome, which was a small but serious risk.[25] The scope of the duty of disclosure of risks very much depended on the patient's basic right to be informed in order to be able to choose whether or not to undergo the surgery in question.

One of the concerns raised by a departure from the *Bolam* test is that, by focusing on a patient-based standard of disclosure, the patient would only need to show that he or she would not have undergone the treatment in question if the required disclosure of risks had been made, in order to establish the causal link. The medical practitioner would therefore face the danger of being exposed to the patient's self-serving testimony or "hindsight and bitterness".[26] These concerns have influenced the way in which the issue of causation has been treated in disclosure of risks cases in England.[27]

However, in *Chester*, the majority of the House of Lords stressed the importance attached to patient autonomy and the patient's right to make an informed choice, and that the law should provide a remedy if this right is not respected.[28] The House of Lords was prepared to vindicate this right by "a narrow and modest departure from the traditional causation principles."[29] The House of Lords found in favour of Ms. Chester on the basis that, had the appropriate warning been given, Ms. Chester would not have had the operation on that day (or by that surgeon) and the small but significant risk of injury may not have eventuated.

It follows from the above decisions that there seems to be a shift in the position taken by the English courts away from the paternalism inherent in the *Bolam* test, although they have yet to do so clearly and unequivocally.

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[23] *Supra* note 20 at 59 (Lord Woolf M.R.). See Margaret Brazier & José Miola, "Bye-Bye *Bolam*—A Medical Litigation Revolution" (2000) 8 Med. L. Rev. 85 at 109, for a discussion of this case. See also the decision in *Penney v. East Kent Health Authority* [2000] Lloyd's Rep. Med. 41 (Lord Woolf M.R.) where the Court of Appeal accepted that two sets of competent experts may hold differing opinions and that the *Bolam* test has no application where what the judge is required to do is to make a finding of fact.

[24] [2004] 4 All E.R. 587 [*Chester*].

[25] *Ibid*. at 600-3 (Lord Hope of Craighead at paras. 48-55), 613 (Lord Walker of Gestingthorpe at paras. 90-2). Both the Lords relied on Lord Scarman's strong dissent in *Sidaway*, *supra* note 12, and the other observations of the majority of the House of Lords in that decision. See also Lord Steyn who observed that a surgeon owes a legal duty to a patient to warn that patient in general terms of the possible serious risks involved and that a patient has a "*prima facie* right to be informed by a surgeon of a small but well established risk of serious injury as a result of surgery": *ibid*. at 594 (at para. 16).

[26] Dieter Giesen & John Hayes, "The Patient's Right to Know—A Comparative View" (1992) 21 Anglo-Am. L. Rev. 101 at 118.

[27] In *Bolam*, *supra* note 3 at 590-1, the jury was directed by McNair J. to consider the question whether, if a warning had been given, would it have made any difference to the patient? McNair J. instructed the jury that, unless the plaintiff has satisfied the jury that he would not have taken the treatment had he been warned, "there is really nothing in this point [the issue of causation]".

[28] *Chester*, *supra* note 24. In this case, Ms. Chester claimed that she had asked about the risks of the proposed operation during the initial consultation but had not been warned of the 1 to 2% risk of cauda equina syndrome, which in fact eventuated.

[29] *Ibid*. at 596 (Lord Steyn at para. 24).

C. *A 'Patient-Centred' Approach in Australia*

Even prior to the Australian High Court decision in *Rogers*,[30] the approach of the English courts to the standard of care in disclosure of risks cases did not commend itself to the Australian courts.[31]

In determining the scope and content of the surgeon's duty of care, which included the duty to warn and advise Mrs. Whitaker of the material risks inherent in the surgery, the High Court of Australia in *Rogers*[32] expressed the view that "it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the 'paramount consideration that a person is entitled to make his own decision about his life'."[33] The High Court therefore resoundingly rejected the application of the *Bolam* test in Australia.

Thus, in cases pertaining to the disclosure of risks,[34] the decision in *Rogers*[35] effectively took away from the medical profession in Australia the right to determine, in proceedings for negligence, what amounts to acceptable medical standards. The issue of whether a patient has been given all the information relevant to choosing between undergoing and not undergoing the proposed treatment[36] no longer depends entirely on medical standards or practices, since "no special medical skill is involved in disclosing the information including the risks attending the proposed treatment."[37]

As for the content of the duty of disclosure of risks, the High Court made the following pronouncement:

> The law should recognise 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 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 [the objective limb] or if the

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30 *Supra* note 4.

31 See for example, *F v. R* (1983) 33 S.A.S.R. 189 at 192-4 (King C.J.). This case involved a medical practitioner's failure to warn a married couple of the risk of recanalisation in sterilisation, where this risk did eventuate. In this case, King C.J. held that the court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law. In the view of King C.J., the ultimate question was "not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community".

32 *Supra* note 4.

33 *Ibid*. at 487.

34 It must be noted that whilst there remained some uncertainty after the decision in *Rogers* as to whether the *Bolam* test still applied in the realm of diagnosis and treatment, the High Court of Australia in *Naxakis v. Western General Hospital* (1999) 73 A.L.J.R. 784 [*Naxakis*] (*per* Gaudron, McHugh and Kirby JJ.) confirmed that the *Bolam* test does not apply to advice, diagnosis and treatment in medical negligence cases in Australia. See however *infra* note 43.

35 *Supra* note 4.

36 The relevant information would include the risks of a proposed treatment, the likelihood of occurrence of such risks, alternatives to such treatment and the implications thereof, as well as the consequence of not proceeding with the proposed treatment: Ian Kennedy & Andrew Grubb, eds., *Principles of Medical Law* (Oxford: Oxford University Press, 1998) at 158-9.

37 *Rogers*, *supra* note 4 at 489-90.

> 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 [the subjective limb]. This duty is subject to the therapeutic privilege.[38]

In view of the above formulation, the High Court in *Rogers* found that Mrs. Whitaker would have likely attached significance to the risk of sympathetic ophthalmia, and thus required a warning of such risk, particularly as she had incessantly questioned the surgeon as to the possible complications of the surgery in question.[39] The surgeon was therefore found in breach of his duty.

The test of materiality in *Rogers* and the forseeability of the risk involved stems from the recognition that a patient has the fundamental right to know and to make an informed choice about a proposed treatment, save in the instances where the therapeutic privilege applies, namely, where there is an emergency or necessity.[40] Of course, the question of what risks are material and inherent will be up to the courts to decide, based on medical and other evidence available.[41]

By focusing on the "paramount consideration that a person is entitled to make his own decision about his life", the High Court in *Rogers* effectively established a 'patient-based' standard of disclosure of risks. Such a patient-based standard of disclosure of risks recognises that the choice of the patient is crucial and that such a choice can only be properly exercised if it is based on adequate information relevant to making that choice.

This approach was reaffirmed by the High Court of Australia in *Rosenberg*, as giving recognition to the principle that a patient has a right to determine what should be done with the patient's own body and to make decisions affecting the patient's life.[42]

The *Rogers* test remains the position of the law on *this issue* in Australia.[43]

The issue of causation was not analysed in *Rogers.*[44] However, in *Chappel v. Hart*,[45] the Australian High Court held by a narrow majority that the patient who

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[38] *Ibid*. at 490. In applying this materiality test, the High Court in *Rogers* also approved the factors referred to by King C.J. in *F v. R*, *supra* note 31 at 192-93, as being relevant considerations when deciding whether to disclose or advise of a risk in the proposed treatment, namely the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient, and the general surrounding circumstances.

[39] *Ibid*. at 491.

[40] *Ibid*. at 489.

[41] In *Rosenberg v. Percival* (2001) 205 C.L.R. 434 at 439 [*Rosenberg*], Gleeson C.J. clarified that the decision in *Rogers* did not deny the relevance of professional practice and opinion, only its conclusiveness, and that in many cases, "professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act. But in an action brought by a patient, the responsibility for deciding the content of the doctor's duty of care rests with the court and not with his or her professional colleagues".

[42] *Ibid*. at 477 (Kirby J.).

[43] The enactment of the Civil Liability Acts in the various states in Australia introduced a modified *Bolam* test in respect of all areas of medical negligence *except* for situations where there is an allegation of a breach of the duty to disclose risks. See for example, ss. 5H and 5I of the *Civil Liability Act 2002* (N.S.W.) and s. 21 of the *Civil Liability Act 2003* (Qld.).

[44] Since this issue was not raised in argument at the appeal before the High Court: *supra* note 4.

[45] (1998) 156 A.L.R. 517 [*Chappel*].

developed an infection after the operation which could have developed no matter which qualified person might have performed the operation, was entitled to recover damages.[46] This was because the surgeon had not advised her of the risk of infection and because the High Court found that she would have postponed the operation and sought the most experienced surgeon in the field had she been informed of the risk.

The High Court in *Chappel*[47] adopted a subjective approach which had regard to what the particular patient's response would have been, had proper information been given. Similarly, the High Court in *Rosenberg*[48] confirmed that Australian law is committed to a subjective test in determining whether a patient would have refused to undergo a medical procedure if that person had been warned of the risk of relevant injury. The onus of proof as to causation is on the patient.

However, as cautioned in *Chappel*[49] and in *Rosenberg*,[50] the courts had to observe the need for "great care" in evaluating the patient's assertions and testimony.[51] The courts would also need to look at objective considerations or facts to test the patient's subjective assertions in proof of what the patient would have done if warned of the risks involved.[52]

The common law position in Australia on the issue of causation in disclosure of risks cases has been somewhat modified by legislation.[53]

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46 *Ibid*., *per* Gaudron, Gummow and Kirby JJ., with McHugh and Hayne JJ. dissenting. On the facts in this case, it was found that the patient had indicated that she did not want to end up like Neville Wran, the then premier of New South Wales: *ibid*. at 542 (Kirby J.).

47 *Supra* note 45.

48 *Supra* note 41 at 449 (McHugh J.), 462 (Gummow J.), 484 (Kirby J.), 501 (Callinan J.).

49 *Supra* note 45 at 547-8 (Kirby J.).

50 *Supra* note 41 at 485-6 (Kirby J.).

51 *Ibid*. As reiterated by Kirby J. (*ibid.* at 486):

> If a reasonable person would have undergone treatment, regardless of disclosure, then in the absence of personal characteristics or circumstances which would explain a refusal, it must be difficult for a court to conclude that the plaintiff would have rejected the treatment no matter what the plaintiff now genuinely believes that he or she would have done. It should be remembered that causation in other areas of negligence presents similar difficulties.

52 *Ibid*. at 449 (McHugh J.), 488 (Kirby J.) and 505 (Callinan J.). In this case, the High Court accepted the trial judge's refusal to accept the plaintiff's assertion that she would 'never' have had the operation had she been warned of the risk, in view of the objective facts such as the plaintiff's awareness, as a highly experienced practising and teaching nurse, of risks going beyond those of frequent and regular occurrence; her stressed desire at the time of consultation for the best result; as well as the fact that the plaintiff's denial that she would have had the operation had she been warned was made only upon being recalled to give evidence at the trial: *ibid*. at 505.

53 See *Civil Law (Wrongs) Act 2002* (A.C.T.); *Civil Liability Act 2002* (N.S.W.); *Personal Injuries (Liabilities and Damages) Act 2003* (N.T.); *Civil Liability Act 2003* (Qld.); *Civil Liability Act 1936* (S.A.) substantially amended by the *Law Reform (Ipp Recommendations) Act 2004* (S.A.); *Civil Liability Act 2002* (Tas.); *Wrongs Act 1958* (Vic.) substantially amended by the *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic.) and the *Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002* (Vic.); *Civil Liability Act 2002* (W.A.). See also Commonwealth of Australia, *Review of the Law of Negligence Report* by the Panel of Eminent Persons to Review the Law of Negligence (2002), online: <http://revofneg.treasury.gov.au/content/review.asp> [*Ipp Report*]. It is beyond the scope of this article to examine the reasons behind or the implications arising from the changes introduced by these legislation.

D. *Some Observations*

The decision in *Rogers* sparked controversy and raised concerns[54] among the medical and legal fraternities in Australia. Despite these concerns, however, the decision in *Rogers* has withstood more than a decade as authority without being challenged in Australia and has instead been affirmed in *Rosenberg*. The *Rogers* decision recognises as its basic premise patient autonomy rather than paternalism, in that a patient has a right to know the material risks inherent in a proposed treatment, so that the ultimate choice as to whether to undergo or forego such treatment rests with the patient.

The English common law on the duty of disclosure of risks remains, however, entrenched in its past, despite the various attempts to throw off its shackles that seem to have been made in *Bolitho* and in *Pearce*. In view of the House of Lords decision in *Chester* which embraced patient autonomy, it is possible that the English courts may soon depart from the *Bolam* test.

Having examined the common law developments in England and Australia, the developments in Malaysia on the issue of the duty of disclosure of risks will now be examined.[55]

III. The Malaysian Position

A. *Before* Foo Fio Na—*A Mixed Bag of Cures*

Since independence in 1957, the Malaysian courts have continued to adopt the English courts' deferential position towards the medical profession.[56] In several early

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[54] Some of the concerns arising from this decision include concerns that the requirements for disclosure of risks would impose onerous obligations on the part of medical practitioners, involve expenditure of time and effort which would not be cost-effective, open the floodgates to medical litigation and lead to defensive medical practices: see for example Ian H. Kerridge & Kenneth R. Mitchell, "Missing the Point: *Rogers v. Whitaker* and the Ethical Ideal of Informed and Shared Decision Making" (1994) 1 J.L. & Med. 239 at 243-4; Peter H. Schuck, "Rethinking Informed Consent" (1994) 103 Yale L.J. 899 at 933-41; Norman A. Olbourne, "The Influence of *Rogers v. Whitaker* on the Practice of Cosmetic Plastic Surgery" (1998) 5 J.L. & Med. 334 at 342-4; Seham Tawfick Girgis, Colin Thomson & Jeanette Ward, "The Courts Expect the Impossible: Medico-Legal Issues as Perceived by New South Wales General Practitioners" (2000) 7 J.L. & Med. 273. Space constraints do not permit an examination of these issues in this article.

[55] It must be noted that as there are very few medical negligence reported decisions in Malaysia that relate to the issue of disclosure of risks, the decisions relating to negligent diagnosis and treatment will also be considered in order to understand the development of this area of Malaysian law.

[56] See *Swamy*, *supra* note 5, where at first instance, the High Court cited with approval Lord Denning's caution in *Roe*, quoted *supra* notes 5-6 above. See also *Swamy*, *supra* note 5 at 140, where the Federal Court reiterated its deference for the medical profession, that:

> [A]n action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body—perhaps even more so. And an action for negligence could wound his reputation as severely as a dagger could his body. The jury must therefore not find him negligent simply because one of the risks inherent in an operation actually took place, or because in a matter of opinion he made an error of judgment. They should find him guilty when he had fallen short of the standard of reasonable medical care, when he was deserving of censure.

cases involving negligent diagnosis and treatment,[57] the Malaysian courts adopted the *Bolam* test for the standard of care expected of a medical practitioner.

In *Kow Nan Seng v. Nagamah*,[58] the Federal Court of Malaysia accepted that the medical practitioner's standard of care towards the patient was that of an ordinary competent medical practitioner and approved the *Bolam* test.[59] However, the Federal Court took it upon itself to determine what was a fair and reasonable standard of care expected of the doctor on the face of the expert medical evidence as well as on the other evidence relating to the care of the patient.[60]

The *Bolam* test nevertheless became an entrenched part of Malaysian medical negligence law up until the mid-90s.[61] The various High Courts[62] in Malaysia, however, then had the opportunity to consider the *Bolam* test in light of the High Court of Australia's decision in *Rogers*.

In *Kamalam a/p Raman v. Eastern Plantation Agency (Johor) Sdn. Bhd. Ulu Tiram Estate, Ulu Tiram, Johore*,[63] Talalla J. stated that the current state of the law in respect of medical negligence is as set out in *Rogers*. The various legal principles enunciated by the Federal Court in *Kow Nan Seng*[64] and by the High Court of Australia in *Rogers* were considered by Talalla J. who then observed:

> I should emphasise that while due regard will be had to the evidence of medical experts, … I am not bound by the *Bolam* principle. Rather do I see the judicial function in this case as one to be exercised as in any other case of negligence,

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57 In *Chin Keow v. Government of Malaysia* [1967] 2 M.L.J. 45, the Privy Council approved the trial judge's adoption of the first part of the *Bolam* test in that the standard of care expected of a medical practitioner prior to prescribing the injection was that of the ordinary skilled man exercising and professing to have that special skill: *ibid*. at 47. See also *Elizabeth Choo v. Government of Malaysia* [1970] 2 M.L.J. 171 at 172, where the second part of the *Bolam* test, namely that the standard of care of a medical practitioner was to be established by a responsible body of medical opinion, was expressly adopted as part of Malaysian law.

58 [1982] 1 M.L.J. 128 at 129 [*Kow Nan Seng*]. This case involved the issue of whether a complete plaster cast applied to the patient's leg had caused the loss of circulation in that leg which led to gangrene and the amputation of that leg, and whether there was a lack of proper skill and care on the part of the medical practitioner in the application and monitoring of the plaster cast.

59 *Ibid*. at 130.

60 *Ibid*. at 131.

61 See for example, *Inderjeet Singh a/l Piara Singh v. Mazlan bin Jasman* [1995] 2 M.L.J. 646 at 654-5 where Foong J. found against the doctors at a government hospital for neglecting to carry out the appropriate tests and treatments upon the patient contrary to general medical practice, which led to and caused the injuries suffered by the patient. This was because the doctors had failed to exercise a fair and reasonable standard of care and skill pursuant to the *Bolam* test. Similarly, in *Abdul Rahman bin Abdul Karim v. Abdul Wahab bin Abdul Hamid* [1996] 4 M.L.J. 623 at 635-6 (Ishak J.), the High Court applied the *Bolam* test to the standard of care expected of a traditional eye healer who had sought to perform an eye operation on the patient.

62 There are 2 High Courts of co-ordinate jurisdiction under Article 121(1) of the *Malaysian Constitution*—the High Court of Malaya with divisions located in each state in Peninsular Malaysia, and the High Court of Sabah & Sarawak with divisions located in the states of East Malaysia. The High Courts have original, appellate and supervisory jurisdiction. In the exercise of its original jurisdiction, the High Courts have unlimited civil powers (no upper limit as to quantum): see Part II of the *Courts of Judicature Act, 1964* (Malaysia). Appeals against decisions of the High Courts lie to the Court of Appeal.

63 [1996] 4 M.L.J. 674 at 687 [*Kamalam*]. This case arose as a result of alleged negligent diagnosis and treatment of the deceased who was suffering from hypertension and then suffered a fatal stroke.

64 *Supra* note 58.

> unshackled, on the ordinary principles of the law of negligence and the overall evidence.[65]

Subsequent High Court decisions[66] fluctuated between applying the *Bolam* test and adopting the approach in *Rogers*, giving rise to a period of uncertainty in this area of medical negligence law.

B. *What Happened in* Foo Fio Na

In *Foo Fio Na*,[67] Ms. Foo suffered paralysis after an open reduction procedure (the first operation) by the defendant surgeon (the surgeon), during which the surgeon had inserted a wire loop to stabilise Ms. Foo's spinal cord. A neurosurgeon examined Ms. Foo and found that the wire loop was pressing on her spinal cord. The surgeon then carried out a second surgical procedure (the second operation) to remove the wire loop, after which Ms. Foo remained unable to move her legs although she was now able to move her hands.

In addition to alleging that the surgeon was negligent in carrying out the two operations which resulted in her paralysis, Ms. Foo alleged that the risks of the two operations were not explained to her even though she had asked the surgeon about the dangers of these operations. She also alleged that she had not given her consent to these operations.

The trial judge, after a period of four years after the trial, delivered his judgment in favour of Ms. Foo and against the surgeon and the hospital upon several grounds.[68]

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65 *Kamalam*, *supra* note 63 at 691. In this case, Talalla J. proceeded to accept the opinion of the medical experts called by the plaintiff, despite there being a body of medical opinion that approved the practice which had been adopted by the doctor in question. Here, the High Court was prepared to depart from the *Bolam* test in the area of diagnosis and treatment.

66 In *Liew Sin Kiong v. Dr. Sharon D.M. Paulraj* [1996] 5 M.L.J. 193 at 205 (Ian Chin J.), the High Court found that it was unnecessary in this case to decide whether to follow the decision in *Sidaway* or that in *Rogers* in respect of the standard and scope of the duty of disclosure of risks but nevertheless endorsed a doctor-centric approach to the standard and scope of such disclosure. In *Tan Ah Kau v. Government of Malaysia* [1997] 2 A.M.R. 1382, the High Court endorsed the approach of Gaudron J. in *Rogers*, *supra* note 4 at 494, that the duty of disclosure extends "at the very least to information that is relevant to a decision or course of action which if taken or pursued, entails a risk of a kind that would, in other cases found a duty to warn". In *Chelliah a/l Manickam v. Kerajaan Malaysia* [1997] 2 M.L.J. 1856 at 1860, the High Court adopted the first part of the *Bolam* test as being the law in Malaysia, yet proceeded to evaluate the conflicting medical expert evidence and made a determination as to the reasonableness of such bodies of expert evidence. In *Hong Chuan Lay v. Dr. Eddie Soo Fook Mun* [1998] 7 M.L.J. 481 at 496, the High Court applied the decision in *Rogers* as the High Court was of the view that the duty to warn arises from the patient's right to know of the material risks, which is in turn derived from the patient's right to decide whether to undergo or forgo the proposed treatment. See also *K.S. Sivananthan, Dr. v. Government of Malaysia* [2001] 1 M.L.J. 35 (Gill J.), where the High Court applied the *Rogers* materiality test, albeit without much analysis, where it found the doctor negligent in failing to warn or advise the plaintiff of the risks of an early discharge from the hospital.

67 *Foo Fio Na v. Hospital Assunta* [1999] 6 M.L.J. 738 (at first instance) [*Foo Fio Na* (first instance)]. Ms. Foo had been in a car accident and had admitted herself into Assunta Hospital complaining of neck pains.

68 *Ibid*. at 752-3 (Sidin J.).

First, the trial judge held that the two consent forms signed by Ms. Foo were not valid.[69]

Second, the trial judge found that Ms. Foo had not been told by the surgeon that the first operation was a major one which involved the risk of paralysis. On the basis of an earlier Malaysian High Court decision[70] which had applied Gaudron J.'s decision in *Rogers*, the trial judge held that the surgeon was negligent in not giving a proper warning about the risk of paralysis to Ms. Foo. In finding for Ms. Foo, the trial judge further held that it is the court that had to decide on the surgeon's negligence after weighing the standard of skills practiced by the medical profession and also the fact "that a person is entitled to make his own decision on his life."[71]

Third, the trial judge found that the insertion of the wire loop by the surgeon during the first operation had caused the paralysis and the surgeon was therefore negligent in his treatment of Ms. Foo who was now a quadriplegic.

As a result, Ms. Foo was awarded general and special damages amounting to RM500,000.00, a substantial award by Malaysian medical negligence standards.

The surgeon and the hospital appealed to the Court of Appeal against this decision. The Court of Appeal[72] allowed the appeal on the basis that the trial judge had not made any determination on whether Ms. Foo had discharged her burden of proof that the conduct of the surgeon and/or the hospital had caused her paralysis.[73]

Having dealt with the issue of causation on the facts, the Court of Appeal proceeded to briefly deal with four other matters, of which only one is relevant here.[74] The Court of Appeal was asked to depart from the *Bolam* test. Although the Court of Appeal was tempted to "jettison the *Bolam* test" in favour of the Australian approach in *Rogers*[75]

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69 This was because the first consent form was signed at a time when it was not known whether there was any necessity for Ms. Foo to undergo an operation, and since the second consent form was affixed with the thumbprint of Ms. Foo at a time when she was already suffering paralysis: *ibid*.

70 *Tan Ah Kau v. Government of Malaysia* [1997] 2 A.M.R. 1382 at 1402. It is uncertain as to why the Malaysian High Court in this case did not make any reference to the main judgment in *Rogers*.

71 *Foo Fio Na* (at first instance), *supra* note 67 at 765-6.

72 *Soo Fook Mun, Dr. v. Foo Fio Na* [2001] 2 M.L.J. 193 at 201 (C.A.) (Sri Ram J.C.A.) [*Foo Fio Na* (C.A.)]. The issues of consent and the non-disclosure of risks were not dealt with by the Court of Appeal, perhaps due to the procedural defects relating to the judgment of the trial judge. The Court of Appeal found that, as a matter of procedure, the trial judge had failed to hear and determine the surgeon's application for particulars of the plaintiff's general allegations of negligence. This failure on the part of the trial judge was criticised to be "an extreme example of procedural unfairness and oppression", since the surgeon was denied both his right to have his interlocutory application dealt with, and his right to appeal arising from such an application.

73 *Ibid*. at 205.

74 *Ibid*. at 205-8. As for the three other matters, first, Sri Ram J.C.A. scathingly admonished the trial judge for the four-year delay to deliver his judgment which had the result of diminishing the weight to be placed on the trial judge's assessment and views as to the credibility of the witnesses and his finding of facts. Second, the trial judge was criticised for allowing counsel for Ms. Foo to raise an unpleaded case of negligence against the surgeon and the hospital, despite Ms. Foo having the benefit of advice during the trial from an eminent medical expert. Third, the trial judge came under further criticism in the way the surgeon's expert witness and counsel for the surgeon were treated by both the trial judge and counsel for Ms. Foo during the trial.

75 *Supra* note 4.

and *Naxakis*,[76] it nevertheless declined to do so.[77] The Court of Appeal proceeded to confirm that the *Bolam* test in its original form still stood as the law in Malaysia.[78]

Ms. Foo was granted leave to appeal by the Malaysian Federal Court[79] against the decision of the Court of Appeal, on the single question of law as to "whether the *Bolam* test … should apply in relation to all aspects of medical negligence". In so granting leave to appeal, the Federal Court confined the question of law to "the particular aspect of medical negligence [that] relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment."[80]

The appeal to the Federal Court was heard in early May 2002[81] and the Federal Court reserved its judgment.

In the interim, a number of cases[82] were heard by the Malaysian High Courts, which reverted to the *Bolam* test in light of the Court of Appeal decision in *Foo Fio Na*.[83] These cases were decided at a time when medical negligence law remained at the crossroads pending the decision of the Federal Court in *Foo Fio Na*.

C. *The Federal Court in* Foo Fio Na[84]

Four years after hearing the appeal, the Federal Court of Malaysia delivered its much awaited judgment in *Foo Fio Na.* The Federal Court answered the question posed

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76 *Supra* note 34, where the Australian High Court clarified that the *Rogers* decision applied equally to the areas of diagnosis and treatment.

77 *Foo Fio Na* (C.A.), *supra* note 72 at 207. Sri Ram J.C.A. briefly explained this part of the decision on two broad grounds. First, it was not open to the Court of Appeal, as an intermediate court, to alter the law, a task reserved for the Federal Court. Second, the Court of Appeal was persuaded by the possible threat of an increasing practice of defensive medicine if the higher threshold which a plaintiff needs to satisfy, as established by the *Bolam* test, were to be lowered. However, Sri Ram J.C.A. proceeded to caution that "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.": *ibid*. at 208, echoing perhaps his extra-judicial comments made one year earlier: Gopal Sri Ram (Justice), "The Standard of Care: Is the *Bolam* Principle Still the Law?" (2000) 3 M.L.J. lxxxi at lxxxviii–lxxxix.

78 In confirming this issue, the Court of Appeal did not make any distinction between the realms of treatment, diagnosis or disclosure of risks: *Foo Fio Na* (C.A.), *supra* note 72 at 207.

79 *Foo Fio Na v. Dr. Soo Fook Mun* [2002] 2 M.L.J. 129 [*Foo Fio Na* (leave)].

80 *Ibid*. at 130.

81 The author was present at the hearing of the appeal before the Federal Court, where the then Chief Justice of the Federal Court appeared to remain unconvinced by the argument that the time had come for Malaysia to discard the *Bolam* test.

82 See for example, *Payremalu Veerappan v. Dr. Amarjeet Kaur* [2001] 3 M.L.J. 725 (Singham J.); *Asiah Kamsah v. Dr. Rajinder Singh* [2001] 4 C.L.J. 269 (Foong J.); *Hor Sai Hong v. University Hospital* [2002] 5 M.L.J. 167 (Hussain J.); *Hassan Datolah v. The Government of Malaysia* [2003] 5 C.L.J. 355 (Hussain J.); *Udhaya Kumar Karuppusamy v. Penguasa Hospital Daerah Pontian* [2005] 1 C.L.J. 143 (Tan J.)—in this case, the judge examined the position of the law as it currently stood and found that although leave to appeal had been granted by the Federal Court in *Foo Fio Na (leave), supra* note 79, the *Bolam* test remained the *locus classicus* as had been reaffirmed by the Court of Appeal in *Foo Fio Na* (C.A.), *supra* note 72. See also *Tan Eng Siew v. Dr. Jagjit Singh Sidhu* [2006] 1 M.L.J. 57 (Foong J.); *Foong Yeen Keng v. Assunta Hospital (M) Sdn. Bhd.* [2006] 5 M.L.J. 94 (Sharif J.)—in this case, although not expressly making reference to the *Bolam* test, the judge effectively applied this test in accepting one medical opinion over another.

83 *Foo Fio Na* (C.A.), *supra* note 72.

84 *Supra* note 2.

on appeal[85] in the negative, allowed the appeal and reinstated the orders of the High Court in favour of Ms. Foo.[86]

In arriving at its decision, the Federal Court examined McNair J.'s decision in *Bolam* and the formulation of what has now come to be known as the *Bolam* test.[87]

The Federal Court[88] then reviewed the findings of fact made by the trial judge in *Foo Fio Na*,[89] and accepted the trial judge's findings that Ms. Foo was not warned of the risk of paralysis from undergoing the first operation and that had she been so warned, she would not have agreed to undergo the first operation. The Federal Court also accepted that there was sufficient evidence before the trial judge to arrive at his conclusion that the first operation had caused the plaintiff's paralysis, thereby setting aside the Court of Appeal's conclusion on this issue.[90]

The Federal Court went on to state:

> That said, we are of the opinion that the *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.[91]

Having arrived at the above conclusion, the Federal Court examined the English and Australian positions on the duty of disclosure of risks as well as the divergent Malaysian cases,[92] some of which had adopted the *Bolam* test and those that had applied the *Rogers* decision.

The Federal Court then concluded that:

> [T]here is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis we are of the view that the *Rogers* test would be a more appropriate and viable test of this millennium then [than] the *Bolam* test. To borrow a quote from Lord Woolf's inaugural lecture ... in 2001,

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85 There remains some doubt as to whether the Federal Court answered the broader question for which leave to appeal was sought (whether the *Bolam* test should apply to all aspects of medical negligence) or the narrower question for which leave to appeal appears to have been granted (whether the *Bolam* test should apply to disclosure of risks cases). See *infra* notes 94-102 and accompanying text.

86 *Foo Fio Na*, *supra* note 2 at 612.

87 *Ibid*. at 601. The Federal Court examined the two limbs to the *Bolam* test and commented that this "over protective and deferential approach perhaps conform(s) to the well known phrase that 'A doctor knows best'."

88 *Ibid*. at 599-603.

89 *Foo Fio Na* (first instance), *supra* note 67.

90 Whether the Federal Court was entitled to interfere with the findings of the Court of Appeal on questions of fact is debatable: see Margaret Fordham, "Doctor does not always know best" [2007] Sing. J.L.S. 128 at 134.

91 *Foo Fio Na*, *supra* note 2 at 611.

92 *Ibid*. at 608-10. See *supra* notes 56-66 and accompanying text.

the phrase 'Doctor knows best' should now be followed by the qualifying words 'if he acts reasonably and logically and gets his facts right'.[93]

D. *Shortcomings in* Foo Fio Na

The decision of the Federal Court in *Foo Fio Na* brought relief to Ms. Foo almost 25 years after her injury. Equally significant, this decision heralds a turning point in Malaysian medical negligence law, at least in relation to the duty of disclosure of risks. By accepting the test in *Rogers* over the *Bolam* test, the Federal Court has put some finality on the way in which the Malaysian courts will now deal with disclosure of risks cases. However, the decision in *Foo Fio Na* is flawed in a number of aspects and these shortcomings dilute the significance of this decision.

First, there remains some doubt as to whether the decision in *Foo Fio Na* applies only to cases involving disclosure of risks or whether it extends to all aspects of medical negligence. Although the Federal Court in *Foo Fio Na* specifically opined that the *Bolam* test had no relevance to the duty and standard of care in providing advice on the risks of the proposed treatment,[94] the Federal Court went on to consider several English and Australian cases relating to negligent treatment and diagnosis including the decision in *Naxakis* as having settled the doubt that the test in *Rogers* also applied to the areas of diagnosis and treatment.[95] The Federal Court further reinstated the findings of the trial judge on both the surgeon's failure to warn Ms. Foo of the risk of paralysis as well as on the surgeon's negligence in treating Ms. Foo which resulted in her paralysis.

The Federal Court then went on to answer "the question posed in the appeal" in the negative[96] without clarifying whether this decision was confined to disclosure of risks cases or applied to all areas of medical negligence.

This lack of clarity has resulted in one subsequent Court of Appeal decision[97] accepting that the Federal Court's decision in *Foo Fio Na* applies to the realm of medical treatment and diagnosis. Conversely, a High Court[98] has applied the Federal Court's decision in *Foo Fio Na* to the question of disclosure of risks to the patient and

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93 *Ibid*.

94 See *supra* note 91 and accompanying text.

95 *Foo Fio Na*, *supra* note 2 at 611.

96 *Ibid*. at 612.

97 *Dominic Puthucheary v. Dr. Goon Siew Fong* [2007] 5 M.L.J. 552 at 559 (Sri Ram J.C.A.). In this case, which involved a claim for negligent diagnosis of the deceased patient's injury at the time of admission in hospital, the Court of Appeal accepted that "the standard of care that a medical attendant should exercise is now a question which is for the ultimate consideration of the courts and no longer one for the medical profession alone to decide through a responsible body of medical opinion."

98 *Lechemanavasagar a/l S. Karuppiah v. Dr. Thomas Yau Pak Chenk* [2008] 1 M.L.J. 115 at 122 and 132. In this case, the plaintiff claimed that the defendant doctor failed to advise him of the risks associated with the surgery performed to remove a fish bone in his throat (including esophageal perforation) and was negligent in his post-operative treatment, which resulted in an infection to the plaintiff's right lung. The High Court found on the evidence that the doctor had explained the risk, and that even if he had not, there was no evidence to indicate that any other option was available to the plaintiff except for surgery to remove the fish bone. As for the post-operative treatment, the High Court found that, applying the modified *Bolam* test as established in *Bolitho*, there was no evidence to suggest that the doctor had deviated from the accepted practice in giving the plaintiff a conservative treatment for his esophageal perforation.

has applied the modified *Bolam* test as set out in *Bolitho* to the question of whether there was negligent treatment of that patient.

The Federal Court in *Foo Fio Na* ought to have made clear the scope of its decision—whether it intended to abandon the *Bolam* test in *all* areas of medical negligence or only in relation to the duty of disclosure of risks. By not doing so, the Federal Court has left room for inconsistent future decisions of the courts in Malaysia as seen in the two recent cases referred to above.[99]

It is this author's view that the decision in *Foo Fio Na* must be confined to disclosure of risks cases as that seems to be the basis upon which leave to appeal was granted by the earlier Federal Court[100] and the basis upon which the Federal Court in *Foo Fio Na*[101] accepted that leave to appeal was granted. Any apparent endorsement by the Federal Court that the *Rogers* test now applies to all areas of medical negligence, can only be considered *obiter*.[102]

Second and more problematically, the Federal Court's acceptance of the *Rogers* test seems to be a superficial one, as the Federal Court then went on to make reference to the phrase that the "Doctor Knows Best", "if he acts reasonably and logically and gets his facts right",[103] tacitly approving the modified *Bolam* test as set out in *Bolitho*. This suggests that if the doctor in question acts reasonably and logically according to a body of opinion—that is "responsible, reasonable and respectable"—that standard of conduct would be accepted by the court.

The *Rogers* test—that it is for the courts to decide on the appropriate standard of care in disclosure of risks cases and not the medical profession (or a class of that profession), and that what must be disclosed to the patient are material risks inherent in the proposed treatment—stems from the recognition that a patient has a fundamental right to know and to make an informed choice about that proposed treatment. Conversely, the *Bolam* test and even the modified *Bolam* test endorse a paternalistic approach to the standard of care in disclosure of risks cases where this is to be measured by what a responsible and reasonable body of medical opinion accepts as proper. The *Bolam* test arguably would allow even a small proportion of the medical profession to represent a responsible body of opinion that may accept the non-disclosure of risks in a particular treatment as proper practice.[104]

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99 See *supra* notes 97-8.

100 *Foo Fio Na (leave), supra* note 79 at 130.

101 *Foo Fio Na, supra* note 2 at 601.

102 This is more so since the Federal Court failed to consider subsequent developments in Australia relating to negligent diagnosis and treatment. See the *Ipp Report*, *supra* note 53, and the legislative developments in Australia pursuant to the Civil Liability Acts in relation to the areas of diagnosis and treatment: *Civil Law (Wrongs) Act 2002* (A.C.T.); *Civil Liability Act 2002* (N.S.W.); *Personal Injuries (Liabilities and Damages) Act 2003* (N.T.); *Civil Liability Act 2003* (Qld.); *Civil Liability Act 1936* (S.A.) substantially amended by the *Law Reform (Ipp Recommendations) Act 2004* (S.A.); *Civil Liability Act 2002* (Tas.); *Wrongs Act 1958* (Vic.) substantially amended by the *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic.) and the *Wrongs and Other Acts* (*Public Liability Insurance Reform*) *Act 2002* (Vic.); *Civil Liability Act 2002* (W.A.).

103 *Foo Fio Na*, *supra* note 2 at 611.

104 Walter Scott, *The General Practitioner and the Law of Negligence*, 2nd ed. (London: Cavendish Publishing Limited, 1995) at 22. The *Bolam* test has been aptly described as "simply a hang-over of the Victorian age" that reflects "the unwillingness of one profession (the law represented by the judges) to countenance ordinary people challenging the rules laid down by another profession (medicine).": Michael Kirby (Justice), "Patient's Rights: Have we gone too far? [Part I]" (1993) 2:2 Australian Health Law Bulletin 12 at 14.

The additional comments by the Federal Court in *Foo Fio Na* thus dilute its endorsement of the decision in *Rogers* and casts doubt over its appreciation or understanding of the fundamental difference between the *Rogers* test and the *Bolam* test.

Third, the Federal Court in *Foo Fio Na* seems to have had as its focus the need for the court to stand guard against substandard professional practices and for "members of the medical profession to stand up to the wrong doings"[105] of their fellow practitioners. This line of reasoning is consistent with the approach of the Court of Appeal in *Foo Fio Na*[106] which indicated it would only consider departing from the *Bolam* test if standards of medical practice continued to decline. This approach sends an incorrect message—that the courts are 'punishing' doctors who fail to meet this test—instead of focusing on the patient's valuable right to know about the risks involved in the proposed treatment.

Fourth, the decision in *Foo Fio Na* reflects a piecemeal adoption of a number of different principles that are not all consistent with the rationale and essence of the decision in *Rogers*. In this author's opinion, the Federal Court did not pay sufficient attention to the main thrust of the *Rogers* decision, which favours patient autonomy by giving recognition to a patient's right to know and to make fully informed decisions about a proposed treatment, over the paternalistic approach that the 'doctor knows best' when it comes to disclosure of information and risks to the patient. The *Rogers* decision has at its heart the paramount consideration that the patient has a right to make decisions about the patient's health and quality of life. By failing to fully appreciate this distinction, the Federal Court has left open the possibility for the resurfacing of a modified version of the *Bolam* test which, at its heart, remains paternalistic in nature.

Fifth, the issue of causation in disclosure of risks cases remains yet to be considered by Malaysia's apex court, albeit this issue was not one of the grounds for which leave to appeal to the Federal Court was granted in *Foo Fio Na*. This issue remains left to be addressed by the Federal Court on some other occasion.

Finally, the Federal Court did not consider the more recent decisions in England subsequent to *Bolitho*,[107] or the more recent developments in Australia.[108] These developments have had implications on the evolution of the duty and standard of disclosure of risks in England and Australia respectively and these implications ought to have been considered by the Federal Court when it sought to depart from the *Bolam* test in *Foo Fio Na*. By not considering these developments, the Federal Court's decision in *Foo Fio Na* on the issue of the disclosure of risks is, in this author's view, incomplete and unsatisfactory.

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[105] These words echo the sentiment expressed in Kamalanathan Ratnam (Justice), "Medical Negligence in Malaysia" [2000] 1 M.L.J. I at xvi. Prior to his appointment to the Malaysian judiciary, Justice Ratnam had been Ms. Foo's counsel at the trial of her case.

[106] *Foo Fio Na* (C.A.), *supra* note 72 at 208.

[107] *Supra* note 19. See for example the decisions in *Pearce*, *supra* note 20 and in *Chester*, *supra* note 24, which take a more patient-centred approach and give recognition to patient autonomy and the patient's right to make decisions about proposed treatment.

[108] See for example, the High Court of Australia's decision in *Rosenberg*, *supra* note 41. See also *supra* note 102 for the legislative developments in Australia pursuant to the Civil Liability Acts in relation to the areas of diagnosis and treatment (in addition to the area of disclosure of risks).

E. *Reactions*

Despite the shortcomings highlighted above, the decision in *Foo Fio Na* remains a landmark case in medical negligence jurisprudence in Malaysia. Its significance is even more so since a 5-judge Federal Court bench refused to review this decision on the basis that it was not a proper case for the exercise of the Federal Court's inherent power to do so.[109] The decision in *Foo Fio Na* is a remarkable departure from the previous deference exhibited by the Malaysian superior courts towards the medical profession. This decision has been welcomed by the medical profession[110] but not necessarily by individual doctors[111] who have raised concerns that this decision will require the disclosure of *all* risks to patients, open the floodgates of medical litigation, increase the cost of health care and lead to the practice of defensive medicine.[112]

The decision in *Foo Fio Na* was an opportunity for the Federal Court to establish a patient's right to know about material risks and to make a fully informed decision about a proposed treatment, within the context of a doctor's duty to disclose these risks. However, the Federal Court did not make full use of this opportunity. Instead, the decision in *Foo Fio Na* is confusing, conflicting in the principles it has endorsed, and does not meet its apparent promise of a more patient-centred approach to the duty of disclosure of risks.

This author contends that the Federal Court could have and ought to have developed a more appropriate framework for the duty of disclosure of risks and a patient's right to know in Malaysia instead of the piecemeal approach it has taken in *Foo Fio Na*. Given the shortcomings in the decision in *Foo Fio Na* highlighted above, this author proposes that a more appropriate framework in Malaysia for the duty of disclosure of risks is required—one that takes into consideration the convergence of the legal and ethical principles relating to this duty and one that places a patient's right to know and to make informed decisions about the patient's health, on a constitutional footing.

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[109] The defendants applied for a review of the decision by the full Federal Court but this was refused on 4 October 2007: C.L.Y. Ng, "Court raises the bar for medical professionals" *The Star Online* (4 October 2007), online: <http://thestar.com.my/news/story.asp?file=/2007/10/4/nation/20071004190206&sec=nation>. As yet, there is no reported judgment of the decision by the full Federal Court for a review of its earlier decision in *Foo Fio Na*.

[110] Malaysian Medical Association, "MMA welcomes ruling on *Bolam* test" *Materia Medica Malaysia* (30 December 2006), online: <http://malaysianmedicine.wordpress.com/2006/12>.

[111] See the blog of T.E. Cheah, "Unclear Ruling" *Malaysian Medical Resources* (30 December 2006), online: <http://medicine.com.my/wp/?p=1757>, and the responses and comments that follow at <http://medicine.com.my/wp/?p=1757&cp=all#comments>. Some of these reactions are the result of the 'sensationalised' reporting of the decision in *Foo Fio Na* in the Malaysian newspapers (see for example, C.L.Y. Ng, "Courts puncture docs' defence" *The Star Online* (30 December 2006), online: <http://thestar.com.my/news/story.asp?file=/2006/12/30/nation/16445027&sec=nation>; V. Anbalagan, "Now easier to win suits against specialists" *New Straits Times Online* (30 December 2006), online: <http://www. nst.com.my/Current_News/nst/Saturday/National/20061230084018/Article/local1_html>) or the result of a failure to fully appreciate the test in *Rogers*.

[112] These concerns are similar to those raised in Australia after the decision in *Rogers*. See *supra* note 54.

IV. Patient Autonomy—Convergence of Legal and Ethical Principles

A. *The Legal Principles*

The decision in *Rogers*[113] reflects the Australian courts' recognition of patient autonomy and the right of a patient to know the material risks involved as the patient is entitled to make an informed decision about the medical treatment in question. The patient's right to know has been placed in the context of a duty to disclose risks arising from a doctor's overall duty to exercise reasonable care. As succinctly put by Lord Scarman in *Sidaway*:

> The doctor's duty arises from his patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor's corresponding duty are easy to understand: for the proper implementation of the right requires the doctor be under a duty to inform his patient of the material risks inherent in the treatment.[114]

By placing patient autonomy in relation to the disclosure of risks in the context of the tort of negligence, the *Rogers* test imposes a high threshold of proof on the part of a patient. The patient, under this test, needs to show that the doctor has failed in his or her duty of disclosure of risks and that had the risk been disclosed, the patient would have refused to undergo the treatment (or postponed that treatment) and would not have suffered the injury.

This high threshold is tempered by the requirement that the standard of the duty of disclosure of risks is a matter for determination by the courts and not the medical profession. In this author's opinion, the rejection of the 'doctor knows best' *Bolam* test in favour of a patient-based standard of disclosure, can only be seen as being logical and in accordance with the general principles of the law of negligence. The disclosure of risks and the quantum of such disclosure are not pure questions of medicine and may be determined by the courts.[115] After all, questions relating to the disclosure of the risks and benefits of the proposed treatment, the consequences of carrying out or not carrying out the proposed treatment and the content and quality of such information are not questions requiring technical medical expertise and knowledge. These are questions of values and can therefore be properly assessed by the courts.

The materiality test set out in *Rogers* represents a minimum legal obligation on the part of the doctor as to what needs to be communicated to the patient and which is to be assessed on an objective criterion of the reasonable person in that patient's position *and* having regard to what the doctor knows or ought to know about that particular patient. A doctor ought to know the circumstances and priorities that a patient may attach to certain issues, such as the quality of life as opposed to the

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[113] *Supra* note 4.

[114] *Supra* note 12 at 885-88 (Lord Scarman), a view that was agreed with by the Australian High Court in *Rogers*, *supra* note 4.

[115] Brian Bromberger, "Patient Participation in Medical Decision Making: Are the Courts the Answer?" (1983) 6 U.N.S.W.L.J. 1 at 18.

length of life,[116] which can only be achieved through disclosure and communication with the patient.

However, the materiality test permits a doctor in limited situations, such as in a case of emergency or out of necessity to prevent physical and mental harm to the patient, to withhold disclosure under the defence of therapeutic privilege. This allows the medical practitioner some discretion in the exercise of the duty to disclose risks.

As recognised by the Australian High Court in *Rosenberg*,[117] great care will be required when assessing the patient's testimony and the courts will take into account objective criteria in making such an assessment.[118] This approach serves to ensure that a patient is only able to establish a claim in negligence for non-disclosure of risks if the causal connection can be clearly proven to the court on the evidence as a whole.

It is the view of this author that by evolving from medical paternalism towards patient autonomy, the legal principles enunciated in *Rogers* and reaffirmed in *Rosenberg* do not place an unreasonable burden on the members of the medical profession. In fact, these legal principles are consistent and converge with the fundamental ethical principles in medicine that are currently adopted in most jurisdictions, including Malaysia.

B. *The Ethical Principles*

It is recognised that fundamental to any meaningful doctor-patient relationship and essential for good patient care, is the fact that the relationship must be based on mutual respect, trust and confidence between the doctor and the patient.[119] To achieve this, there must be respect for the patient's right to decide whether to accept or reject advice and to make decisions about treatment or procedures. This respect must also be evident even where the doctor disagrees with the patient's informed decision.[120]

Such respect is emphasised in most Codes of Medical Ethics,[121] including the *Declaration of Lisbon* adopted by the World Medical Association.[122] The *Declaration*

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[116] A case in point is *Tan Ah Kau v. Government of Malaysia* [1997] 2 A.M.R. 1382, where the non-disclosure of a risk of immediate paralysis due to the invasive procedure, as opposed to gradual paralysis over a period of twenty years if no surgery was carried out, vitiated the decision of the patient to proceed with the invasive procedure.

[117] *Supra* note 41.

[118] *Ibid*. at 449 (McHugh J.), 488 (Kirby J.) and 505 (Callinan J.). See *supra* notes 50-52 and accompanying text.

[119] Kerry J. Breen, Vernon D. Plueckhahn & Stephen M. Cordner, *Ethics, Law and Medical Practice* (New South Wales: Allen & Unwin, 1997) at 12.

[120] Kerridge & Mitchell, *supra* note 54 at 243; Geoffrey J. Riley & Ralph L. Simmonds, "Informed Consent in Modern Medical Practice" (1992) 157 Medical Journal of Australia 336 at 338.

[121] See Malaysian Medical Association, *Patient's Charter* (1995), online: <http://www.mma.org.my/Resources/Charters/Patientscharter/tabid/81/Default.aspx>. The *Patient's Charter* is a Charter adopted by the Malaysian Medical Association, the Federation of Malaysian Consumers Associations, the Malaysian Dental Association and the Malaysian Pharmaceutical Society. See also Malaysian Medical Association, *Code of Medical Ethics* 2001 (Revised 2002), online: <http://www.mma.org.my/html/pdf/MMA_ethicscode.pdf>; Australian Medical Association, *Code of Ethics 2004 Revised Editorially 2006*, online: <http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP>; American Medical Association, *Fundamental Elements of the Patient-Physician Relationship* (1992), online: <http://www.ama-assn.org/ama/pub/category/8313.html>; General Medical Council (England), *Good Medical Practice* (2006), online: <http://www.gmc-uk.org/guidance/good_ medical_practice/index.asp>.

[122] World Medical Association, *Declaration of Lisbon* (September 1981), online: <http://www.euroethics.de/lisbon.htm>.

of Lisbon sets out some of the principal rights which the medical profession seeks to provide patients, including the patient's right to "accept or to refuse treatment after receiving adequate information."[123]

Even in England, the ethical standards imposed on the medical profession include a requirement of giving patients sufficient information in order to enable them to exercise their right to make informed decisions about their care.[124]

As for Australia,[125] the ethical standards for medical practitioners seek to foster better communication between the doctor and patient and good medical practice, so that "patients are able, with their doctors, to make the best decisions about their medical care."[126] *The Guidelines* reflect the doctor's "existing common law responsibility to always take reasonable care"[127] as well as the community's recognition that patients are entitled to make their own decisions about their medical treatment based on information and advice given by the doctor.

Likewise, the *Patient Charter* adopted in Malaysia expressly recognises that the relationship between the healthcare provider and the patient is sacrosanct and that the highest traditions of healthcare mandate mutual trust and respect between the healthcare provider and the patient.[128] The *Patient's Charter* sets out the following as part of the patient's rights recognised by the medical profession and other healthcare providers in Malaysia:

- A patient, who has received adequate information …, shall have the right to accept or refuse treatment.
- Before any treatment or investigation, a patient shall have the right to a clear concise explanation in lay terms of the proposed procedure and of any available alternative procedure. Where applicable, the explanation shall incorporate information on significant risks, side effects, or after-effects, problems relating to recuperation, likelihood of success, risks thereof.
- A patient shall have the right to participate in decision-making affecting the patient's health.[129]

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123 *Ibid*.

124 General Medical Council (England), *Seeking Patient's Consent: The Ethical Considerations,* November 1998, online: <http://www.gmc-uk.org/guidance/current/library/consent.asp>; General Medical Council (England), *Good Medical Practice* (2006), online: <http://www.gmc-uk.org/guidance/good_medical_practice/index.asp>.

125 National Health and Medical Research Council, *General Guidelines for Medical Practitioners on Providing Information to Patients* [*The Guidelines*] (1993, reissued 2004), online: <http://www.nhmrc.gov.au/publications/synopses/_files/e57.pdf>. In 2004, the National Health and Medical Research Council also issued a companion publication to *The Guidelines—Communicating with Patients: Advice for Medical Practitioners* (2004), online: <http://www.nhmrc.gov.au/publications/synopses/_files/e58.pdf>. *The Guidelines* are based on the recommendations contained in a report entitled *Informed Decisions about Medical Procedures* issued by the Australian, Victorian and New South Wales Law Reform Commissions in June 1989, after empirical studies were conducted by the Victorian Law Reform Commission on doctors' attitudes to and practices in giving information to patients, and into patients' experiences and expectations in receiving information from doctors.

126 *The Guidelines*, *supra* note 125 at 3.

127 *Ibid*. at 8.

128 The Malaysian Medical Association, *Patient's Charter* (1995), online: <http://www.mma.org.my/Resources/Charters/Patientscharter/tabid/81/Default.aspx>.

129 *Ibid*.

The principles in the *Patient's Charter* are reflected in the Malaysian *Code of Medical Ethics*,[130] thus confirming the medical profession's ethical recognition and commitment to patient rights and autonomy.

C. *Convergence*

Patient autonomy—from both the legal and ethical perspectives—is about *good communication* between the doctor and the patient and *active patient participation* in the decision-making process relating to the patient's health. These are matters that are vital to the mutual respect and confidence that should be reposed in the doctor-patient relationship. Good communication requires a dialogue between the doctor and the patient, and an understanding by each of the views, values and expectations of the other.[131] Good communication facilitates the flow of information between the doctor and patient. Good communication supports patient autonomy by allowing the patient to have a reasonable awareness of the possible risks, benefits and outcomes of the treatment or procedure. Active patient participation enables the patient to take part in the process of making that patient better.

Patient autonomy correctly recognises that the patient has a right to a relationship with his or her doctor that is based on trust and dignity—trust, that the doctor will be honest and communicative; and dignity, that the patient's wishes will be respected.[132] A doctor who communicates properly with the patient and encourages the patient to make his or her own decisions will build up a relationship of mutual trust. This in turn will tend to avoid legal complaints brought by a disappointed patient whose hopes had been raised to unrealistic levels because certain risks were not explained or divulged.[133] A breakdown in communication and the withholding of information underlie many of the complaints made by patients against doctors, whether in Malaysia or elsewhere.[134]

Thus, communication, openness and a sharing of information are crucial in facilitating informed decision-making on the part of the patient.[135] These factors serve to improve the quality of health care by enhancing the patient's satisfaction that the patient has been listened to and has been provided with adequate explanations.

From both a legal and ethical viewpoint, patient autonomy is simply about *good patient care*.

This author takes the view that the legal principles enunciated in *Rogers*—which promote respect for patient autonomy and a patient's right to know in the context of

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[130] Malaysian Medical Association, *Code of Medical Ethics 2001* (Revised 2002), online: <http://www.mma.org.my/html/pdf/MMA_ethicscode.pdf>.

[131] M. Wallace, *Healthcare and the Law*, 3d ed. (Sydney: Law Book Company Limited, 2001) at 63.

[132] *Ibid*.

[133] Giesen & Hayes, *supra* note 26 at 116; Loane Skene & Richard Smallwood, "What Should Doctors Tell Patients?" (1993) 159 Medical Journal of Australia 367 at 368.

[134] See Victorian Law Reform Commission, *Informed Decisions about Medical Procedures: Doctor and Patient Studies* (1989); Australian Law Reform Commission, *Informed Decisions about Medical Procedures* (1989), quoting the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions, Vol 2: Empirical Studies of Informed Consent*, (United States, 1982).

[135] Roger V. Clements, *Safe Practice in Obstetrics and Gynaecology: A Medico Legal Handbook* (London: The Bath Press, 1994) at 21.

the doctor-patient relationship—have converged with the ethical principles already recognised by the medical profession in Malaysia under its *Patient's Charter*. These legal principles are also in accordance with what should be good medical practice and good patient care. This convergence, in the view of this author, achieves a proper balance between the law, the doctor and the patient.

The Malaysian Federal Court in *Foo Fio Na* could have and ought to have recognised the convergence of the legal and ethical principles as outlined above when it sought to abandon the *Bolam* test in duty of disclosure of risks cases—as this framework recognises patient autonomy as its basic premise. If the Federal Court had done so, it would have arrived at a more robust and conclusive decision in *Foo Fio Na* instead of adding uncertainty to the duty of disclosure of risks in Malaysia.

In addition, as argued below, the Malaysian Federal Court in *Foo Fio Na* ought to have availed itself of the opportunity to place a patient's right to know on a constitutional footing.

V. A Patient's Right to Know in Malaysia?

A. *A Basic Right*

The doctor-patient relationship is one that turns on an inevitable imbalance of power. The medical practitioner has the information, technical skills and expertise which the patient seeks, and the privilege, if the patient consents, to touch and invade the body of the patient.[136] In treating the patient, the medical practitioner exercises a degree of power and control over the patient. This exercise of power and control over the patient, however, is subject to limits imposed by the ethical and legal recognition of patient rights. These limits include the patient's right to make decisions about his or her own life by knowing what the proposed treatment entails, "so that one may say no, if so minded."[137]

The decision in *Rogers* gives legal recognition to patient autonomy. In essence, this decision seeks to protect basic human rights, namely the right of a patient to make an informed decision about his or her own body, and the right to respect and dignity to make that decision. As confirmed in *Rosenberg*, the decision in *Rogers* is a recognition of patient autonomy that is to be viewed in the wider context of an "emerging appreciation of basic human rights and human dignity."[138]

These basic rights must be respected within the context of a doctor-patient relationship, so as to redress the imbalance of power between the medical practitioner and the patient. It is respect for the rights of the patient that generates the duty of the medical practitioner not to overstep his or her authority "in the name or the interests of professional or technical superiority."[139] It is respect for the rights of the patient that imposes a duty on the medical practitioner to disclose all relevant information including material risks to the patient to enable proper decision-making on the part

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[136] Ian Kennedy, "Patients, Doctors and Human Rights" in *Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press, 1991) at 387.

[137] *Ibid*. at 389.

[138] *Rosenberg*, *supra* note 41 at 480 (Kirby J.).

[139] Sheila McLean, *A Patient's Right to Know: Information Disclosure, the Doctor and the Law* (Hants: Dartmouth Publishing Company, 1989) at 22.

of the patient. To repeat the illuminating words of Lord Scarman in *Sidaway*, "the doctor's duty of care extends not only to the health and well-being of his patient but also to a proper respect for his patient's rights", and as such, "the doctor's duty arises from his patient's rights".[140]

The aim of the duty of disclosure of risks should therefore be the protection of patient rights and patient autonomy, which involves more than just an exercise of technical medical skills on the part of the medical practitioner.

The decisions in *Rogers* and *Rosenberg*, and the approach taken by Lord Scarman in *Sidaway*, reflect the courts' recourse to the common law to protect the patient's right to know about the inherent risks in the proposed treatment and to make decisions about the patient's own life. This recognition is also evident in the House of Lords decision in *Chester*.

Whilst the common law has an equal part to play in conferring recognition of patient rights within the context of Malaysian jurisprudence, this author contends that in Malaysia, these patient rights are clearly conferred protection by the fundamental guarantees enshrined in the *Malaysian Constitution*.[141] Whether the Malaysian Federal Court would be willing to give constitutional recognition to these patient rights—as discussed below—remains to be seen.

B. *A Constitutional Right?*

The *Malaysian Constitution* is the supreme law in Malaysia. Article 5(1) of the *Malaysian Constitution* provides the fundamental guarantee that "no person shall be deprived of his life or personal liberty, save in accordance with law."

In *Tan Tek Seng v. Suruhanjaya Perkhidmatan Pendidikan*,[142] the Malaysian Court of Appeal held that the word "life" in Article 5(1) of the *Malaysian Constitution* did not refer to "mere existence", but "incorporates all those facets that are an *integral part of life itself* and those matters which go to form the *quality of life*."[143] These facets include the right to livelihood and the right to live in a reasonably healthy environment.[144] In this case, the right to livelihood and the right to work were held to be guaranteed under the *Malaysian Constitution*. The Court of Appeal took the approach that a liberal reading was necessary to give effect to the spirit and intention of the *Malaysian Constitution* as a living and dynamic documentation of the supreme law of Malaysia.[145] The Court of Appeal therefore discarded the narrow

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[140] *Sidaway*, *supra* note 12 at 885 and 888 (Lord Scarman).

[141] A similar argument has been proposed by this author in the context of information privacy. See Mathews Thomas, "Is Malaysia's MyKad the 'One Card to Rule Them All'? The Urgent Need to Develop a Proper Legal Framework for the Protection of Personal Information in Malaysia" (2004) 28 Melb. U. L. Rev. 474 at 505-7.

[142] [1996] 1 M.L.J. 261 (Sri Ram J.C.A.) [*Tan Tek Seng*].

[143] *Ibid*. at 288 (emphasis added). In this case, the Court of Appeal held that a person had the right to seek and be engaged in lawful employment, the removal from which had to be in accordance with fair procedure.

[144] *Ibid*.

[145] Sri Ram J.C.A. further held that judges "should, when discharging their duties as interpreters of the supreme law, adopt a liberal approach in order to implement the true intention of the framers" of the *Malaysian Constitution*: *ibid*. See also M.P. Jain, *Administrative Law of Malaysia and Singapore*, 3rd

and literal approach previously taken by the Malaysian courts in the interpretation and application of the *Malaysian Constitution*.[146]

A similar approach to Article 5(1) of the *Malaysian Constitution* was taken in *Hong Leong Equipment Sdn. Bhd. v. Liew Fook Chuan.*[147] In this case, the Court of Appeal stated that the "high standards of social justice" established within the *Malaysian Constitution* should not be lowered in any way by the courts.[148]

Subsequent decisions of the Court of Appeal have expanded the range of protection conferred by Article 5(1) of the *Malaysian Constitution*. In *Sugumar Balakrishnan v. Pengarah Imigresen Negeri Sabah*,[149] the expression "personal liberty" in Article 5(1) of the *Malaysian Constitution* was similarly construed in a broad and liberal fashion by the Court of Appeal to include the liberty of an aggrieved person to seek redress from the courts, including judicial review. This was held to be one of the many facets of personal liberty guaranteed by this provision of the *Malaysian Constitution*.[150]

In *Lembaga Tatatertib Perkhidmatan Awam, Hospital Besar Pulau Pinang v. Utra Badi a/l K. Perumal*,[151] the Court of Appeal took the view that "when a person is deprived of his reputation", this would amount to a deprivation of 'life' within Article 5(1) of the *Malaysian Constitution*. In this case, the Court of Appeal held that the right to reputation is "part and parcel of human dignity" and is a fundamental right of every person in Malaysia.[152]

In arriving at the decisions in the cases mentioned above, the Court of Appeal has given constitutional recognition to derived or non-enumerated rights that flow from the express rights guaranteed by the *Malaysian Constitution*. In doing so, the Court of Appeal has relied on the spirit and intended meaning of Article 8(1) of the *Malaysian Constitution*,[153] which provides that "all persons are equal before

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ed. (Kuala Lumpur: Malayan Law Journal, 1997) at viii; Cyrus Das, "'Life' under Article 5: What Should It Be?" (2002) 31:4 Insaf: The Journal of the Malaysian Bar 68 at 71.

146 This narrow and literal approach can be seen in the following cases: *Karam Singh v. Menteri Hal Ehwal Dalam Negeri* [1969] 2 M.L.J. 129; *Andrew Thamboosamy v. Superintendant of Pudu Prisons* [1976] 2 M.L.J. 156; *Public Prosecutor v. Khong Teng Khen* [1976] 2 M.L.J. 166; *Loh Kooi Choon v. Malaysia* [1977] 2 M.L.J. 197; *Malaysia v. Loh Wai Kong* [1979] 2 M.L.J. 33.

147 [1996] 1 M.L.J. 481 [*Hong Leong Equipment*].

148 *Ibid*. at 510 (Sri Ram J.C.A.).

149 [1998] 3 M.L.J. 289 [*Sugumar Balakrishnan*].

150 *Ibid*. at 308 (Sri Ram J.C.A.). However, on appeal, the Federal Court held that the statute in question evidenced Parliament's express intention to exclude judicial review by the courts except on procedural grounds: *Pihak Berkuasa Negeri Sabah v. Sugumar Balakrishnan* [2002] 3 M.L.J. 72 at 93 (Dzaiddin F.C.J.). The Federal Court nevertheless did not expressly comment on the scope and ambit of Article 5(1) of the *Malaysian Constitution* although it favoured the contention of the appellant that "personal liberty" in Article 5(1) referred to rights relating to the person or body of the individual as opposed to the liberty to seek judicial review in all cases.

151 [2000] 3 M.L.J. 281 at 294 (Sri Ram J.C.A.) [*Utra Badi*]. On appeal, the Federal Court reversed the decision of the Court of Appeal on other grounds: *Lembaga Tatatertib Perkhidmatan Awam, Hospital Besar Pulau Pinang v. Utra Badi a/l K. Perumal* [2001] 2 M.L.J. 401.

152 *Ibid*. See also the Court of Appeal's decision in *Esso Production Malaysia Inc. v. Aladdin bin Mohd Hashim* [2000] 3 M.L.J. 270 at 275, where Sri Ram J.C.A. held that the accused was entitled to legal representation in this case even more so because the issue in dispute revolved around a bribery allegation which, if proved, would demolish the reputation of the accused.

153 See Gopal Sri Ram (Justice), "The Role of Judges and Lawyers in Evolving a Human Rights Jurisprudence" *Infoline: The Official Newsletter of the Malaysian Bar* (January 2003) 17 at 20; See also generally Gopal Sri Ram (Justice), "The Workman and the Constitution" (2007) 1 M.L.J. clxxii.

the law and entitled to the equal protection of the law". The Court of Appeal has interpreted the express rights guaranteed in the *Malaysian Constitution*, including those contained in Article 5(1), as being subject to the "brooding omnipresence"[154] of Article 8(1) of the *Malaysian Constitution*. This has enabled the Court of Appeal to give recognition to several derived rights as outlined above.

It must be noted however that these cases are a reflection of activism on the part of the Court of Appeal, specifically when presided by Sri Ram J.C.A., in translating the basic human rights protected by the *Malaysian Constitution* into 'real' rights. Other judges of the Court of Appeal[155] have either tacitly accepted the broad interpretation of "life" under Article 5(1) in *Tan Tek Seng*[156] or taken a more conservative stance on the interpretation of the rights guaranteed by the *Malaysian Constitution*.[157]

Despite Sri Ram J.C.A.'s attempts to put into place a *constitutional* framework for the recognition and protection of basic human rights in Malaysian jurisprudence,[158] the Malaysian Federal Court has not taken a similarly proactive stance on this issue.

Although not rejecting the broad interpretation of "life" in *Tan Tek Seng*, the Federal Court in *Sugumar Balakrishnan*[159] was not willing to take a more expansive interpretation of this right and instead sought to restrict the scope of the right to 'personal liberty' in Article 5(1) of the *Malaysian Constitution*. The Federal Court's conservatism on this issue was also evident when it heard the appeal in *Utra Badi*.[160] The Federal Court has thus far been hesitant and reluctant to embrace a constitutional basis for human rights jurisprudence or to break out of the constraints currently restricting the versatility and dynamism inherent in the principles contained in Article 5(1) and Article 8(1) of the *Malaysian Constitution*.[161]

It is the view of this author that the premise of patient autonomy in the context of the duty of disclosure of risks in a doctor-patient relationship is consistent with and supported by the fundamental right to *life* guaranteed in Article 5(1) of the *Malaysian*

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154 *Maneka Gandhi v. India*, A.I.R. 1978 S.C. 597 (Bhagwati J.), approved by the Court of Appeal in *Sugumar Balakrishnan*, *supra* note 149 at 305 (Sri Ram J.C.A.).

155 See for example, *Board of Engineers v. Leong Pui Kun* [2007] M.L.J.U. 0533 (unreported) where the Court of Appeal (Sidin J.C.A., Ong J.C.A., Ng J.C.A.) gave tacit approval to the interpretation of 'life' under Article 5(1) as held in *Tan Tek Seng*, *supra* note 142, and in *Hong Leong Equipment*, *supra* note 147.

156 *Supra* note 142.

157 See for example, *Sivarasa Rasiah v. Bar Council Malaysia* [2006] 1 M.L.J. 727 where the Court of Appeal preferred a more literal approach to the interpretation of "personal liberty" under Article 5(1), following the approach of the Federal Court in *Pihak Berkuasa Negeri Sabah v. Sugumar Balakrishnan* [2002] 3 M.L.J. 72.

158 It must be noted that Sri Ram J.C.A. in *Foo Fio Na* (C.A.), *supra* note 72 did not consider giving constitutional recognition of a patient's right to know and to be informed of risks—although in this case, this issue was not raised. In extra-judicial comments, Sri Ram has urged that judicial activism in evolving a human rights jurisprudence depends on lawyers raising these issues in submissions: Sri Ram, *supra* note 153.

159 *Pihak Berkuasa Negeri Sabah v. Sugumar Balakrishnan* [2002] 3 M.L.J. 72 at 93 (Dzaiddin F.C.J.).

160 *Lembaga Tatatertib Perkhidmatan Awam, Hospital Besar Pulau Pinang v. Utra Badi a/l K. Perumal* [2001] 2 M.L.J. 401.

161 See however, the decision of the Federal Court in *Ooi Kean Thong v. Public Prosecutor* [2006] 3 M.L.J. 389 at 403-4, where the Federal Court stated that even if it accepted the broad interpretation of the word "life" in Article 5(1) to mean "right to livelihood", which includes deprivation of one's reputation (as determined by the Court of Appeal in *Utra Badi*, *supra* note 151), this wide interpretation did not mean that a by-law which prohibited the appellant from behaving in a "disorderly manner" in a public park (kissing and hugging) infringed Article 5(1) of the *Malaysian Constitution*.

Constitution. A patient's right to know and to be informed of material risks inherent in a proposed treatment, as well as the patient's right to make an informed decision about his or her health and quality of life, are—in the view of this author—rights that are inherent within the right to life guaranteed by Article 5(1) of the *Malaysian Constitution*. These patient rights are rights relevant to the "life" and the "quality of life" of the individual patient.

Patient autonomy is, and therefore should, be recognised as a "legally protectable interest"[162] under the *Malaysian Constitution*. It is arguable that with the enactment of the *Human Rights Act 1998* in England, which incorporates the provisions of the *European Convention on Human Rights* into English law, the English courts will need to focus on the patient's rights as the basis for the standard of disclosure of risks, rather than the standard of disclosure of risks set by a body of medical opinion.[163] Malaysian courts do not require a *Human Rights Act* as an impetus to develop a medical jurisprudence based upon patient rights, since these rights are already enshrined in the *Malaysian Constitution*. However, recognition of such rights through the process of derivation already embarked upon by the Court of Appeal depends on continued judicial activism as well as more rigorous articulation of these issues by lawyers.[164]

A constitutional basis for the protection of patient autonomy does not in any way take away from the medical profession the law's recognition of the vital role played by doctors in rendering their medical expertise for the benefit of patients. Rather, the constitutional protection of patient autonomy serves as a safeguard to ensure respect for the patient's choice as to whether or not to accept that medical expertise. In any event, this constitutional protection reflects the ethical standards and principles already recognised by the medical profession in Malaysia under its *Patient's Charter* and *Code of Medical Ethics*.

C. *A Case for Further Judicial Activism*

There have been vast changes in medicine and medical practice since the *Bolam* test was formulated. Correspondingly, there have been vast changes in the attitudes and expectations of the population at large and thus of patients—there is greater awareness, understanding and discussion on matters concerning health and medical

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[162] Marjorie M. Shultz, "From Informed Consent to Patient Choice: A New Protected Interest" (1985) 95 Yale L.J. 219 at 219. See also New Zealand's *Code of Health and Disability Services Consumer Rights* (1996) which has the force of law (see in particular, Right 6 which gives patients the right to the disclosure of information in order to make an informed choice about treatment), cited in Joanna Manning, "Informed Consent To Medical Treatment: The Common Law and New Zealand's Code of Patients' Rights" (2004) 12:2 Med. L. Rev. 181.

[163] Lord Irvine (Lord Chancellor), *supra* note 13 at 267. Accordingly, patient rights will have to now be given due prominence by the English courts in its development of medical negligence law. See also the Scottish Government's *Consultation on a Patients' Rights Bill for Users of the NHS in Scotland* (2008), online: <http://www.scotland.gov.uk/Publications/2008/09/22091148/4>, which proposes the introduction of "a clear legal framework of rights for patients to support them in knowing what their rights are and to provide effective redress where they consider that their rights are not being fully delivered." These rights include the right to clear and accessible communication, the right to information about services, treatment and care options, and the right to be involved in and supported in making informed decisions about treatment.

[164] Sri Ram, *supra* note 153 at 20.

care. These changes were perhaps the impetus for the Malaysian Federal Court to adopt the *Rogers* approach in *Foo Fio Na*.

The decision in *Foo Fio Na* is a step in the right direction towards the recognition of patient autonomy in the context of the duty of disclosure of risks. Despite this, the shortcomings of this decision have diluted its significance, cast doubt over the Federal Court's understanding of the *Rogers* test and left open the possibility of the re-emergence of a paternalistic approach to the duty of disclosure of risks.

The framework outlined above—one that takes into consideration the convergence of the legal and ethical principles relating to the disclosure of information and risks to patients and one that places a patient's right to know about material risks on a constitutional footing—would lend greater clarity and vibrancy to the duty of disclosure of risks in the Malaysian context. This framework focuses on patients' rights as the basis for the standard of disclosure of risks and requires these rights to be given due prominence by the courts in the development of a more patient-centred approach to the duty of disclosure of risks.

The courts remain the most appropriate forum for the development of a medical jurisprudence which gives legal recognition to patient autonomy and a patient's right to know. There is room and need for further judicial activism in the development of the legal standard and scope of the duty of disclosure of risks expected of the medical profession in Malaysia to achieve this. Such a development, in this author's view, would not necessarily change the final decision made by the patient, but would place greater emphasis on the patient's active participation in the decision making process about his or her treatment and care. This can only improve doctor-patient relationships and the quality of healthcare in Malaysia. Left as it stands, the decision in *Foo Fio Na* does not achieve this end.

VI. Conclusion

The doctor-patient relationship is sacrosanct. The significant role played by the doctor as the primary health care provider is unquestionable. However, the doctor-patient relationship is about doctors and patients working together towards the common goal of the patient's health. What must not be overlooked is that it is the patient's health and quality of life that are at stake. Thus, patient autonomy must be fully respected.

The decision in *Foo Fio Na* is a step in this direction. In arriving at its decision in this case, the Malaysian Federal Court relied heavily on its consideration of the developments in England and Australia. The Federal Court was not incorrect to seek guidance from these two jurisdictions.

The developments in England and Australia in relation to the duty of disclosure of risks have contributed to a rich source of jurisprudence in this area of medical negligence law. The current difference between the positions in these two jurisdictions—as determined by the modified *Bolam* test in *Bolitho* and as established in *Rogers* respectively—is not large, but it is significant. Its significance lies in the recognition of a patient's fundamental right to know and to be informed of material risks so as to make an informed choice about his or her health.

The legal principles enunciated in *Rogers* promote respect for patient autonomy within the doctor-patient relationship in the context of the duty of disclosure of risks. By favouring the decision in *Rogers* over the *Bolam* test, the Federal Court in *Foo Fio*

Na has signalled its willingness to embrace a patient-centred approach to this duty. Unfortunately, the decision in *Foo Fio Na* fails to fully appreciate the significant difference between the decision in *Rogers* and the *Bolam* test, and instead blurs the distinction between the two. This will only lead to future confusion over the standard and scope of the duty of disclosure of risks in Malaysia.

There therefore remains a need for the Malaysian courts to proactively take on the role of developing a more appropriate framework for the duty of disclosure of risks which encompasses greater respect for patient autonomy and which enhances doctor-patient relationships in Malaysia. The framework proposed in this article is one that takes into consideration the convergence of the legal principles established in *Rogers* with the ethical principles already recognised in Malaysia, and that recognises the constitutional basis for a patient's right to know about material risks and to make informed decisions about the patient's health. The quality of healthcare in Malaysia can only benefit from such a development.