THE STANDARD OF MEDICAL CARE IN MALAYSIA:

THE CASE FOR LEGISLATIVE REFORM

By

JOSEPH MING YONG LEE

LLB (Hons) University of Tasmania

Advocate & Solicitor of the High Court of Malaya (Malaysia)

Submitted in fulfilment of the requirements for the degree of

Master of Laws

University of Tasmania

November 2012

DECLARATION

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

This thesis may be made available for loan and limited copying and communication in accordance with the *Copyright Act 1968* (Cth).

…….....**...**

JOSEPH MING YONG LEE

This thesis states the law as at 14th November 2012

ACKNOWLEDGMENTS

There are a number of people at the University of Tasmania (UTAS) Law Faculty who helped me during the course of writing this thesis and to whom I am indebted. Among them was my primary supervisor, Distinguished Professor Donald Chalmers. I thank him for patiently providing the guidance, advice and comments to assist me accomplish the mission of completing this thesis. I also express my gratitude to co-supervisor Professor Margaret Otlowski for her tireless efforts in providing comments on many drafts of this thesis. Her critique was meticulous, timely and full of insights. I was impressed by my supervisors' professionalism and dedication. Special thanks are also accorded to Professor Gino Dal Pont at the UTAS Law Faculty. His prompt and valuable comments on the previous drafts of this thesis are deeply appreciated.

I express my gratitude to UTAS, and more specifically, the UTAS Law Faculty. The completion of this thesis would not have been possible without the fee waiver scholarship and financial assistance that were granted to me throughout the duration of my candidature. I also thank the Law Faculty librarian, Deborah Bowring, and her team members for their patience whenever I needed assistance in researching materials. My appreciation equally extends to Morag Porteous, Louise Oxley and Belinda Miller at the UTAS Student Learning Centre who spent many hours over the past year advising me on how to present my research.

At the personal level, I thank my friends at the Sandy Bay Baptist Church and Methodist Chinese Church, both of Hobart, for their prayers and encouragement when I needed them the most. Last but not least, my parents. Both of them showed great interest over the progress of this thesis although they were far away in Malaysia. I thank them for their understanding and sacrifice to allow me pursue my dream despite having undergone major surgery in recent years. These few years have been tough for both of them. I dedicate this thesis to my parents.

ABSTRACT

This thesis analyses the law relating to the standard of care expected of doctors in the areas of diagnosis and treatment in Malaysia. The analysis does not deal with issues concerning disclosure of risk.

The central argument in this thesis is that the law for determining the standard of care of doctors in the areas of diagnosis and treatment in Malaysia is ambiguous and uncertain, and that legislation is the most effective reform method to resolve these problems. A clear and predictable legal framework is recommended for legislative enactment in Malaysia. One of the main objectives of this proposed legal framework is to strike a balance between the interests of defendant doctors and that of injured patients in medical negligence litigation concerning issues of diagnosis and treatment.

This thesis traces the historical development of the law in Malaysia, from the application of the original English *Bolam* test in the 1960s to the current legal position as decided by the highest Malaysian court decision in *Foo Fio Na v Dr Soo Fook Mun* (2007) 1 MLJ 593. It takes a cross-jurisdictional approach to examine the corresponding legal development in the United Kingdom, Singapore and the Australian states. A consistent trend in these jurisdictions is the adoption of the original *Bolam* test with modifications, albeit in different forms.

It is argued that the decision in *Foo Fio Na* was a lost opportunity for the highest Malaysian court to give a definitive statement for determining the standard of care in the areas of medical diagnosis and treatment. The basis for this argument is the ambiguity in *Foo Fio Na* on the issue of negligent treatment and the conflicting interpretations of this decision by academic scholars and judges in subsequent Malaysian lower court cases. It is proposed that Malaysia should codify the qualified version of the *Bolam* test in legislation as a means of resolving the uncertainty and ambiguity in the current state of the law.

It is also suggested that the proposed legislation should implement the procedural rules on the use of expert witnesses similar to those under the *Uniform Civil Procedure Rules 1999* (Qld), although with slight modifications. The proposed procedural framework requires

the appointment of a single agreed or a single court-appointed expert prior to the commencement of legal proceedings. Litigants may also appoint an additional agreed or court-appointed expert or experts after legal proceedings have started. Under the proposal, the courts are also given the authority to allow litigants to engage their own medical experts provided that certain conditions are satisfied. These recommendations aim to save costs, facilitate a speedy resolution of medical disputes and provide flexibility in the adjudication of the standard of care in medical diagnosis and treatment.

TABLE OF CONTENTS

CHAPTER 1
INTRODUCTION

The law of medical negligence concerns not just an injured patient and a defendant doctor in a dispute. Political and economy decision-making by the Executive of a government can also be influenced by how the law develops.[1] This is because the developments of the law of medical negligence can impact on the number of medical claims and the size of compensation awarded against defendant doctors. When there is a continual increase in medical negligence claims and the amount of damages awarded, public confidence in the delivery of health care service may be undermined and the medical indemnity industry may be under pressure to increase indemnity premiums. This thesis examines one of the important elements for establishing liability for medical negligence in Malaysia: the issue of standard of care of doctors. The analysis focuses on two areas, medical diagnosis and treatment. This thesis examines the central questions of whether the law for deciding the standard of care of doctors in medical diagnosis and treatment in Malaysia is satisfactory and, if it is not, what reforms should be implemented.

1.1 SETTING A CONTEXT

The law for determining the issue of the standard of care in medical negligence concerning diagnosis and treatment in Malaysia is founded upon English common law. This development is attributable to the country's historical background as a former British colony. Before Malaysia gained independence from the United Kingdom, English law had already been statutorily incorporated into its legal system. After Malaysia was declared an independent state in 1957, reliance on English common law by judges in this jurisdiction continued as a matter of common practice. These historical and legal underpinnings explain why Malaysian judges adopted the English common law principle, the *Bolam* test, in the 1960s as the yardstick for deciding the standard of care in medical negligence cases concerning diagnosis and treatment.

The *Bolam* test is a product of the evolution of English common law of more than one hundred years. Ironically, the test was pronounced, not by the English highest court, but

[1] Ken Mason and Graeme Laurie, *Mason and McCall Smith's Law and Medical Ethics* (Oxford University Press, 8th ed, 2011) 122.

rather a first instance court in *Bolam v Friern Hospital Management*,[2] from which it has obtained its name. In a nutshell, the test states that a doctor is not negligent if his or her actions or omissions are supported by a responsible body of medical opinion. The *Bolam* test is grounded upon the doctrine of reasonable care and skill. Case law in the United Kingdom prior to and after *Bolam* has consistently interpreted the doctrine as referring to the standard of ordinary competent doctors, not the highest professional standard. It has also been settled that this standard requires the courts to measure the action or omission of a defendant doctor against accepted practice of the medical profession. What remained contentious about the *Bolam* test in the United Kingdom was who should be the final arbiter on the required standard of care in medical negligence litigation dealing with issues of diagnosis and treatment: judges or the medical profession.

In the United Kingdom, the *Bolam* test received its highest endorsement by the English House of Lords[3] in the 1980s. During this period, the English highest court made it clear that expert medical opinion, or the medical profession, is determinative of the issue of the standard of care in medical negligence cases.[4] In other words, the role of judges was limited to evaluating the credibility of medical experts and the reliability of their opinions. The rationale for this interpretation, the House of Lords noted, is that judges do not possess the necessary expertise to adjudicate complex technical issues concerning medical diagnosis and treatment. Despite these interpretations, the legal position of the *Bolam* test in the United Kingdom remained uncertain in the 1990s. This period saw the emergence of several English Court of Appeal cases in which judges questioned the merits of expert medical opinions and decided whether these opinions represented 'a responsible body of medical opinion'.

There was further development on the legal status of the *Bolam* test in the United Kingdom. In 1997 the House of Lords decision in *Bolitho v City and Hackney Health*

---

2 [1957] 2 All ER 118.

3 The Supreme Court replaced the House of Lords as the highest appellate court in the United Kingdom since 1-10-2009 by virtue of Part 3 of the *Constitutional Reform Act 2005* (United Kingdom). It has jurisdiction in all matters under English law, Northern Irish law and Scottish civil law. However, the High Court of Justiciary remains the highest appellate court for criminal cases in Scotland. Previously, the Supreme Court of England and Wales referred to the Crown Court, High Court and the Court of Appeal under the *Supreme Court Act 1981* (England and Wales). As a result of the reform, the *Supreme Court Act 1981* was renamed the *Senior Courts Act 1981* (England and Wales), and the Crown Court, High Court and the Court of Appeal are collectively known as the Senior Courts of England and Wales.

4 *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, 639 (Lord Scarman) (English House of Lords).

Authority[5] qualified the *Bolam* test by holding that the courts must be satisfied that expert medical opinion has a 'logical basis' for it to be considered as part of 'a responsible body of medical opinion'. *Bolitho* was significant because it has retained the courts' right to have the final say on the issue of breach of duty of care in medical negligence cases concerning diagnosis and treatment. However, scholarly commentary by English judges and academics has suggested that *Bolitho* falls short of altering judicial deference to the medical profession under the *Bolam* test. This critique points to the statements of the Court in *Bolitho* that the authority of the courts in rejecting expert medical opinion can only be exercised sparingly; and that the opinion of medical experts of high standing are more likely to satisfy the 'logical basis' test.

The *Bolitho* principle was adopted in Singapore by its highest court, the Court of Appeal,[6] in *Dr Khoo James v Gunapathy d/o Muniandy*[7] and in the Australian states, although in different forms. These jurisdictions had previously applied the *Bolam* test in medical negligence cases as it had been interpreted by the English House of Lords in the 1980s. Essentially, the Singaporean version of the *Bolitho* principle model is a replica of its English version, but with a restrictive interpretation on judicial function of scrutinising expert medical opinion. The important feature of the Singaporean version of the *Bolitho* principle is that judges in this jurisdiction are not bound to show deference to the opinions of medical experts of high standing and they may reject any expert medical opinion which does not satisfy the 'logical basis' test.

There are a number of important developments in Australia prior to the adoption of the *Bolitho* principle by its state jurisdictions. In 1999 the Australian High Court in *Naxakis v General Western Hospital*[8] rejected the *Bolam* test in both the areas of diagnosis and treatment, and conferred the ultimate authority on the courts to decide the issue of breach of duty of care based on an assessment of all available evidence, not just expert medical opinion. This decision was followed by the medical indemnity crisis in the early 2000s, which involved the imminent collapse of its largest medical defence organisation, United Medical Protection, and as a result there was a drastic increase in medical indemnity premiums. One

5 [1998] AC 232 (*Bolitho*).

6 The Court of Appeal is Singapore's court of final appeal. The second highest court in the island republic is the High Court. This is followed by the Subordinate Courts which consist of the District Court and the Magistrates' Court.

7 [2002] 2 SLR 414 (*Gunapathy*).

8 (1999) 197 CLR 269 (*Naxakis*).

of the major contributing factors to the medical indemnity crisis, the Australian Commonwealth government argued, was the common law principle in medical negligence. The common law was perceived by the Australian governments as exposing medical practitioners to great risk of medical negligence claims.

Following the crisis, a law reform committee was set up by the Australian Commonwealth government to review the common law, and upon which recommendations were made to codify the *Bolitho*-type *Bolam* test in issues concerning negligent diagnosis and treatment in legislation. Individual legislation was enacted in New South Wales, Queensland, South Australia, Western Australia, Tasmania and Victoria to implement the recommendations.[9] The Australian Capital Territory and Northern Territory did not implement the recommendation. Northern Territory maintains the status quo under the common law. The Australian Capital Territory, on the other hand, qualified the common law with statutory provisions.

The Australian modified *Bolam* test is similar but not identical to the English version of the *Bolitho* principle. There are various forms of the Australian modified *Bolam* test among the six state jurisdictions. Nonetheless, they all share a common feature by providing a defence for a defendant doctor whose action or omission is supported by 'widely accepted' opinions in a particular medical field,[10] provided that these opinions are neither 'irrational'[11] nor 'unreasonable'.[12] Extrinsic evidence to these statutory provisions, however, suggests that the courts may reject expert medical opinion under the 'irrational' or 'unreasonable' provisos in exceptional cases. Essentially, this legislative reform is intended to protect doctors and to avoid a recurrence of the medical indemnity crisis in Australia.

In Malaysia, the *Bolam* test has been applied in medical negligence litigation concerning diagnosis and treatment for close to four decades since the 1960s. The process of transplantation of the *Bolam* test into Malaysian courts did not significantly alter its English

---

9 The *Bolitho*-type *Bolam* test under these States' legislation is also referred to as 'the Australian modified *Bolam* test' in this thesis.

10 *Civil Liability Act 2002* (NSW) Section 5O(1); *Civil Liability Act 2002* (Tas) Section 22(1); *Wrongs Act 1958* (Vic) Section 59(1); *Civil Liability Act 1936* (SA) Section 41(1); *Civil Liability Act 2002* (WA) Section 5PB(1); *Civil Liability Act 2003* (Qld) Section 22(1).

11 *Civil Liability Act 2002* (NSW) Section 5O(2); *Civil Liability Act 1936* (SA) Section 41(2); *Civil Liability Act 2002* (Tas) Section 22(2); *Civil Liability Act 2003* (Qld) Section 22(2).

12 *Wrongs Act 1958* (Vic) Section 59(2); *Civil Liability Act 2002* (WA) Section 5PB(4).

characteristics. This is because a majority of appellate court cases in Malaysia adopted the approach to rely solely on expert medical opinion when adjudicating the issue of the standard of care. The test was subject to a slight modification, notably in a small number of Malaysian cases, where it was held that judges may decide on the issue of breach of duty of care where matters concerning diagnosis and treatment are straightforward. There was also a minority of lower court decisions which rejected the *Bolam* test. This latter group of cases, which notably emerged in the 1990s, took the view that expert medical opinion was relevant but not determinative of the issue of the standard of care. These conflicting approaches, although not a serious phenomenon, nonetheless added uncertainty to the legal status of the *Bolam* test in Malaysia.

The *Bolam* test was reviewed by the Malaysian Federal Court,[13] its highest court, in *Foo Fio Na v Dr Soo Fook Mun*[14] in late 2006. This seminal case ruled that the *Bolam* test is not applicable in 'all aspects of medical negligence cases'.[15] In *Foo Fio Na*, the Court gave special attention to the issue of the duty of doctors to warn patients of medical risk. In adopting the principle as enunciated by the Australian High Court in *Rogers v Whitaker*,[16] the Court in *Foo Fio Na* held that a medical practitioner is under a duty to warn his or her patients of all material risks associated with a medical treatment; and that the extent of disclosure of this information will be decided by the courts.

There is a lack of clear pronouncement in *Foo Fio Na* on the legal position of the standard of care in medical diagnosis and treatment. Although the Federal Court explicitly stated that the *Bolam* test is not relevant in 'all aspects of medical negligence cases', its ruling on the issue of medical treatment in the case itself indicates that the test is still applicable. In its legal analysis, the Court provided a thorough examination of the cases of *Bolitho* and

---

13 The Federal Court hears appeals of civil and criminal decisions from the Court of Appeal subject to leave being granted. The Court of Appeal is the second highest court in the hierarchy below the Federal Court. This appellate court was only created in 1994. The third highest court in Malaysia are the High Courts. There are two separate High Courts in Malaysia, the High Court of Malaya in West Malaysia and the High Court of Sabah and Sarawak in East Malaysia by virtue of Article 121 of the *Federal Constitution* (Malaysia). The High Courts have unlimited civil jurisdiction, hearing actions where the claim exceeds RM250,000 (approximately A$78,125), except cases involving motor vehicle accidents, landlord and tenant disputes. The Sessions Courts and the Magistrates' Court are two subordinate courts following the High Courts. Both courts hear civil and criminal actions. Civil cases are filed in the Sessions Courts where their claims exceed RM25,000 (estimated at A$7,812.50) but do not exceed RM250,000. The Magistrates Courts have jurisdiction over civil claims with less than RM25,000 in dispute.

14 [2007] 1 MLJ 593 (*Foo Fio Na*).

15 Ibid 612.

16 (1992) 175 CLR 479.

Naxakis, but did not draw a conclusion as to whether the principle in either case should replace the *Bolam* test. These ambiguities in the decision of *Foo Fio Na* has given rise to different interpretations by academic scholars and Malaysian judges in subsequent lower court decisions, the latter applying either the *Bolam* test, the decision in *Bolitho* or the principle in *Naxakis* to issues of negligent diagnosis and treatment.

1.2 THE ARGUMENTS AND AIMS OF THIS THESIS

This thesis argues that there was a lost opportunity in *Foo Fio Na* to give a definitive principle for deciding the issue of the standard of care in the areas of diagnosis and treatment. It shows that the current state of the law in Malaysia is ambiguous, and that since the 1960s there has been uncertainty in the application of the principle for determining the issue of standard of care in medical diagnosis and treatment. This area of Malaysian medical negligence jurisprudence is at an important crossroads. It is further contended that the current rules of the courts on the use of expert witnesses in Malaysia may lead to biased expert medical opinion, and contributes to the problem of inordinate delay in the resolution of medical negligence litigation. All of these have raised the important question as to how the issue of standard of care in medical negligence litigation of diagnosis and treatment may be more appropriately adjudicated.

This thesis proposes a legislative framework that may facilitate the adjudication of the issue of standard of care in medical diagnosis and treatment in Malaysia. The underlying objectives of this proposed reform are to provide a clear legal principle that can ensure certainty in outcomes and to protect the interests of patients and doctors in medical disputes. The recommended reform also involves codification of procedural rules in the proposed legislation on the use of expert witnesses in medical negligence litigation concerning issues of diagnosis and treatment. This procedural reform aims to ensure a fair assessment of expert medical opinions and to expedite the resolution of medical negligence litigation in Malaysian courts.

1.3 THE SCOPE OF THIS THESIS AND RESEARCH METHODOLOGY

Analysis in this thesis is limited to an examination of the legal developments on the standard of care in medical diagnosis and treatment in the United Kingdom, Singapore, Australia and Malaysia. The first three jurisdictions are chosen because they have all applied the *Bolam* test

in medical negligence cases and have since reviewed the test, as in Malaysia. Equally important is the fact that these jurisdictions have rejected the *Bolam* test in favour of its qualified version under the *Bolitho* principle, although in different forms, as explained earlier.

This thesis does not involve any empirical studies. Primary sources are drawn from case law, statutes and extrinsic materials to the relevant statutory rules. Key decisions on the issue of the standard of care in medical diagnosis and treatment from United Kingdom, Singapore, Australia and Malaysia are examined. Analysis is also made of the various states legislation that codifies the Australian modified *Bolam* test and the statutory rules on the use of expert witnesses from the United Kingdom and Queensland, Australia. There is also a critique of commentary by judges and academics from various jurisdictions.

1.4 SIGNIFICANCE OF THIS STUDY

This thesis contains recommendations for legislative reform to address the current problems of uncertainty and unpredictability in the law pertaining to the standard of care in medical diagnosis and treatment in Malaysia. There are also proposals for procedural rules on the use of expert witnesses to ensure a speedy and fair resolution of medical negligence litigation concerning issues of diagnosis and treatment in this jurisdiction. It is hoped that these recommendations may influence legislative policy or, alternatively, permeate judicial decision-making on the issue of the standard of care in the areas of diagnosis and treatment. If legal reforms do not materialise, it is intended that the analysis of the legal problems and the proposals for reform in this thesis will stimulate more informed and reasoned debates on this area of the law, and that further legal and empirical studies may be conducted in Malaysia.

1.5 OUTLINE OF CHAPTERS

This thesis comprises of seven main chapters divided into three parts. In PART I (Chapter 2), analysis is made of the *Bolitho* principles in the United Kingdom and Singapore. In Chapter 2, the discussion includes a review of the *Bolam* test in its historical context, its legal underpinnings and its interpretation by the English House of Lords in the 1980s. It then proceeds to an analysis of the House of Lords decision in *Bolitho* and scholarly commentary on this seminal case. The study takes a cross-jurisdictional approach to examine the *Bolitho* principle that was interpreted by the Singaporean Court of Appeal in *Gunapathy*. A

comparative analysis is also undertaken between the Singaporean and English versions of the *Bolitho* principles.

In PART II (Chapters 3, 4 and 5), the legal positions in Australia, both under common law and legislation is examined. In Chapter 3, an analysis is made of the evolution of the common law principle on the standard of care in the areas of diagnosis and treatment in Australia: from the rejection of the *Bolam* test in some Australian Supreme Court cases in the late 1970s and early 1980s to the endorsement of this rejection by the Australian High Court in *Naxakis* in the late 1990s. A critique is made of the principle in *Naxakis* and how these criticisms relate to the subsequent legislative reform which implemented the Australian modified *Bolam* test.

Chapter 4 analyses the medical indemnity crisis in Australia. This chapter undertakes an evaluation of the crisis and the extent to which the Australian governments, both State and Commonwealth, addressed the root causes of the crisis. Chapter 5 critiques the Australian modified *Bolam* test, which has been codified in legislation in six state jurisdictions. The analysis examines the materials extrinsic to the legislation with a view to deciphering the intention of the state parliaments on the important wording of the statutory provisions. It questions the defensibility of the legal and factual bases of the legislative reform. This chapter ends with an analysis of a number of important cases with a view to examining how the test was interpreted and applied by Australian judges.

PART III (Chapter 6, 7, 8 and 9) contains analysis of the past and current legal positions on the standard of care in medical negligence cases concerning diagnosis and treatment in Malaysia; recommendations for reforms to the law; and conclusions of this thesis. Chapter 6 examines the process of transplantation of the *Bolam* test into Malaysian courts between the 1960s and early 2000s. It assesses the extent to which the *Bolam* test changed its English characteristics since its transplantation into Malaysian medical negligence jurisprudence. This chapter also explores the reasons why the *Bolam* test, which was interpreted by the House of Lords in the 1980s, survived major modifications in Malaysia during this period.

Chapter 7 analyses the Federal Court case of *Foo Fio Na*. It highlights the problems of uncertainty and ambiguity in the law concerning the standard of care in the areas of diagnosis

and treatment. In doing so, assessment is made of the ruling of the Federal Court concerning issues of medical treatment, the Court's analysis of legal precedents, scholarly literature and subsequent lower court cases which have applied the decision. It is suggested in this chapter that the *Bolitho*-type *Bolam* test is the appropriate legal principle for reform in Malaysia. The main justification for this proposal is that it will place the legal position in Malaysia in line with the legal developments in the United Kingdom, Singapore and the Australian states. It is also recommended that legislation is a more appropriate means than case law development to addressing the current legal problems of ambiguity and uncertainty in the law. The advantages and disadvantages of introducing legislation to regulate the law in Malaysia is considered.

Chapter 8 contains the substantive principle of the proposed *Bolitho*-type *Bolam* test for Malaysia and recommendations for procedural changes to the use of expert witnesses in medical negligence litigation. The proposed Malaysian reform model is based on the Singaporean version of the *Bolitho* principle, with further clarifications. This chapter also highlights the potential lack of independence of expert medical opinion that is brought about by the current rules of the courts on the use of expert witnesses in civil proceedings and the issue of inordinate delays in the resolution of medical negligence litigation in Malaysia. Procedural reforms are suggested to address these issues. These may involve implementation under legislation the compulsory appointment of a single agreed or a single court-appointed expert prior to the commencement of medical negligence litigation.[17] Proposals are also made to allow litigants to appoint more than one agreed or court-appointed expert at any stage of legal proceedings should the need arise. The proposed procedural framework also provides for exceptional circumstances in which the court may exercise discretion to permit litigants to engage their own experts and this issue would be determined by the court at the early stage of legal proceedings. It is hoped that these proposals will save time and costs, as well as provide a fair, flexible and speedy resolution of medical negligence litigation involving issues of diagnosis and treatment.

Finally, Chapter 9 sums up the study. It concludes that the law on the standard of care in medical diagnosis and treatment is unsatisfactory and is in need of reform. Two options are

[17] This reform proposal is grounded upon the Queensland model on the use of expert witnesses in civil proceedings under the amended *Uniform Civil Procedure Rules 1999* (Qld), which was implemented in 2004. Sections 8.4.2 and 8.4.3 of Chapter 8 elucidate this recommendation.

available for legal reform: awaiting another Malaysian Federal Court decision that deals with the issue of negligent diagnosis and treatment, or changing the law by legislation. This chapter argues that legislation to codify the reforms proposed in this thesis is a more effective way than case law development to address the problems that riddle medical negligence litigation concerning issues of diagnosis and treatment in Malaysia.

CHAPTER 2
THE *BOLAM* TEST AND ITS SUBSEQUENT DEVELOPMENTS IN THE UNITED KINGDOM AND SINGAPORE

2.1 INTRODUCTION

The *Bolam* test was the *locus classicus* formulation for deciding whether a doctor has breached his or her duty of care in medical negligence cases in the United Kingdom. The test, which derived its name from the case of *Bolam v Friern Hospital Management Committee*,[1] requires that the standard of care that is expected of a medical practitioner be measured against that of an ordinary competent doctor who possesses and exercises a particular field of expertise. In the context of medical negligence disputes, the determination of this standard is assisted by expert testimony which has to represent 'a responsible body of medical opinion'.[2]

The debates about the *Bolam* test had centred upon the issue of who should ultimately decide the required standard of care in cases dealing with diagnosis and treatment. Scholarly literature has consistently suggested that the courts, not the medical profession, should have the final say as to whether the doctors' duty of care has been breached. In reality, however, the English House of Lords, due to various policy considerations, showed deference to the medical profession under the *Bolam* test. This approach allows expert medical opinion to be determinative of the issue of breach of duty of care in the areas of diagnosis and treatment. Despite this development, a few English Court of Appeal decisions reported in the 1990s took a broader approach, authorising judges to examine the merits of expert medical opinion before concluding whether the opinion could be considered as 'a responsible body of medical opinion'.

These two different interpretations of the *Bolam* test were put to rest in 1997 before the House of Lords in *Bolitho v City and Hackney Health Authority*.[3] Seeking to reinterpret the test, the Court in *Bolitho* held that the courts, not the medical profession, are the ultimate arbiters of the issue of the standard of care in medical negligence cases dealing with issues of diagnosis and treatment. Since the decision, academic scholars and judges have given

---

1 [1957] 2 All ER 118 (*Bolam*).
2 Ibid 122.
3 [1998] AC 232 (*Bolitho*).

divergent views on its significance on changing the *Bolam* jurisprudence in the United Kingdom.[4] Against this backdrop of academic appraisals of *Bolitho* in the United Kingdom, one Commonwealth jurisdiction, Singapore, has adopted its principle in *verbatim*, though with further refinement.

In view of the legal developments in the United Kingdom and Singapore, this chapter examines the *Bolam* jurisprudence and the *Bolitho* principle in both jurisdictions. The analysis of this chapter is divided into three parts. The first section traces the evolution of the *Bolam* test in the United Kingdom. In doing so, it identifies its underpinnings and assesses the academic literature on its legal basis. The conflicting interpretations of the *Bolam* test by the English House of Lords and the Court of Appeal respectively are also examined. This section explores the reasons why the House of Lords showed deference to the medical profession under the *Bolam* test.

The second section evaluates the significance of *Bolitho* in changing judicial deference to the medical profession under the *Bolam* test. The analysis traces its decision from the first instance court, the Court of Appeal and the House of Lords. It highlights the pronouncement of the House of Lords with regard to the *Bolitho* principle. There are two sides of scholarly arguments on the effectiveness of *Bolitho* in altering judicial deference to the medical profession under the *Bolam* test. One side contends that it has retained the courts' right to reject expert opinions which do not withstand logical analysis. The other argues that the effects of *Bolitho* have not changed the problem of judicial deference to the medical profession under the *Bolam* test. This chapter takes the latter view, contending that the House of Lords in *Bolitho* has created more problems than it meant to solve. There are limitations in the principle which hinder a fair evaluation of expert medical opinion. There are also statements from the House of Lords requiring English judges to unnecessarily defer to the opinion of high-standing medical experts.

The final section compares the *Bolitho* principle in the United Kingdom with that in Singapore. The decision of the Singaporean highest court adopting the *Bolitho* principle is examined. The assessment highlights the interpretation given to the *Bolitho* principle in Singapore. Upon closer scrutiny of the *Bolitho* principles in both jurisdictions, it is argued

[4] This is elaborated in Section 2.7 of this chapter.

that the Singaporean version is the preferred choice due to its clarity and fairness in the evaluation of expert medical opinion.

2.2 THE HISTORICAL DEVELOPMENT OF THE *BOLAM* TEST

The development of the *Bolam* test in the United Kingdom was gradual, spanning over 100 hundred years before the case of *Bolam*.[5] One principle that had been consistently upheld by the courts during this period, however, was the notion of reasonable care and skill in medical negligence cases. In other words, the standard that is expected of a doctor is not the highest professional skill but an average doctor professing particular attributes of the practice of that doctor. The analysis in this section begins with two nineteenth century cases which played a significant role in shaping the legal foundation of the *Bolam* test.[6] They were *Lanphier v Phipos*[7] and *Rich v Pierpoint*,[8] both of which concerned actions for medical negligence.

2.2.1 Lanphier v Phipos

Lanphier dealt with a straightforward issue of negligent medical treatment. The plaintiff patient suffered an injury to her arm due to a fall. The defendant doctor treated the swollen arm of the plaintiff by merely putting splints on the arm, binding it from below the elbow to the wrist. The splints were kept on for seven weeks but the inflammation spread to the plaintiff's shoulder. Dissatisfied with the treatment of the defendant, the plaintiff engaged another doctor who prescribed lotions and successfully reduced the inflammation. The plaintiff commenced legal proceedings against the defendant doctor for negligence, alleging that the doctor should have prescribed lotions to reduce the inflammation. The jury returned a verdict of negligence. The significance of *Lanphier* lies in the comments given by Tindal CJ to the jury:

> 'Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake if he is an attorney, that at all events you shall gain your case, nor does a surgeon

---

5 John Keown, 'Doctor Knows Best?: The Rise and Rise of "The *Bolam* Test"', [1995] *Singapore Journal of Legal Studies* 342, 347.

6 See also Robert B M Howie, 'The Standard of Care in Medical Negligence', (1983) 21 *The Juridical Review* 193, 203.

7 (1838) 173 ER 581; (1838) 8 Car & P 475 (*Lanphier*).

8 (1862) 176 ER 16; [1862] 3 F & F 35 (*Rich*).

undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill.'[9]

Statements of a similar nature were also found in a subsequent case of *Rich v Pierpoint*. However, *Rich* further clarified what was meant by the notion of reasonable care and skill as articulated by Tindal CJ in *Lanphier*.

2.2.2 Rich v Pierpoint

This was a case where the plaintiff suffered an abortive delivery, resulting in the death of the unborn child. The plaintiff alleged that the defendant doctor had wrongfully administered a drug whilst she was in labour. The jury found in favour of the defendant. The importance of the decision resides in the principle of the Court that the question as to whether a doctor is liable for medical negligence is to be decided by reference to the standard of ordinary competent doctors:

> 'To render a medical man liable, even civilly, for negligence, or want of due care or skill, it is not enough that there has been a less degree of skill than some other medical men might have shown, or a less degree of care than even he himself might have bestowed; nor is it enough he himself acknowledges some degree of want of care; there must have been a want of competent and ordinary care and skill, and to such a degree as to have led to a bad result'.[10]

Essentially, both *Lanphier* and *Rich* established the general principle that negligence in the medical context is evaluated with the standard of reasonable care and skill, not the highest professional skills. This threshold standard in civil actions is satisfied by reference to what an ordinary competent doctor would or would not have done in the circumstances. Later in the early twentieth century, this statement of the law was endorsed in dicta by the House of Lords in *R v Bateman*.[11]

---

9 *Lanphier* (1838) 173 ER 581, 583; (1838) 8 Car & P 475, 479.
10 *Rich* (1862) 176 ER 16, 16-17; [1862] 3 F & F 35, 35.
11 [1925] All ER (Reprint) 45.

2.2.3 R v Bateman

The facts of this case concerned a doctor who was subjected to a criminal charge for gross negligence following the death of his patient whilst undergoing medical treatment. Although the case concerned issues of criminal liability, it is nonetheless relevant to civil actions mainly due to the affirmation by the House of Lords of the doctrine of reasonable care and skill in medical negligence cases. Lord Hewart stated in *R v Bateman* that:

> '... If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care and knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward… The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned... As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man...'.[12]

Although this passage is notably a dictum, it profoundly impacted on the subsequent development of the doctrine of reasonable care and skill in medical negligence law in the United Kingdom. Since *R v Bateman*, the majority of English cases have used the standard of reasonable care and skill as the yardstick for determining the issue of breach of duty of care in medical negligence cases concerning issues of diagnosis and treatment.[13] Two of these seminal cases are *Roe v Ministry of Health*[14] and *Bolam*.

2.2.4 Roe v Ministry of Health

Roe concerned an appellant patient who suffered from permanent paralysis as a result of the administration of a contaminated spinal anaesthetic, Nupercaine, before undergoing surgical operation. Prior to use, the Nupercaine was contained in glass ampoules which were

---

12 Ibid 48.
13 Robert B M Howie, above n 6, 204.
14 [1954] 2 QB 66 (*Roe*).

immersed in a phenol solution. Unbeknown to the anaesthetist who was involved in the surgical operation, phenol percolated through invisible cracks in the ampoules and contaminated the Nupercaine. The incident occurred in 1947 but the trial commenced in 1954. Expert medical opinion was adduced by the anaesthetist that this risk was not appreciated by a competent specialist in the field of anaesthesia in 1947.[15] The English Court of Appeal accepted this evidence and held, *inter alia*, that the anaesthetist was not negligent as the medical knowledge in 1947 did not suggest any medical liability. Denning LJ in *Roe* held that the standard of reasonable care connotes that doctors should not be held negligent whenever a medical incident occurs. Neither is this standard to be judged in hindsight.[16] The rationales, Denning LJ stated, are to safeguard against the spectre of defensive medicine and ensuring the proper development of medical science:

> '... But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure...'.[17]

These policy considerations were significant because they were later adopted by the trial judge in the case of *Bolam* as the basis for formulating the *Bolam* test.

2.2.5 Bolam v Friern Hospital Management Committee

This is the case where the modern-day *Bolam* test originated. The plaintiff, Mr Bolam, was suffering from acute depression. He had undergone electro-convulsive therapy, the only available cure for the illness at the time. No relaxant drug was administered to him nor was any restraint used to cushion the convulsive movements which occur during the course of the treatment. He suffered a fracture to his hip in the course of the administration of the

---

15 Ibid 83. This evidence, Denning LJ stated, was given by 'the greatest [anaesthesia] specialists' in the United Kingdom.

16 Ibid 84.

17 Ibid 86-87. See also *Hatcher v Black* [1954] CLY 2289 (Denning LJ).

treatment. At that time, divergent professional opinions were held over the use of relaxant drugs and physical restraint and in relation to whether patients should be warned of the risk of fractures. The case rested on the issues of alleged negligent advice and treatment. McNair J first elaborated the doctrine of reasonable care as it applies to the general law of negligence. His Lordship stressed the key point that reasonable care in medical negligence cases is not measured against the standard of a reasonable man in the street, but rather of a competent ordinary doctor exercising and possessing a particular skill:

> '… where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art…'.[18]

This passage represents the first part of the *Bolam* test. McNair J went a step further to formulate the second tier of the test by reference to the judgment of Clyde LP in the Scottish case of *Hunter v Hanley*.[19]

In *Hunter* the defendant doctor broke the needle while administering a penicillin injection. A remnant of the needle remained embedded in the patient's hip. The trial judge had erroneously applied a criminal standard of 'gross negligence' in determining the question of breach of duty. The plaintiff moved for a retrial to the Court of Session. In granting a retrial, Clyde LP commented on the issue of standard of care in medical negligence:

> 'To succeed in an action based on negligence, whether against a doctor or anyone else, it is of course necessary to establish a breach of that duty to take care which the law requires, and the degree of want of care which constitutes negligence must vary with circumstances... But where the conduct of a doctor, or indeed of any professional man, is concerned, the circumstances are not so precise and clear cut as in the normal case. The true test for establishing

[18] *Bolam* [1957] 2 All ER 118, 121.
[19] [1955] SC 200 (*Hunter*).

> negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.'[20]

As 'a different way of expressing the same thought' as the above passage by Clyde LP, McNair J reiterated that a doctor is not liable for negligence if his or her conduct in question is deemed an acceptable practice by a responsible body of medical opinion, even if other doctors would take a contrary view. Quoting the policy statements of Denning LJ in *Roe* as stated earlier,[21] McNair J formulated the second part of the *Bolam* test:

> '... A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that would take a contrary view...'.[22]

2.2.6 A comparative analysis of the formulations in Bolam and Hunter

Contrary to the claim by McNair J in *Bolam* that his formulation was similar to the principle as articulated by Clyde LP in *Hunter*, there are two notable distinctions. One of them relates to the forms of the tests in both cases. The *Bolam* test was stated more positively: a doctor is not liable for negligence if his or her conduct in question complies with accepted practice as approved by a responsible body of medical opinion. Clyde LP's version of the test was stated more negatively, focusing on situations where no ordinary doctor would have acted in similar circumstances.

The formulations in *Hunter* and *Bolam* also differ in their historical origins. The *Bolam* test was founded upon the doctrine of reasonable care and skill whilst the genesis of the principle as stated by Clyde LP in *Hunter* is closely related to the criminal doctrine of gross negligence. This is evident in the judgment of Clyde LP where his Lordship stated that the test for medical negligence in Scotland was laid down by Glegg in his text on *The Law of Reparation in Scotland*. The relevant passage in the textbook read as follows:

---

20 Ibid 204.

21 See Section 2.2.4 of this Chapter.

22 *Bolam* [1957] 2 All ER 118, 122.

> 'Standard of care – A professional man is presumed to be possessed of a fair and average knowledge of his calling. It has been said that he is liable only for gross negligence…*Gross negligence* in this context means such conduct as no man of ordinary skill and prudence in his profession would be guilty of if acting with ordinary care…
>
> Medical men – In general, it may be said that a medical man is not liable for the consequence of error or mistaken judgement, but he is liable for *gross ignorance or neglect* of his patient'. [23] (*Emphasis added*)

Stewart has stated that these passages in fact reflect the law of gross negligence as it had stood for more than a century in Scotland.[24] However, Clyde LP made it clear in *Hunter* that the doctrine of gross negligence does not apply to medical negligence in civil actions in Scotland. Similarly, Lord Russell and Lord Sorn in *Hunter* stated that the legal standard of care in Scottish medical negligence cases was also based on the English doctrine of reasonable care and skill.[25] Irrespective of what the law lords in *Hunter* stated, Smith argues that the test as stated by Clyde LP was rather an 'ingenious' device to rid the concept of gross negligence in the Scottish law of medical negligence and to replace it with the English doctrine of reasonable care and skill.[26] As it is shown in the subsequent analysis of this chapter, most English appellate court judges preferred the formulation articulated by McNair J in *Bolam* to that of Clyde LP in *Hunter*.

2.3 THE DEBATES ABOUT THE THEORETICAL BASES OF THE *BOLAM* TEST

It has been shown that the determination of the standard of care under the *Bolam* test is primarily based on the conduct of ordinary skilled doctors who exercise and profess a particular art of medicine.[27] However, a number of leading medico-legal scholars have argued that the emphasis on the conduct of ordinary skilled doctors under the *Bolam* test is an

---

23 Arthur Thomson Glegg, *The Law of Reparation in Scotland* (W Green & Son, 3rd ed, 1939) 509 (As quoted by Clyde LP in *Hunter* [1955] SC 200, 205).

24 Angus Stewart, '"Best Interests": Towards A More Patient-Friendly Law?', (2007) 11 *Edinburgh Law Review* 62, 70.

25 *Hunter* [1955] SC 200, 207 (Lord Russell) and 208 (Lord Sorn).

26 See also Robert B M Howie, above n 6, 214.

27 *Bolam* [1957] 2 All ER 118, 121.

inappropriate yardstick in medical negligence cases. Shortly after *Bolam* was decided, Montrose raised the concerns that some members of the medical profession may, out of their enthusiasm for a new cure, ignore certain risks which are inherent in a particular diagnostic or treatment procedure. Hence, he suggested that the courts should be in the position to reject medical practice which does not provide adequate precautions against medical risks.[28] This, Montrose argued, could be achieved by bringing the *Bolam* test in line with the basic legal concept of general negligence: by asking the essential question of what a hypothetical reasonably competent doctor ought to have done in the circumstance, rather than what the profession in fact does.[29]

A stronger and more recent critique of the *Bolam* test comes from Michael Jones. Jones argues that negligence is concerned with a departure from the standard of care which the courts consider appropriate, not from the standards that members of the medical profession think.[30] According to him, there may be medical practices which are negligent. The *Bolam* test is unable to safeguard against this danger since it focuses on what the medical profession does instead of what the courts consider to be the appropriate standard of care. Hence, Jones proposes that the standard of ordinary skilled doctors under the *Bolam* test should be replaced with the standard of the reasonably competent doctor. This latter standard, which bears similarity with the proposal of Montrose, would allow the courts to consider what ought to be done in the circumstances after drawing upon all the evidence presented, not just expert medical opinion. [31]

The recommendations by both Montrose and Jones seem problematic. The main difficulty with the proposals is that they rise to unpredictability in the outcome of medical disputes.[32] Understandably, individual judges would have different views on what ought or ought not to have been done in the circumstances. Another problem is that judges, by virtue

---

28 JL Montrose, 'Is Negligence an Ethical or a Sociological Concept?', (1958) 21 *Modern Law Review* 259, 263.

29 Ibid. In advancing this argument, Montrose refers to the famous judgment of Baron Alderson in *Blyth v Birmingham Waterworks Co* (1856) 11 Exch 781, 784 on the definition of negligence in general cases:

> 'Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do'.

30 Michael Jones, 'Breach of Duty' in Ian Kennedy and Andrew Grubb (ed), *Principles of Medical Law* (Oxford University Press, 1st ed, 1998) 335, 337-338.

31 Ibid.

32 See also Raphael Powell, 'The Unreasonableness of the Reasonable Man', (1957) 10 *Current Legal Problem* 104, 119-122.

of their legal training, are ill-equipped to adjudicate over technical medical issues. It is this limitation facing the courts that the *Bolam* test aims to resolve.[33] The test places strong emphasis on expert medical opinion, which would help judges in comprehending the practices of the medical profession and the intricacies of medical science.

A preferable approach is to place significant reliance on expert medical opinion but also empower the courts to ultimately decide the appropriate standard of care. Not only would this achieve a greater degree of predictability in medical disputes, it would allow a certain degree of judicial scrutiny over the practice of the medical profession. In reality, however, only a handful of English Court of Appeal decisions adopted this approach. None of the English appellate court cases followed the suggestions by Montrose and Jones. Most House of Lords decisions showed judicial deference to the medical profession. The following section elucidates these propositions.

2.4 TWO DIFFERENT INTERPRETATIONS OF THE *BOLAM* TEST IN THE UNITED KINGDOM

2.4.1 The interpretation that showed judicial deference to the medical profession

In the 1980s the *Bolam* test was endorsed by the English House of Lords decisions in *Maynard v West Midlands Regional Health Authority*[34] and *Whitehouse v Jordan*[35] in the areas of medical diagnosis and treatment. The interpretation given to the test by the House of Lords was that the medical profession should be given the ultimate role of deciding the

---

33 Iain Goldrein, '*Bolam* – Problems Arising out of "Ancestor" Worship', (1994) 144 (July-December) *New Law Journal* 1237, 1238.

34 [1985] 1 All ER 635, 637-638 (Lord Scarman) (*Maynard*). *Maynard* dealt with issue of medical diagnosis. In *Maynard* two medical specialists employed by the respondent health authority were of the opinion that the appellant might be suffering either from tuberculosis or Hodgkin's disease. Instead of waiting for a pathology report, both specialists conducted an exploratory operation to determine whether the appellant was suffering from Hodgkin's disease. The pathology report later confirmed the disease was tuberculosis. As a result of the operation, the appellant suffered damage to a nerve affecting her vocal cords which caused her speech to be impaired. The House of Lords applied the *Bolam* test held that the specialists were not negligent as the performance of the exploratory operation was an accepted practice of the medical profession, although other medical experts disagreed with it due to the risk the operation carried.

35 [1981] 1 All ER 267, 276-277 (Lord Edmund-Davies) (*Whitehouse*). *Whitehouse* may be classified as a case concerning issue of medical treatment. The respondent doctor, an obstetric, tested forceps delivery of the appellant's baby before proceeding to delivery by Caesarian section. The doctor pulled the appellant's baby several times with obstetric forceps and the baby was born with brain damage. The House of Lords held that the respondent doctor was not negligent as the tested forceps delivery conducted by the doctor was in accordance with the standard of ordinary competent doctors.

required standard of care. Lord Scarman, who approved the *Bolam* test in *Maynard*,[36] interpreted the test in *Sidaway v Bethlem Royal Hospital*[37] as follows:

> '... The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment [sic]'.[38]

In *Maynard*, Lord Scarman also explained the role of judges in the application of the *Bolam* test:

> 'My Lords, even before considering the reasons given by the majority of the Court of Appeal for reversing the findings of negligence, I have to say that a judge's "preference" for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner *whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held* were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate specialty, if he be a specialist) is necessary'.[39] (*Emphasis added*)

Following this line of interpretation, the role of judges in the evaluation of the opinion of the medical experts would be confined to the issues of credibility and truthfulness of the opinion. Judges are not allowed to examine either the internal consistency or the bases of expert medical opinion. Nor are they allowed to choose one opinion over another. Once the opinion of the medical experts is found to be credible and truthful, the court is bound to accept it as a responsible body of medical opinion.

---

36 With whom Lord Fraser of Tullybelton, Lord Elwyn-Jones, Lord Roskill and Lord Templeman in *Maynard* agreed.

37 [1985] AC 871 (*Sidaway*).

38 Ibid 881.

39 *Maynard* [1985] 1 All ER 635, 639. See also *Sidaway* [1985] AC 871, 895 (Lord Diplock).

2.4.2 The broader interpretation

The broader judicial interpretation of the *Bolam* test states that although the medical profession is given the primary role to decide on acceptable practices in medical diagnosis and treatment, the ultimate decision on the required standard of care rests with the courts.[40] In other words, the courts may examine the bases upon which expert medical opinion is formed. One of the early cases is *Hucks v Cole*.[41]

In *Hucks* the appellant patient suffered from septic spots on her skin. Those spots contained an organism that was capable of developing puerperal fever in patients. The respondent doctor, however, failed to treat the appellant with penicillin, a drug that was already well-developed in the 1960s which was capable of killing such an organism. Surprisingly, there were a number of distinguished doctors who testified that they themselves would not have administered penicillin to the patient. The English Court of Appeal held the respondent doctor negligent. In particular, Sach LJ based his decision on the risk-benefit analysis of the opinion in the following words:

> 'On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas.'[42]

The approach of questioning the merits of expert medical opinion was also adopted by other English Court of Appeal judges in the 1990s when dealing with issues of medical diagnosis and treatment, although they did not provide a mechanism by which judges may scrutinise expert medical opinion as Sach LJ did in *Hucks*. In *Joyce v Wandsworth Health Authority*[43] Roch LJ held that a defendant doctor would not be negligent if the court found that the clinical practice in question '[stands] up to analysis'.[44] In another English Court of Appeal case of *De*

---

40 Alasdair Maclean, 'Beyond *Bolam* and *Bolitho*', (2002) 5 *Medical Law International* 205, 207.

41 (1993) 4 Med LR 393 (*Hucks*). The judgment in *Hucks* was delivered in 1968 but was only reported in 1993.

42 Ibid 399.

43 (1996) 7 Med LR 1.

44 Ibid 13-14.

Freitas v O'Brien and Connolly[45] Otton LJ opined that the court, when applying the *Bolam* test, should be concerned about the quality of expert medical opinion, not the number of medical experts who hold this opinion.[46] The emergence of these judicial statements in the 1990s arguably added uncertainty to the application of the *Bolam* test in the United Kingdom, which primarily showed judicial deference to the medical profession.

2.5 THE *BOLAM* TEST IN THE ENGLISH COURT OF APPEAL AND HOUSE OF LORDS

Judicial policies at the English Court of Appeal and House of Lords had been divided on why the medical profession should ultimately determine the standard of care in the areas of diagnosis and treatment under the *Bolam* test. At the Court of Appeal level, there were two dominant reasons for allowing the medical profession to decide the standard of care in cases concerning diagnosis and treatment: protecting doctors against negligence suits, and safeguarding against the spectre of medical practitioners refusing to treat patients for fear of being sued. These common threads, as leading academic McLean analyses, appeared to have come mostly from the decisions of a single judge, Denning LJ.[47] In the Court of Appeal in *Whitehouse v Jordan*,[48] Denning LJ defended judicial deference to the medical profession under the *Bolam* test in the following words:

> 'If [doctors] are to be found liable whenever they do not effect a cure, or whenever anything untoward happens, it would do a great disservice to the profession itself. Not only to the profession but to society at large... Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved...'.[49]

---

45 (1995) 6 Med LR 108.

46 Ibid 115. With whom Leggatt and Swinton Thomas LJJ concurred. Similar approach was also taken by Farquharson LJ in *Bolitho v City and Hackney Health Authority* (1993) 4 Med LR 381, 386 (English Court of Appeal). This decision is examined in Section 2.6.2 of this chapter.

47 Sheila McLean, 'Negligence – Dagger at the Doctor's Back?' in Peter Robson and Paul Watchman (ed), *Justice, Lord Denning and the Constitution* (Gower Publishing, 1981) 99, 103-109.

48 [1980] 1 All ER 650.

49 Ibid 658.

Similar rationales are also found in his Lordship's judgments in other English Court of Appeal decisions before and after the case of *Bolam*, such as in *Hatcher v Black*,[50] *Roe*[51] and *Hucks*.[52]

In contrast, the House of Lords avoided making reference to policy considerations such as those which were advocated by Denning LJ.[53] Instead their Lordships relied on the rationale of limited expertise in supervising the medical profession, particularly in complex technical matters involving medical diagnosis and treatment. This policy was succinctly stated by Lord Diplock in *Sidaway*:

> 'In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; it has to rely on and evaluate expert evidence, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion.[54]

The consideration that judges are ill-equipped to be critical of the medical profession in diagnosis and treatment equally underscores the different judicial approach in other aspects of medical negligence cases such as in the area of provision of advice. This aspect of the doctors' duty of care essentially requires consideration of the extent of the doctor's obligation to warn patients of any material risks inherent in a proposed medical treatment so as to enable the patients to give an informed consent to the treatment. In cases concerning advice, judges are given greater latitude to engage in critical analysis of the expert opinion as issues such as disclosure of risks and consent fall within the legal expertise of judges. Lord Diplock summed up the distinctions in *Sidaway*:

> 'But, when it comes to warning about risks, the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my

---

50 [1954] CLY 2289.
51 [1954] 2 QB 66, 83. See Section 2.2.4 of this chapter for the rationales given by Denning LJ in *Roe*.
52 (1993) 4 Med LR 393, 396.
53 See Jon Holyoak, 'Raising The Standard of Care', (1990) 10(2) *Legal Studies* 201, 210.
54 [1985] AC 871, 895.

> body, and I want to be fully informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment [sic] whether to refuse the advised treatment or not'.[55]

The reasons for the divergent judicial approaches taken by the English Court of Appeal and House of Lords in the interpretation of the *Bolam* test in negligence cases concerning medical diagnosis and treatment are not explicitly stated in their Lordship's judgments. An English academic scholar, Montgomery, however, offers some explanations to this legal trend. He argues that the refusal of the House of Lords to adopt the policies advocated by Denning LJ might be due to a lack of cogent evidence establishing the direct correlation between judicial intervention in medical negligence cases and its adverse impact on the delivery of medical service.[56]

Irrespective of which policy considerations the House of Lords and Court of Appeal in the United Kingdom adopted, Kennedy and Grubb argue that the English appellate courts had virtually placed the practices of the medical profession beyond scrutiny under the *Bolam* test.[57] Given that the determination of the required standard of care under the test requires the courts to primarily rely on expert medical opinions, judges should arguably retain the right to critically examine these opinions.[58] This preferable approach was adopted by the House of Lords in *Bolitho* in 1997, where the Court redefined the *Bolam* test. It is therefore worthwhile to examine the extent to which this decision has changed the *Bolam* jurisprudence in the United Kingdom.

2.6 THE BOLAM TEST AS QUALIFIED BY *BOLITHO* IN THE UNITED KINGDOM

The following section analyses the House of Lords decision in *Bolitho* as well as its proceedings at the Court of Appeal and the first instance stage, the High Court. It examines the significance of the House of Lords' pronouncement relating to the standard of care of

---

55 Ibid.

56 Jonathan Montgomery, 'Medicine, Accountability and Professionalism' (1989) 16 *Journal of Law and Society* 319, 329.

57 Ian Kennedy and Andrew Grubb, *Medical Law: Text With Materials* (Butterworths, 2nd ed, 1994) 452.

58 See also Dieter Giesen, *International Medical Malpractice Law* (Martinus Nijhoff Publishers, 1st ed, 1988) 118.

doctors in the areas of diagnosis and treatment. A critique is made of the implications of the decision for judicial deference to the medical profession under the *Bolam* test in the United Kingdom.

2.6.1 The English High Court

The case of *Bolitho* involved a tragic medical accident which affected a two year old child, Patrick Bolitho (Patrick). Patrick had a past history of hospital treatment for croup. He was readmitted to St Bartholomew's Hospital after having suffered from acute upper respiratory tract obstruction (URTO). The day after his admission, he suffered from three separate episodes of severe breathing difficulties. During the first episode, the doctor in charge was called in but she failed to attend Patrick. When Patrick suffered the second similar episode, the doctor was again summoned. This time the doctor left a message for her senior house officer to attend on her behalf. The house officer did not attend Patrick. Both times, Patrick quickly returned to a stable condition. During the third episode, Patrick's respiratory system collapsed before the nurse managed to contact the doctor in charge. As a result, Patrick suffered a cardiac arrest and sustained severe brain damage. He subsequently died and his mother commenced proceedings for medical negligence against City and Hackney Health Authority in her capacity as the administratrix of his estate.

At the trial, City and Hackney Health Authority conceded that the doctor in charge had breached her duty of care in failing to attend Patrick or to ensure that a suitable deputy attend on her behalf. It was also conceded that intubation would have saved Patrick's life and that the medical procedure would have had to be carried out before the final fatal episode. The key issue before the English High Court, however, centred upon the causal link between the failure to intubate and Patrick's death. The trial judge directed himself to two alternative questions. In the first question, the judge asked whether the doctor would have intubated Patrick had she attended him at the second episode of breathing difficulty.[59] If the answer was in the affirmative, her failure to intubate Patrick caused Patrick's death. However, the doctor stated that she would not have intubated Patrick even if she had attended him.[60] The trial judge went on to inquire into the other question as to whether the failure to intubate was itself contrary to accepted medical practice.[61]

---

59 *Bolitho* [1998] AC 232, 238 (As quoted by Lord Browne-Wilkinson).

60 Ibid.

61 Ibid.

There were two conflicting opinions on whether the failure to intubate was contrary to acceptable medical practice. On behalf of Patrick, five expert witnesses were called, all of whom were of the opinion that any competent doctor would have intubated at least after the second episode. The health authority's three expert witnesses rejected this suggestion. They testified instead that intubation of a child of Patrick's age would involve anaesthetising him, and on the evidence of his condition, this procedure would have carried the risks of mortality and morbidity.

Faced with a division of expert medical opinion, the learned trial judge 'felt compelled to hold' that it had not been proven that any competent doctor, in the position of the doctor in question, would have intubated Patrick before his death.[62] The judge stated that:

> 'It is not for me to make a choice between [the plaintiff's expert] and [the defendant's expert] one of whom is convinced that any competent doctor would, the other that she would not, have undertaken that procedure. Plainly in my view this is one of those areas in which there is a difference of opinion between two distinguished and convincing medical witnesses as to what as a matter of clinical judgment proper treatment requires'.[63]

Accordingly, the High Court ruled that the doctor did not cause the death of Patrick and held that the claims for medical negligence against City and Hackney Health Authority failed.

2.6.2 The English Court of Appeal

Patrick's mother appealed the trial judge's decision to the Court of Appeal on the grounds that the judge should have rejected the defence's expert medical opinion as not representative of a responsible body of medical opinion. Relying on the case of *Hucks*, she argued that the expert opinion failed the test of risk and benefit analysis of intubation. She contended that even though he would have to have been anaesthetised, the risk of intubation was slight. The corresponding risk of not intubating was high, bearing in mind the previous two life-threatening episodes.

---

62 *Bolitho v City and Hackney Health Authority* (1993) 4 Med LR 381, 385 (English Court of Appeal) (As quoted by Farquharson LJ).

63 Ibid. This approach is in accord with the speech of Lord Scarman in *Maynard* [1985] 1 All ER 635, 639.

The majority of the Court of Appeal judges, Farquharson and Dillon LJJ, dismissed the appeal as they were satisfied that the defence's expert medical opinion was a responsible body of medical opinion.[64] They were also uniform in their endorsement of the approach taken by Sachs LJ in *Hucks* empowering the courts to reject expert medical opinion, but fell short of approving the risk-benefit methodology. Farquharson LJ held that the question as to whether a medical opinion can be regarded as responsible should not be counted by number. Instead, it is the courts which have to be satisfied that the opinion or the accepted medical practice 'puts the patient unnecessarily at risk'.[65] His Lordship was of the view that the failure of intubation did not put Patrick 'unnecessarily at risk'.[66] Dillon LJ, on the other hand, ruled that the courts could reject expert medical opinion:

> '... if the courts, fully conscious of its own lack of medical knowledge and clinical experience, was none the less clearly satisfied that the views of that group of doctors were *Wednesbury* unreasonable', ie *views such as no responsible body of doctors could have held...*'.[67] (*Emphasis added*)

This latter statement bears some resemblance to the formulation for determining the standard of care in medical diagnosis and treatment as enunciated by Clyde LP in *Hunter*,[68] although arguably it was an adaptation of the public law principle of *Wednesbury* unreasonableness.[69] Having reviewed the testimony of the defence's experts, Dillon LJ concluded that the opinion was not unreasonable under the *Wednesbury* principle. In conclusion, the majority of the Court of Appeal held that the issue of causation could not be established and the claims of negligence must fail. Patrick's mother appealed the decision to the House of Lords.

---

64 Simon Brown LJ dissented.

65 *Bolitho v City and Hackney Health Authority* (1993) 4 Med LR 381, 386 (English Court of Appeal).

66 Ibid.

67 Ibid 392.

68 [1955] SC 200, 204. The formulation enunciated by Clyde LP in *Hunter* was discussed in Section 2.2.5 of this chapter.

69 The public law doctrine of *Wednesbury* unreasonableness refers to one of the three limbs of the '*Wednesbury* test' that was enunciated by Master of the Rolls, Lord Greene in the English Court of Appeal case of *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, 233-234. Under the *Wednesbury* test, a decision of a public administrative body may be overturned by the court if either: the decision took into account factors that ought not to have been taken into account, it fails to take into account factors that ought to have been taken into account, or it is so unreasonable that no reasonable authority could have come to it. The principle of *Wednesbury* unreasonableness, refers to the third limb of the test, was subsequently endorsed by the House of Lords in *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410 (Lord Diplock).

2.6.3 The English House of Lords

The appeal in the House of Lords centred upon two main issues: whether the *Bolam* test had any application in deciding the issue of causation,[70] and if so, whether judges should intervene in the determination of the standard of care in medical diagnosis and treatment.[71]

In dealing with the applicability of the *Bolam* test to the issue of causation, Lord Browne-Wilkinson made two important pronouncements. His Lordship affirmed the long established principle that the *Bolam* test is not applicable to the issue of causation in general for the reason that the causative issue only requires factual proof rather than making reference to medical standards.[72] The Court, however, added that the test may be relevant to the issue of causation where there was an omission to act. Lord Browne-Wilkinson accordingly approved the approach taken by the trial judge with regard to the issue of causation.[73]

The more important aspect of the decision, however, is with regard to the second issue of the appeal in which Lord Browne-Wilkinson reinterpreted the *Bolam* test. Lord Browne-Wilkinson held that the courts may hold a doctor liable for negligence if they are satisfied that the expert medical opinion supporting the action or omission of the doctor cannot be regarded as reasonable or responsible. In stating this principle, Lord Browne-Wilkinson revisited the case of *Bolam* and *Maynard* and highlighted three key words that were previously articulated by McNair J and Lord Scarman in *Bolam* and *Maynard* respectively—*responsible*, *reasonable* and *respectable*. From these words, Lord Browne-Wilkinson drew the conclusion that they are acceptable analytical tools that allow judges to critically analyse expert medical opinion to ensure that it has a 'logical basis':

> '... The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis ...'.[74]

---

70 *Bolitho* [1998] AC 232, 239-241.

71 Ibid 241-244.

72 Ibid 240, citing the reasoning of Hobhouse LJ in *Joyce v Merton, Sutton and Wandsworth Health Authority* (1996) 7 Med LR 1, 20. See also *Cavanagh v Bristol and Weston Health Authority* (1992) 3 Med LR 49, 56 (Macpherson J).

73 *Bolitho* [1998] AC 232, 241.

74 Ibid 241-242.

His Lordship defined the 'logical basis' test as follows:

> '... In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, *the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter*.'[75] (*Emphasis added*)

In defending the independence of the courts in the context of medical negligence cases concerning diagnosis and treatment, Lord Browne-Wilkinson relied on the decision in *Hucks* and the Privy Council case of *Edward Wong Finance Co. Ltd v Johnson Stokes & Master (a firm).*[76] However, his Lordship qualified the power of the courts to supervise medical practice in both branches of the doctors' duty of care with the following statements:

> '… In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion ... I emphasise that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence...'.[77]

In other words, although the courts are authorised to disregard expert medical opinion which does not satisfy the requirement for logical basis, judges should exercise this power sparingly.

In *Bolitho* Lord Browne-Wilkinson held that on the basis of a risk and benefit analysis, the opinion of the respondent health authority's experts was not illogical. His Lordship accepted the opinion of these experts that the risk of Patrick developing a total respiratory failure was small. Intubation, as the opinion suggested, would have been an invasive and risky procedure to the two year old toddler. In conclusion, the Court ruled that

---

75 Ibid 242.
76 [1984] AC 296.
77 *Bolitho* [1998] AC 232, 243.

the failure of the doctor to intubate Patrick did not cause his death and hence dismissed the appeal.

2.7 AN ASSESSMENT OF ACADEMIC LITERATURE ON THE ENGLISH *BOLITHO* PRINCIPLE

Academic literature written on the decision in *Bolitho* can be divided into two main categories: one which argues that it has altered the pro-doctor interpretation of the *Bolam* test and the other that contends that the status quo under the *Bolam* jurisprudence is largely intact. Having evaluated the conflicting scholarly commentaries, this chapter takes the stand that *Bolitho* has failed to provide a fair and well balanced analysis of expert medical opinion. The analysis culminates with proposals for reform to address the weaknesses.

2.7.1 Judicial deference to the medical profession under the Bolam test has largely survived Bolitho

Over the years, academic scholars and judges have been divided on the impact of *Bolitho* in authorising the courts to scrutinise the accepted practice of the medical profession. One of the influential critiques of *Bolitho* is Lord Irvine. Lord Irvine argues extra-curially that although *Bolitho* has signalled a more interventionist approach by the English highest court, his Lordship is unconvinced that the decision will herald any change.[78] His Lordship directs the criticism at the judgment of Lord Browne-Wilkinson which shows deference to the medical profession, particularly the opinion of experts of high standing.[79] Academic scholars also raised similar objections to this part of the ruling. Jones contends that it is wrong to make a prior assumption that the opinion of reputable experts will most likely be regarded as reasonable, where the opinion has not been subjected to detailed analysis of its reasoning in the first place.[80] Finally, the statement of Lord Browne-Wilkinson restricting the courts to reject expert medical opinion in 'rare' cases is also problematic. This part of the ruling, Khan argues, not only undermines the significance of the entire judgment in *Bolitho*, it is also an assurance by the Court that logical basis would be found in most expert medical opinions.[81]

---

78 Lord Irvine, 'The Patient, the Doctor, Their Lawyers and the Judge: Rights and Duties', (1999) 7 *Medical Law Review* 225, 260.

79 Ibid.

80 Michael Jones, 'The *Bolam* Test and the Responsible Expert', (1999) 7 *Torts Law Review* 226, 241.

81 Malcolm Khan, '*Bolitho*—Claimant's Friend or Enemy?', (2001) 20 *Journal of Medicine and Law* 483, 488.

2.7.2 Bolitho has altered judicial deference to the medical profession in the United Kingdom

Conversely, there are extra-curial judicial statements and academic literature stressing the positive impact of *Bolitho* on altering the *Bolam* jurisprudence in the United Kingdom. In his Lordship's Provost lecture,[82] Lord Woolf views *Bolitho* as a representation of a gradual erosion of 'excessive judicial deference' towards the British medical profession.[83] The diminution in this judicial deference, as Lord Woolf reasons, is attributable to the greater awareness of patients' rights and the changed societal values requiring that the medical profession is brought under greater scrutiny.[84] Lord Woolf believes that the 'courts are going to take Lord Browne-Wilkinson's injunction to review the logical basis of the expert medical testimony seriously'.[85]

Some leading scholars are equally supportive that *Bolitho* has significantly altered judicial deference to the medical profession under the *Bolam* test in the United Kingdom.[86] Leading medico-legal scholars such as Kennedy and Grubb hail *Bolitho* as a landmark case for 'reasserting the courts as the final arbiters' of the issue of standard of care in medical negligence cases.[87] This reassertion of the courts, Maclean argues, will enable the courts to evaluate expert medical opinion critically to ensure that the opinion is reasonable.[88] Other leading academics such as Brazier and Miola believe that *Bolitho* would make a difference to the way medical negligence litigation is conducted. They argue that *Bolitho* has put in place a process whereby judges could scrutinise the accepted practice of the medical profession by

---

82 The lecture was held at University College London in 2001.

83 Lord Woolf, 'Are The Courts Excessively Deferential to the Medical Profession?' (2001) 9 *Medical Law Review* 1, 2-4.

84 Ibid. Lord Woolf identified the following as the contributing factors to the diminution in judicial deference to the medical profession: i). the seemingly decline of the standard of care among health professionals as evident from some major medical malpractice cases that were published in the press; ii). The increase in medical litigations which does not correspond with the low success rates in litigation against medical professionals; iii). The increasing awareness of patients' autonomy in health care; iv). The increasing rate of medical litigation shows that doctors and hospitals alike could hardly be relied on in terms of resolving genuine medical complaints fairly; and v). Judges have to deal with fundamental ethical issues in litigation such as the right to terminate life, patient's right to refuse treatment and questions about who should make decisions of best interests on behalf of patients suffering from disability. All these emerging ethical issues have prompted judges to take a more interventionist approach to medical negligence cases:

85 Ibid 10.

86 Margaret Brazier and Jose Miola, 'Bye-bye *Bolam*: A Medical Litigation Revolution?', (2000) 8 *Medical Law Review* 85, 99.

87 Andrew Grubb and Ian Kennedy, 'Consent to Treatment: The Competent Patient' in Andrew Grubb and Ian Kennedy (eds), *Principles of Medical Law* (Oxford University Press, 1st ed, 1998) 109, 173.

88 Alasdair Maclean, above n 40, 208.

using 'the same mixture of common sense and logical analysis' as in negligence claims against other professionals such as architects and accountants.[89]

2.7.3 A critique of the English Bolitho principle

Bolitho is an important decision in the history of the law of medical negligence in the United Kingdom. The decision is significant because it places the courts as the final arbiters of the required standard of care in negligence cases concerning medical diagnosis and treatment. One criticism that may be levelled at *Bolitho*, however, is that it falls short of enabling the courts to conduct a fair and open analysis of expert medical opinion. The main objection to the principle in *Bolitho* is the restrictions placed on the authority of the courts to reject expert medical opinion. In *Bolitho* Lord Browne-Wilkinson made it clear that judges could only reject expert medical opinion in 'rare cases'. This condition gives very little guidance on situations where judges may disregard expert opinion which does not satisfy the test of logic.[90] More significantly, it unnecessarily restricts the power of the courts to intervene even though judges may consider that the opinion of an expert lacks logical basis.[91]

The other limitation of *Bolitho* is that it has left a certain category of expert medical opinion unchecked: the testimonies of distinguished experts. Given that judges are not medically trained, they would have to strongly rely on expert medical opinion in the adjudication of the required standard of care in the areas of diagnosis and treatment.[92] However, it is another thing to overly emphasise the reputation and seniority of medical experts, so much so that standing and credibility of expert witnesses become the parallel conditions to satisfying the test of logic. This position is unsatisfactory. A litigation process that does not provide a thorough scrutiny of expert medical opinion could create a temptation for parties in medical trials to manipulate experts' testimony and escalates the existing problem of experts' bias in the civil justice system.[93] This problem has been judicially recognised in the United Kingdom. In the English Court of Appeal case of *Abbey National*

---

89 Margaret Brazier and Jose Miola, above n 86, 103.

90 See also Harvey Teff, 'The Standard of Care in Medical Negligence—Moving on from *Bolam*', (1998) 18 *Oxford Journal of Legal Studies* 473, 481.

91 Margaret Fordham, 'The *Bolam* Test Lives On: *Bolitho v City and Hackney Health Authority*', [1998] *Singapore Journal of Legal Studies* 140, 148.

92 *Bolitho* [1998] AC 232, 243.

93 Lord Goldsmith, 'Expert Evidence: The Problem or the Solution? The Role of Expert Evidence and Its Regulation', [2007] 2 *Quarterly Law Review* 50, 54. Lord Goldsmith is a retired Attorney-General of England and Wales.

Mortgages v Key Surveyors Nationwide,[94] Sir Thomas Bingham MR observed that in civil actions:

> ' …For whatever reason, and whether consciously or unconsciously, the fact is that expert witness instructed on behalf of parties to litigation often tend, if called as witnesses at all, to espouse the cause of those instructing them to a greater or lesser extent, on occasion becoming more partisan than the parties…'.[95]

It is therefore suggested that *Bolitho* could only make a real difference to the *Bolam* jurisprudence if two restrictions are removed from the principle in this case. One is that the test of logic ought to be applied in all circumstances irrespective of the seniority and standing of the experts. Furthermore, the requirement that judges could only reject expert opinion in 'rare cases' should also be dispensed with. The removal of these restriction would give judges greater liberty to evaluate expert medical opinion with the test of logic and reject opinions which do not withstand the analysis.

2.8 THE SINGAPOREAN VERSION OF THE *BOLITHO* PRINCIPLE

In 2002, the Singaporean Court of Appeal in *Dr Khoo James v Gunapathy d/o Muniandy*[96] revisited the application of the *Bolam* test in medical negligence cases. In this landmark decision, the Court ruled that the *Bolam* test should no longer apply when determining the standard of care in the areas of diagnosis and treatment. The Court instead adopted the English *Bolitho* principle, but with certain modification. The following section analyses how the *Bolitho* principle was transplanted into Singaporean medical negligence jurisprudence by the Court in *Gunapathy*.

2.8.1 The Singaporean High Court

The case of *Gunapathy* involved a sad medical incident. In this case, Mrs Gunapathy suffered from brain cancer. She was treated by Dr Khoo James who performed open brain surgery to remove the brain tumour in October 1995. Following the surgery, an MRI scan was

---

94 [1996] 3 All ER 184.
95 Ibid 191.
96 [2002] 2 SLR 414 (*Gunapathy*).

conducted in February 1996. This scan revealed a small nodule in the area where the tumour was removed. The radiologist took the view that the nodule was a scar from the surgical operation and recommended no further action to be taken. Dr Khoo James, on the other hand, diagnosed it a remnant tumour and recommended radiosurgery.[97] There was no pathology examination of the lesion to clarify whether it was a tumour. The radiosurgery was performed by Dr Khoo and two other specialists in January 1997. Two months after the procedure, Mrs Gunapathy suffered from serious physical and mental disabilities. She sued, among others, Dr Khoo James for medical negligence alleging that the doctor had given misleading advice, misdiagnosed her medical condition and administered wrongful medical treatment. The following analysis only deals with the issues of diagnosis and treatment.

The main issue before the Singaporean High Court was whether the lesion was a scar or a tumour. There were divided opinions on this question. An expert, called at the request of the trial judge to testify for Mrs Gunapathty, was of the opinion that there was no significant change in the size of the lesion but without offering any conclusion whether the nodule was a scar or tumour. On the other hand, all the defence experts agreed that the nodule had grown and thus took the view that the lesion was a tumour. These experts also testified that the benefit of performing the radiosurgery by Dr Khoo outweighed the risk of not removing the tumour, which they considered to be a rare case in Singapore. In support of this opinion, they relied on two protocols which had yet to be widely used by neurosurgeons in Singapore due to their novelty. One of the protocols was supplied by an American company which manufactured the machine used in the radiosurgery.[98] The other was provided to Dr Khoo during his four-day training course in Sydney, Australia in October 1996. The course was organised by the American manufacturer. Mrs Gunapathy's experts, on the other hand, relied on a protocol which was sent out to all neurosurgeons in Singapore in 1998 which stated that radiosurgery was an inappropriate treatment in the circumstances.

In applying the *Bolam* test, the High Court accepted the testimony of the court-appointed expert that the lesion did not enlarge in size during the period between the identification of the lesion in February 1996 and the performance of the radiosurgery in

---

97 Radiosurgery is a one-shot treatment procedure which involves the application of a high dose radiation to the exact location of the tumour.

98 This machine was stated as a newly developed technology and was acquired by Mount Elizabeth Hospital in September 1996, a Singaporean private hospital at which Dr Khoo practised as a neurosurgeon.

January 1997. Based on this evidence, the trial judge concluded that the nodule was a scar and dismissed the opinions of all the defence expert witnesses. Following this reasoning, the High Court ruled that no responsible practitioner would have recommended radiosurgery in similar circumstances. The trial judge also found that Dr Khoo had used an excessive dosage of radioactive substance during the course of the surgery. The Court therefore held that Dr Khoo James was negligent for, *inter alia*, misdiagnosing Mrs Gunapathy's illness and providing inappropriate medical treatment to her. Dr Khoo appealed these decisions to the Court of Appeal.

2.8.2 The Singaporean Court of Appeal

The key issue confronting the Court of Appeal was whether the trial judge had wrongly applied the *Bolam* test to question of fact and concluded that the nodule was a scar and not a tumour. The analysis of the Court began with a review of the legal status of the *Bolam* test in medical negligence cases in Singapore. The Court compared the *Bolam* test as established by a series of House of Lords[99] and Privy Council[100] cases with the qualified version of the test as articulated by Lord Browne-Wilkinson in *Bolitho*. In concluding that the latter principle is the preferred formulation for Singapore, Yong Pung How CJ, who delivered the unanimous judgment of the Court,[101] gave the following justifications:

> 'In our view, *Bolitho* presented a timely addendum to the *Bolam* test. It gave voice to a commonsense understanding which was hitherto unexpressed – that the *Bolam* test did not represent immunity from judicial inquiry over the medical process. It was not to be satisfied by the production of a dubious expert whose professional views existed at the fringe of medical consciousness. An expert view, in order to qualify as representative of a 'responsible' body of medical opinion, had to satisfy the threshold test of logic.'[102]

This passage suggests two main rationales for substituting the *Bolam* test for its qualified version under the *Bolitho* principle in Singapore. The Court of Appeal was of the view that the *Bolam* test absolves judges of the responsibility of scrutinising the accepted practices of

---

99 *Whitehouse* [1981] 1 All ER 267, 277 (Lord Edmund-Davies), *Maynard* [1985] 1 All ER 635, 638 (Lord Scarman) and *Sidaway* [1985] AC 871, 881 (Lord Scarman) and 895 (Lord Diplock).

100 *Chin Keow v Government of Malaysia* [1967] 2 MLJ 45.

101 With whom Chao Hick Tin JA and Tan Lee Meng J concurred.

102 [2002] 2 SLR 414, 433.

the medical profession. The other reason was that the principle in *Bolitho* provides a mechanism by which the courts may assess expert medical opinion to determine whether it is a responsible body of medical opinion.

The Court of Appeal defined the ambit of the Singaporean version of the *Bolitho* principle. Yong CJ reiterated that the 'logical basis' test involves a two-stage inquiry. The first question to be considered is whether the expert opinion that supports the case of a defendant doctor has undertaken a comparative risk and benefit analysis relating to the matter in a given case.[103] This inquiry is to be adjudicated by the courts to ensure that the expert witnesses have considered and weighed all the countervailing factors relevant to the issue. The second stage of inquiry requires the courts to consider whether the opinion arrived at by a medical expert constitutes a defensible conclusion.[104]

The Court placed two limitations on the requirement for 'defensible conclusion' under the 'logical basis' test. According to Yong CJ, the term 'defensible conclusion' that applies in Singapore requires the courts to be satisfied of two criteria. The first is that the medical opinion must be internally consistent.[105] The second demands that the opinion must accord with extrinsic facts, for instance, proven medical information or new developments in medical science.[106] Yong CJ justified the imposition of these restrictions on the grounds that the open-texture of the term 'defensible conclusion' would enable judges to overly intervene in the practice of the medical profession:

> '... Interpreted liberally, *Bolitho* could unwittingly herald invasive inquiry into the merits of medical opinion. For if 'defensible' were to be given a meaning akin to 'reasonable', the *Bolam* test would only be honoured in lip service. A doctor would then be liable when his view, as represented by the defence experts, was found by the court to be unreasonable. We do not think this was the intention of House of Lords in *Bolitho*...'.[107]

---

103 Ibid.
104 Ibid.
105 Ibid 433-434.
106 Ibid 434.
107 Ibid 433.

These statements indicate a more restrictive interpretation of 'defensible conclusion' than the case of *Bolitho* itself.[108] It is worthwhile to probe into the justifications for this reasoning.

The Court of Appeal proffered two reasons for tightening up the requirement for 'defensible conclusion' under the *Bolitho* principle. It was concerned about the problem of excessive judicial intervention if judges are left to make conclusions as to the reasonableness or defensibility of expert medical opinion without clear guidance. An overly interventionist approach, the Court stated, would lead to the spectre of 'defensive medicine', bringing about the adverse consequences of rising medical costs and 'wastage of precious medical resources'.[109] The other rationale for tightening up the 'defensible conclusion' requirement is the argument of lack of expertise among judges. This limitation is particularly acute in the areas of diagnosis and treatment where the issues involved are often 'complex and resolvable only by long-term research and empirical observation'.[110] This concern was re-emphasised by Yong CJ with these strong cautionary remarks:

> '... In determining whether a doctor has breached the duty of care owed to his patient, a judge will not find him negligent as long as there is a responsible body of medical opinion, logically held, that supports his actions... It would be pure humbug for a judge, in the rarified [sic] atmosphere of the courtroom and with the benefit of hindsight, to substitute his opinion for that of the doctor in the consultation room or operating chamber. We often enough tell doctors not to play God; it seems only fair that, similarly judges and lawyers should not play at being doctors'.[111]

Finally, the Court addressed the right of the trial judge in *Gunapathy* to make a finding of fact. Yong CJ reiterated the well-settled principle that a question of fact does not fall within the province of either the *Bolam* test or its qualified version, citing the English Court of Appeal decision in *Penney v East Kent Health Authority*.[112] In examining the issue whether the High Court erred in making the finding that the nodule was a tumour and not a scar, his Honour also compared the facts in *Penney* with *Gunapathy*. In *Penney*, the appellant

---

108 Kumaralingam Amirthalingam, 'Judging Doctors and Diagnosis the Law: *Bolam* Rules in Singapore and Malaysia', [2003] *Singapore Journal of Legal Studies* 125, 137.

109 *Gunapathy* [2002] 2 SLR 414, 454.

110 Ibid.

111 Ibid 419.

112 [2000] Lloyd's Rep Med 41.

underwent a cervical smear test. The cytology screeners who were employed by the respondent failed to diagnose the specimen of the appellant as cancerous. She subsequently developed cervical cancer. In *Penney* Lord Woolf MR held that the question of what was to be seen on the slides was a question of fact and could be adjudicated by the trial judge. His Lordship found the trial judge had, after hearing expert evidence, rightly made his finding based on the balance of probabilities that the specimen on the slides was cancerous.

Turning back to the appeal in *Gunapathy*, Yong CJ stated that the issue as to whether the nodule was a scar was a question of diagnosis which should have been ultimately concluded by medical experts instead of by the trial judge. On this basis, his Honour found that the trial judge had applied the wrong 'method of reasoning' which would otherwise 'surreptitiously import into *Bolam* by the back door a practice of adjudicating between medical experts on a balance of probabilities'.[113] Accordingly, the Singaporean Court of Appeal accepted the evidence of the defence experts that the lesion was a tumour and their risk and benefit analysis supporting the radiosurgery was defensible. In conclusion, the Court overturned the trial judge's findings of negligence in diagnosis and treatment.[114]

2.9 THE SINGAPOREAN AND ENGLISH VERSIONS OF THE *BOLITHO* PRINCIPLES: A COMPARATIVE ANALYSIS

The preceding section has shown that there have been a number of modifications of the Singaporean version of the *Bolitho* principle. The following analysis identifies the differences between the *Bolitho* principles in the United Kingdom and in Singapore, and their respective implications for each of the jurisdictions.

2.9.1 The authority to question expert medical opinion

Comparatively, English judges have greater authority than their Singaporean counterparts to question expert medical opinion based on the 'logical basis' test. This is because the Court of Appeal in *Gunapathy* has interpreted the requirement for 'defensible conclusion' under the

113 *Gunapathy* [2002] 2 SLR 414, 435-436.

114 Ibid 454. The Court affirmed the application of the *Bolam* test in negligent advice cases in Singapore. On the facts, since the information that was disclosed by the appellant to Mrs Gunapathy before the radiosurgery was supported by a respectable body of medical opinion, the Court of Appeal held that the appellant 'had not given negligent advice'.

'logical basis' test more restrictively than in the case of *Bolitho* itself.[115] In *Gunapathy*, Singaporean judges have been specifically reminded that no findings about the reasonableness of expert testimonies should be made under the criterion of 'defensible conclusion'. Instead, they have to evaluate the defensibility of expert medical opinion in accordance with the strict guidelines that were spelt out by the Court of Appeal in *Gunapathy*. Within the ambit of the guidelines, judges in Singapore are only allowed to analyse the internal consistency of expert medical opinion and to ensure that this opinion is supported by extrinsic medical facts or advances in medical science.[116] English judges are not restricted by these limitations.

2.9.2 The right of judges to reject expert medical opinion

With regard to rejection of expert medical opinion for want of 'logical basis', English judges may be less likely to exercise this authority than their Singaporean counterparts. This is due to two limitations in the judgment of *Bolitho*. One of the limitations is the statement of Lord Browne-Wilkinson that the power to reject expert medical opinion should only be exercised in rare cases:

> '... I emphasise that, in my view, it will *very seldom* be right for a judge to reason the conclusion that views genuinely held by a competent medical expert are unreasonable...'.[117] (*emphasis added*)

The other constraint in English *Bolitho* principle is the presupposition of Lord Browne-Wilkinson that the opinion of 'distinguished experts' would 'in a vast majority of cases' be considered as reasonable. In contrast, both constraints are absent in the judgment of Yong CJ in *Gunapathy*. The ramification of the position in Singapore is that judges in this jurisdiction have more liberty than the English courts to dismiss expert medical opinion which does not satisfy the 'logical basis' test. All medical evidence will be subject to logical analysis irrespective of the seniority and reputation of the experts. In this regard, it may be stated that the Singaporean version of the *Bolitho* principle does not impose undue exercise of judicial deference to expert medical opinion.

---

115 Kumaralingam Amirthalingam, above n 108, 137.
116 *Gunapathy* [2002] 2 SLR 414, 433-434.
117 [1998] AC 232, 243.

2.9.3 A critique of the Bolitho principles in Singapore and the United Kingdom

The *Bolitho* principle as interpreted by the Court of Appeal in *Gunapthy* is arguably a preferable model than the original English version as it contains a clear mechanism to assist judges to evaluate the defensibility of expert medical opinion. A number of academic scholars, however, criticise the judicial functions under the Singaporean version of the *Bolitho* principle as too limited.[118] Sim, in particular, suggests that the power of judges to reject expert medical opinion under the requirement for 'defensible conclusion' should be broadened to encompass cases where the weighing up of risk and benefit involve 'social, moral and political values of society'.[119] Although these matters are within the expertise of judges to adjudicate, this proposal would likely lead to arbitrary setting of medical standards. This is because individual judges understandably have different views on societal, moral and political values. There is also the question as to how judges should gather credible information about the public perception of these issues. The preferable approach would be to leave the assessment of risk and benefit entirely to the medical experts, or in general, the medical profession.

2.10 CONCLUSION

This chapter has provided an analysis of the historical development of the *Bolam* test in the United Kingdom and of how the *Bolam* test was qualified by the House of Lords case of *Bolitho* in 1997. In tracing the development of the *Bolam* test, this chapter has found that the test was founded upon the notion of reasonable care and skill. This doctrine requires the courts to use the standard of ordinary skilled doctors as the benchmark for determining the standard of care in diagnosis and treatment. However, subsequent interpretation of the *Bolam* test in the United Kingdom demonstrated that expert medical opinion was conclusive on the issue of breach of duty of care, thus absolving the courts of the responsibility to have the final say on the matter. This legal position became uncertain with the emergence of a small minority of English Court of Appeal cases in the 1990s, in which judges examined the merits of expert medical opinions and made conclusions as to whether these opinions constituted 'a responsible body of medical opinion'.

---

118 Kumaralingam Amirthalingam, above n 108, 137; Kelvin Low Fatt Kin and Lee Yuan Zhen, '*Bolam* in Singapore: Special Treatment for Doctors?', [2003] *Singapore Journal of Legal Studies* 610, 630; Disa Sim, '*Dr Khoo James & Anor v Gunapathy d/o Muniandy and Another Appeal*: Implications for the Evaluation of Expert Testimony', [2003] *Singapore Journal of Legal Studies* 601, 604-605.

119 Disa Sim, above n 118, 604-605.

The ambiguity in the law was resolved in 1997 by the House of Lords in *Bolitho*. The highest English court has qualified the *Bolam* test with the condition that judges must be satisfied that expert medical opinion has a 'logical basis'. The 'logical basis' test consists of two parts. Medical experts will make an assessment of risk and benefit. The defensibility of the analysis will be determined by the courts. There are two sides to the argument by academic scholars and judges alike commenting on the impact of *Bolitho* on the long-standing judicial attitude of showing deference to the medical profession under the *Bolam* test. This chapter takes the view that *Bolitho* falls short of providing a real impact on the *Bolam* test due to two limitations in its principle: the presupposition that the opinions of distinguished experts are more likely to be considered as reasonable, and that expert medical opinion can only be rejected in rare cases. It has been suggested in this chapter that both restrictions ought to be removed so as to create a level playing field in the adjudication of the standard of care in the areas of diagnosis and treatment.

An important development in Singapore, Malaysia's closest common law neighbour, took place in 2002 with the adoption of the *Bolitho* principle as the basis for determining the issue of breach of duty of care in medical diagnosis and treatment. The analysis has found that judicial functions under the Singaporean version of the *Bolitho* principle are more restrictive than under its original English version. The distinction between the two rests on the limited role played by Singaporean judges in evaluating the defensibility of expert medical opinion. Although most Singaporean scholars have argued that the responsibility of judges should be widened, this chapter has contended that any attempt to widen the existing ambit would lead to arbitrary setting of medical standards. It was argued that the *Bolitho* principle in Singapore is preferable to that in the United Kingdom as the former allows a systematic and fairer evaluation of expert medical opinion.

Consistent with the development in Singapore, another Commonwealth jurisdiction, Australia, has also implemented the qualified *Bolam* test under the *Bolitho* principle. The significant feature of the Australian model is that it is codified in legislation. All but the Australian Capital Territory and Northern Territory adopted the legislative changes to replace the common law between 2002 and 2004. The following three chapters examine the developments leading to the legislative reform in Australia. The analysis, however, begins with the common law position prior to the legal reform, which as it stands, is still applicable in the Australian Territories.

CHAPTER 3
THE COMMON LAW POSITION IN AUSTRALIA

3.1 INTRODUCTION

In Australia it is well-established under the common law that the standard of care of medical practitioners in diagnosis and treatment is determined by reference to the conduct of 'ordinary skilled doctors exercising and professing that special skill [in question]'.[1] Since the late 1970s Australian judges have disapproved the *Bolam* test in medical negligence cases concerning issues of diagnosis and treatment. They have taken the view that evidence of compliance with acceptable medical practices, though relevant, is not conclusive of the issue of negligence. This approach was later affirmed in the 1990s as the settled legal principle in Australian medical negligence law.

The common law position on the standard of care in diagnosis and treatment in Australia is different from that of the principle as espoused by the English House of Lords decision in *Bolitho v City and Hackney Health Authority*.[2] Under the English position, judges have to defer to medical opinion in the adjudication of the standard of care in diagnosis and treatment,[3] save for in a 'rare case'.[4] By contrast, the courts in Australia are 'not necessarily bound by what a reasonably competent body of practitioners would have done' in similar circumstances.[5] This is because Australian judges take the approach that medical opinion or customary clinical practice, although relevant, is nonetheless not determinative of the question of negligence in cases of diagnosis and treatment.[6]

Since 2002, however, the Australian common law standard of care in medical diagnosis and treatment has largely been replaced by statutes. In early 2002 the Australian Commonwealth Government established the Ipp Review Committee to reassess, among other things, the legal principle on the doctors' standard of care in diagnosis and treatment under the common law. At the end of its inquiry, the Ipp Review Committee recommended the

---

1 *Naxakis v Western General Hospital* (1999) 197 CLR 269, 275 (Gaudron J) and 297-298 (Kirby J) (*Naxakis*).

2 [1998] AC 232 (*Bolitho*).

3 See also Barbara McDonald, 'The Common Law of Negligence', (2003) 17(2) (June-August) *Commercial Law Quarterly* 12, 26.

4 *Bolitho* [1998] AC 232, 243.

5 John A Devereux, *Australian Medical Law* (Routledge-Cavendish, 3rd ed, 2007) 315.

6 *Naxakis* (1999) 197 CLR 269, 275-276 (Gaudron J), 285-286 (McHugh J) and 297-298 (Kirby J).

reintroduction of the *Bolam* test with certain modifications to be implemented in statutory form. The proposed test is similar, but not identical, to the *Bolam* test. The Australian states, but not the Australian Capital Territory and Northern Territory, subsequently implemented the suggested modified *Bolam* test in their respective *Civil Liability Acts*. All of these are discussed in the following chapters.

This chapter confines its analysis to the common law position prior to these statutory enactments. Although the law on the standard of care in Australia is largely statutory in nature, an examination of the common law principle is significant for two reasons. First, it provides an insight into understanding the legal development and how it relates to the subsequent statutory reform that was undertaken by six Australian State jurisdictions. Second, an evaluation of the common law jurisprudence remains relevant in two Australian Territories which did not opt for statutory reform to implement the modified *Bolam* test.

The analysis in this chapter is divided into two parts. The first section traces the development of common law in Australia relating to the standard of care in medical diagnosis and treatment before as well as leading up to the watershed decision in *Naxakis v Western General Hospital*.[7] The decision in *Naxakis* is significant because it is thus far the first and only Australian High Court decision that explicitly disapproved the *Bolam* test in the areas of diagnosis and treatment. The second section specifically deals with the case of *Naxakis*. It explores the reasoning of the High Court justices and makes some criticisms of the decision in *Naxakis*. It argues that the common law position as articulated by the High Court in *Naxakis* is ambiguous and lacks cohesiveness in its pronouncement. More significantly, the effects of the decision could expose medical practitioners to unnecessary risk of malpractice suits. These criticisms arguably form part of the justification for the statutory changes in the law by the Ipp Review Committee.

3.2 THE HISTORICAL DEVELOPMENT

Since the 1960s, Australian judges have made it clear that accepted practice of a profession or trade is generally not conclusive of the issue of negligence.[8] The extension of this principle to

---

7 (1999) 197 CLR 269 (*Naxakis*).

8 *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588, 593 (Barwick CJ, with whom Kitto, Taylor, Menzies JJ concurred) and 601 (Windeyer J). The Australian High Court in this case dealt with the customary practice of architects.

the spheres of medical diagnosis and treatment in Australia was evident in the 1970s, and may be traced to the South Australian Supreme Court decision in *Goode v Nash*.[9]

3.2.1 Goode v Nash

The defendant doctor in *Goode* was sued for negligence when conducting a public screening for the detection of glaucoma. The tests were conducted by placing a tonometer on the eye. The tonometer was sterilised by placing it in a flame between each test to prevent cross-infection from one person to another. In the case of the plaintiff, the tonometer was not cooled sufficiently after it had been sterilised. As a result, the plaintiff suffered a burn and subsequently permanent injury to his eye. Evidence was adduced by the defendant doctor that the diagnostic procedure was a common practice at the material time and that the incident had never occurred in his prior experience. The justices of the South Australian Supreme Court[10] in *Goode* held the defendant doctor liable for negligence despite the latter's compliance with established diagnostic procedure.

The Court's reasoning in *Goode* was based on the Canadian Supreme Court decision in *Anderson v Chasney*.[11] The Court in *Anderson* took the view that expert medical opinion could not be taken as conclusive evidence of negligence or otherwise particularly in areas which judges were capable of evaluating the opinion. One such issue was the adequacy of safety precautions in medical procedures. Expert evidence may be needed to illuminate the extent of a particular risk. Having understood the nature of the risk, the courts might be able to evaluate whether a defendant doctor has taken sufficient preventive measures to eliminate the risk. The Canadian Supreme Court in *Anderson* unanimously stated the principle as follows:

> 'Expert evidence as to general or approved practice, e.g. by physicians or surgeons, cannot be accepted as conclusive on an issue of negligence, especially where the conduct in question does not involve a matter of technical skill and experience but rather the taking of proper precautions in regard to something on which the ordinary person is competent to determine whether there has been

---

9 (1979) 21 SASR 419 (*Goode*).

10 They were Hogarth, Jacobs and Mohr JJ.

11 [1950] 4 DLR 223 (*Anderson*).

carelessness or not, *e.g.*, failure to remove a sponge used in a tonsil and adenoid operation'.[12]

Based on this passage, the Court in *Goode* took the approach of scrutinising the diagnostic test against the sufficiency of preventive steps to avoid risk of injury. It found that the defendant had failed to take safeguard measures to ensure that the screening instrument 'was not too hot to place upon the patient's eye'.[13]

3.2.2 Albrighton v Royal Prince Alfred Hospital

The approach taken by the justices in *Goode* was later adopted in the New South Wales Court of Appeal case of *Albrighton v Royal Prince Alfred Hospital*,[14] although the appellate court did not cite the South Australian Supreme Court decision. In *Albrighton* the appellant was born with a deformity in her spine. In addition, her spinal cord was tethered to the adjacent structures. This later condition carried the risk of rupture of the spinal cord if traction was applied. In 1971 the appellant was admitted to the first respondent hospital for corrective surgery to straighten and lengthen her spine. The surgical operation involved a procedure known as halo-pelvic traction. A few days after the surgery was conducted, the traction severed the appellant's spinal cord and she became paraplegic. The appellant sued, among others, the second respondent doctor for wrongful surgical procedure.

At the trial, the appellant called a highly qualified British neurologist to give evidence to support her case of negligence against the second respondent doctor. The trial judge admitted the opinion of the foreign witness on the anatomy, the significance of the appellant's symptoms and the risks associated with the traction procedure. The judge, however, precluded this expert from giving evidence as to what 'could or ought to be done' in cases where there was a tethering of the spinal cord because he had never practiced in Sydney.[15] At the end of the trial, the judge withdrew the case against the second respondent doctor on the ground that there was insufficient evidence to establish a breach of the latter's duty of care.

---

12 Ibid 223 (Rinfret CJ as well as Taschereau, Rand, Kellock and Locke JJ). This passage was cited in *Goode* (1979) 21 SASR 419, 423.

13 *Goode* (1979) 21 SASR 419, 423.

14 [1980] 2 NSWLR 542 (*Albrighton*).

15 Ibid 562 (As quoted by Reynolds J).

There were a number of issues raised in the New South Wales Court of Appeal in *Albrighton*. One particular matter that is relevant to the present discussion was the question of admissibility of medical opinion by the British neurologist. The second respondent doctor submitted that the testimony of the medical expert should not have been admitted at all because the witness had no knowledge of the customary medical practice in Sydney.

The Court of Appeal allowed the appeal on the ground that there was adequate evidence to refer the case against the second respondent doctor to the jury. In particular, the Court held that the testimony of the appellant's British medical expert should have been admitted fully. That would include the testimony pertaining to the measures which 'could or should be taken' to avoid risk or injury.[16] Reynolds JA, with whom other justices of the Court agreed,[17] stated that evidence of the customary practice of doctors in Sydney was not conclusive of the question of negligence.[18] That was because the medical practitioners in the locality could have 'habitually' failed 'to take an available precaution to avoid foreseeable risk or injury to their patients'.[19] Rather, the main consideration was whether, in the Court's view, a particular treatment should or should not have been administered.[20] The Court of Appeal accordingly ordered a new trial.

3.2.3 Rogers v Whitaker

In the early 1990s, there were judicial statements from the highest court in Australia that accepted medical practice was not conclusive of the issue of medical negligence, not least in the area of disclosure of risk. This development took place in the Australian High Court decision in *Rogers v Whitaker*.[21] Although *Rogers* specifically dealt with the issue of duty to warn, the decision is arguably significant to the areas of medical diagnosis and treatment for two reasons. Firstly, *Rogers* heralded a less deferential judicial approach towards expert medical opinion in the Australian High Court. Secondly, *Rogers* highlighted the fundamental concept that underscores the doctors' duty to diagnose and treat patients. In particular, the Court explained how the theoretical bases of both branches of the doctors' duty of care

16 Ibid.
17 Namely Hope and Hutley JJ.
18 *Albrighton* [1980] 2 NSWLR 542, 563.
19 Ibid 562.
20 Ibid 563.
21 (1992) 175 CLR 479 (*Rogers*).

determine the required standard of care in medical negligence cases of diagnosis and treatment.

The appellant doctor in *Rogers* was sued for negligence for failing to disclose a remote risk of developing sympathetic opthalmia[22] in eye surgery to the respondent. The risk was estimated at approximately 1 in 14,000. The surgery was intended to restore the eyesight of Mrs Whitaker's right eye which she lost when she was a child. The surgical operation was skilfully performed but the respondent nonetheless developed sympathetic opthalmia, a condition adversely affecting her good eye. This has resulted in total blindness in both eyes. The major argument of the appellant's defence was that the omission to warn of the medical risk was in accordance with a body of medical opinion at the material time.

The Court made it clear that the duty of care of doctors in Australia comprises of a 'single comprehensive duty' to diagnose, treat and provide patients with information of medical risks.[23] The duty of care is discharged by exercising reasonable care and skill.[24] The standard of reasonableness is that of the 'skilled person exercising and professing to have that special skill'.[25] On the issue of disclosure of risks, the High Court held that doctors have a duty to warn patients of all material risks that are inherent in a proposed medical treatment.[26] Evidence of common medical practice is only 'a useful guide for the courts'.[27] Ultimately, it is the courts which will make the final decision as to the amount of information that the medical practitioners should disclose to their patients.[28]

In a strong joint judgment, the majority of the High Court[29] drew an important conceptual distinction between the doctors' duty to provide advice on the one hand, and

---

22 Sympathetic opthalmia is a kind of eye inflammation of both eyes following a trauma to one eye. Symptoms may develop from days to several years after a penetrating eye injury. It can leave patient completely blind.

23 Ibid 489 and 492.

24 Ibid 483 and 492.

25 Ibid.

26 Ibid 490.

27 Ibid 487.

28 Ibid 487-490. In establishing this principle, the High Court in *Rogers* endorsed a line of Australian lower court cases which rejected the *Bolam* test, namely *F v R* (1984) 33 SASR 189, 192-194 (disclosure of risks); *Battersby v Tottman* (1985) 37 SASR 524, 527, 534 and 539-540 (disclosure of risks); *Albrighton* [1980] 2 NSWLR 542, 562-563 (treatment); *E v Australian Red Cross* (1991) 27 FCR 310, 357-360 (diagnosis); the Canadian case of *Reibl v Hughes* (1981) 114 DLR (3d) 1, 13.

29 The joint judgment was delivered by Mason CJ, Brennan, Dawson, Toohey and McHugh JJ. Gaudron J gave a single minority judgment. The seventh member of the full, Deane J, did not participate in this case due to eye illness.

diagnosis and treatment on the other.[30] In respect of the doctor's duty to inform patients of medical risks, the obligation extends to the issue of the patients' consent. In the legal context, the consent would only be valid if the patient is informed of the nature of the intended diagnosis procedure or medical treatment. The patient's choice calls for consideration of information that is known to the medical practitioner and the decision made by the patient. On this basis, the Court stated that it would be inappropriate to determine the amount of information to be provided from the perspective of the practitioner alone.[31] The High Court, therefore, held that the issue of materiality of risks should be considered from the position of a 'reasonable patient' or 'a particular patient'.[32] In addition, all the circumstance of the case must be taken into account when determining whether any information can be concluded as a material risk. They include '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 circumstance'.[33]

The majority of the Court in *Rogers*, on the other hand, stressed that the role of doctors in the areas of diagnosis and treatment is far more significant than that of patients. In diagnosis and treatment, the patient's contribution is limited only to the narration of symptoms and relevant history. Based on the information, the medical practitioner would diagnose and treat the patient according to his or her skill.[34] Since the patient's involvement in the process of diagnosis and treatment is trivial, the question of whether a medical practitioner has breached the duty of care should, therefore, be judged against the standard of reasonableness of the profession.[35] In other words, expert medical opinion 'will have an influential, often a decisive, role to play' in the adjudication of the standard of care in both spheres of medicine.[36] The only issue that the majority did not elaborate, however, was whether the courts should be given the ultimatum to decide the outcome of medical disputes in diagnosis and treatment. This omission might be due to the facts in *Rogers* which related primarily to issue of disclosure of material risk.

---

30 *Rogers* (1992) 175 CLR 479, 489.

31 Ibid.

32 Ibid 490. The High Court in *Rogers* held that a risk is material if:

i) A reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it ('reasonable patient'); OR

ii) The medical practitioner is or should reasonably be aware that the patient, if warned of the risk, would be likely to attach significance to it ('the particular patient').

33 Ibid. The Court cited the judgment of King CJ in *F v R* (1984) 33 SASR 189, 192-193.

34 *Rogers* (1992) 175 CLR 479, 489.

35 Ibid 491.

36 Ibid.

In contrast, Gaudron J in *Rogers* explicitly rejected the *Bolam* test in all aspects of the doctors' duty of care.[37] In her Honour's minority judgment, Gaudron J conceded that medical experts' opinion of diagnosis and treatment 'is of very considerable significance'.[38] However, Gaudron J saw 'no legal basis for limiting the liability' of doctors by the application of the *Bolam* test. In her Honours' view, there are matters, particularly in diagnosis and treatment, of which judges are capable to adjudicate.[39] For instance, questions as to the 'nature of particular risks and their foreseeability' and 'reasonableness of particular precautionary measures'.[40] These issues are 'often matters of simple commonsense' which do not require medical expertise for judicial evaluation.[41]

3.2.4 Lowns v Woods

After the case of *Rogers*, there was disagreement at the lower courts as to whether the rejection of the *Bolam* test equally extended to the doctors' duty to diagnose and treat patients. In *Lowns v Woods*,[42] the New South Wales Court of Appeal did not regard the decision in *Rogers* as limiting the disapproval of the *Bolam* formulation only to cases of warning of medical risks. Kirby P was of the view that the principle in *Rogers* was 'one of general application, governing the relevant communications between a medical practitioner and a patient'.[43] The other member of the Court, Mahoney JA, stated that 'this Court may substitute its conclusion as to what a duty requires for that of the medical profession'.[44] However, his Honour cautioned that judges should be slow to intervene in clinical decisions which involve technical matters such as 'the weighing up of advantages and disadvantages' and 'medical necessities'.[45] These judgments suggest that the Australian High Court in *Rogers* might have rejected the *Bolam* test in the areas of diagnosis and treatment, although the Court in *Lowns* qualified that judges should give considerable weight to expert medical opinion in the adjudication of the required standard of care.

---

37 Ibid.
38 Ibid 493.
39 Ibid.
40 Ibid.
41 Ibid.
42 (1996) Aust Torts Report 81-376, 63,151.
43 Ibid 63,157.
44 Ibid 63,165.
45 Ibid.

3.2.5 Howarth v Adey

The interpretation of the decision in *Rogers* by the justices in *Lowns* was in stark contrast to that in the case of *Howarth v Adey*.[46] In *Howarth*, the Victorian Court of Appeal was of the view that the English *Bolam* test was still applicable to cases of negligent diagnosis and treatment despite the decision in *Rogers*. Winneke P put the legal position as follows:

> 'In the case of negligent treatment and medical management, the principles explained and defined in the *Bolam* case apply; the applicable standard of care is a matter for medical judgment [sic] in the sense that a doctor is not negligent if he acts in accordance with a practice accepted at the relevant time as proper by a responsible body of medical opinion, even though other doctors adopt a different practice: *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871. However, in the area of alleged negligence by reason of failure to disclose material risks or of providing relevant information and advice, the applicable principle is that, whilst accepted medical practice is a useful guide, it is ultimately for the tribunal and not the medical profession to decide what conduct the appropriate standard of care required: *Rogers v Whitaker* at 487-9; *Sidaway's* case at 881, per Lord Scarman'.[47]

In comparison, the interpretation of *Rogers* given in *Howarth* is arguably more appropriate than in *Lowns* as the Australian High Court in *Rogers* dealt solely with the issue of disclosure of risk. It follows that any endorsement of a rejection of the *Bolam* test in the spheres of medical diagnosis and treatment in *Rogers* could not be considered as a *ratio*.

3.2.6 Naxakis v Western General Hospital

More significant development took place in the late 1990s when the Australian High Court in *Naxakis* resolved the ambiguity in the status of the *Bolam* in cases concerning negligent diagnosis and treatment. The facts of *Naxakis* related to alleged misdiagnosis and failure to treat. The appellant in *Naxakis* was a twelve year old boy who had suffered a head injury and was admitted to the first respondent hospital. At the hospital, the appellant was under the care of Dr Jensen, the second respondent doctor, a neurosurgeon. Dr Jensen treated the appellant

---

46 [1996] 2 VR 535 (*Howarth*).

47 Ibid 547.

for a subarachnoid haemorrhage. He did not order an angiogram to check for the possibility of a burst aneurysm.[48] The appellant collapsed two days after he was discharged and was later admitted to another hospital. In the latter hospital, it was discovered that the appellant had a major intracranial bleed from a burst aneurism. The appellant suffered permanent physical and intellectual impairment despite having undergone a surgical operation to stem the bleeding.

The appellant alleged a number of claims in an action for negligence against, *inter alia*, Dr Jensen. However, three allegations were important on the standard of care in diagnosis and treatment. One of them was that the doctor had failed to consider alternative diagnosis.[49] The other concerned the omission to perform an angiogram to establish the cause of the appellant's condition. The third allegation was the failure of the doctor to continue or maintain treatment of the appellant in the face of ongoing symptoms.[50] At first instance, the trial judge dismissed the appellant's action on two grounds that dealt with the issue of misdiagnosis.[51] First, there was an 'overwhelming body of evidence' which suggested that Dr Jensen 'was not at fault in persisting with his diagnosis of traumatic subarachnoid haemorrhage'. Second, the fact that 'not one medical witness said that ... he ... would have ordered an angiogram and none suggested that the failure to order an angiogram was in any way open to criticism'.[52] At the appeal stage, the High Court,[53] however, ordered a new trial on the basis that the jury should have been left to decide the issue of breach of duty of care.[54]

The significance of the decision in *Naxakis* lies in two aspects. The first is the High Court's expressed disapproval of the *Bolam* test in the doctors' duty of care in diagnosis and treatment. The Court held that even though there was overwhelming medical opinion in support of Dr Jensen, the evidence in itself was not conclusive of the issue of liability for negligence. The Court reiterated that the standard of care of doctors is that of 'the ordinary

---

48 An angiogram involves the injection of material into the arteries of the brain so that they can be outlined on X-ray.

49 *Naxakis* (1999) 197 CLR 269, 276 (As quoted by Gaudron J).

50 Ibid.

51 Ibid 273 (As quoted by Gaudron J).

52 Ibid.

53 The High Court judges consisted of Gleeson CJ, Gaudron, McHugh, Kirby and Callinan JJ. Gleeson CJ only delivered a brief judgment.

54 The case was settled out of court after further interlocutory proceedings and before the new trial commenced. See Harold Luntz, '*Rogers v Whitaker*: the Aftermath', (2003) 11(9) *Australian Health Law Bulletin* 102, 103.

skilled person exercising and professing to have that special skill'.[55] Nonetheless, it held that the standard of care is not determined 'solely or even primarily' by reference to the customary practice or responsible opinion of the medical profession.[56]

However, of the three justices[57] who addressed the law on the standard of care in *Naxakis*, three did not provide any qualification to their rejection of the *Bolam* test.[58] McHugh J, for instance, gave an open ended disapproval of the *Bolam* formulation in the following words:

> '... If there is evidence upon which the jury could reasonably find negligence on the part of a doctor, the issue is for them to decide irrespective of how many doctors think that the defendant was not negligent or careless. Nor is it the point that this evidence of [the appellant's expert witness] also shows that a respectable body of medical opinion would not have performed an angiogram in the circumstances of this case. To allow that body of opinion to be decisive would reintroduce the *Bolam* test into Australian law. In *Rogers v Whitaker*, this Court rejected the *Bolam* test and held that a finding of medical negligence may be made even though the conduct of the defendant was in accord with a practice accepted at the time as proper by a responsible body of medical opinion...'.[59]

The only judge in *Naxakis* who placed a limit on judicial intervention in negligence cases of diagnosis and treatment was Gaudron J. Her Honour held that the jury in *Naxakis* should have been allowed to assess the issue of negligence on the basis of 'reasonableness of particular precautionary measures' because the issue was within their knowledge and understanding. This approach was stated by Gaudron J as follows:

> '... it is important to bear in mind that the test for medical negligence is not what other doctors say they would or would not have done in the same or similar circumstances... To treat what other doctors do or do not do as decisive is to

---

55 *Naxakis* (1999) 197 CLR 269, 274-275 (Gaudron J), 285-286 (McHugh J) and 293-294 (Kirby J).

56 Ibid.

57 They were Gaudron, McHugh and Kirby JJ.

58 In comparison, the House of Lords in *Bolitho* [1998] AC 232, 242 qualified the *Bolam* test by conferring upon judges the ultimate authority to decide whether expert medical opinion has a 'logical basis'.

59 *Naxakis* (1999) 197 CLR 269, 285-286. See also 297-298 (Kirby J).

> adopt a variant to the direction given to the jury in *Bolam v Friern Hospital Management Committee* (the *Bolam* rule)... In *Rogers v Whitaker*', I pointed out that at least in some situations, "question as to the reasonableness of particular precautionary measures are ... matters of commonsense"'.[60]

The other significant aspect of *Naxakis* is the Court's decision that the issue of breach of duty of care in diagnosis and treatment may be determined by one direct medical opinion or, in certain circumstances, the absence of such testimony to support a case of negligence. The Court held that a case of medical negligence should be left to the jury if the evidence in support of the appellant's claims was more than 'a scintilla'.[61] In the context of negligence trials, 'scintilla of evidence' means a 'mere surmise that there may have been negligence on the part of the defendant'.[62] The important question is: how much evidence would be considered as more than 'a scintilla'?

The judges in *Naxakis* were equally split as to the threshold level of medical opinion that is required to leave the issue of breach of duty of care to the jury. Among all the judges, only McHugh J managed to identify one responsible body of medical opinion which supported the view that an angiogram should have been performed. According to his Honour, that evidence alone would have been sufficient to enable the jury to decide whether Dr Jensen was liable for negligence. McHugh J stated:

> '... I think that it was open to the jury to conclude from the above extract of evidence and other evidence of [the appellant's expert witness] the that, when he said that an angiogram should have been considered, he was intending to say that he himself would have performed one if he had had the plaintiff under his care at the time. That itself would have been enough to leave the case to the jury even if every other medical witness had testified to the contrary'.[63]

Three other judges, Kirby, Gaudron and Callinan JJ, were of the view that the jury could decide the required standard of care without the presence of any direct medical opinion

---

60 Ibid 275-276.

61 Ibid 274-275 (Gaudron J), 282 (McHugh J) and 288-289 (Kirby J).

62 Ibid 282 (McHugh J), citing an old English case of *Toomey v London, Brighton and South Coast Railway Co* (1857)140 ER 694, 696; (1857) 3 CB (NS) 146, 150 (Williams J).

63 *Naxakis* (1999) 197 CLR 269, 286.

to support the claim of negligence. Their Honours held that the present case could equally have been left to the jury where reasonable inference of facts pointed to the view that an angiogram should have been performed.[64] Kirby J made the position clear in the following statements:

> 'Special caution is needed before withdrawing from the jury the resolution of a dispute of facts where the case is not one of direct proof but of the reasonable and definite inferences which are to be derived from the evidence given. Because claims in negligence quite often depend upon circumstantial evidence and the inferences therefrom, once some evidence is adduced which, if accepted, could found a verdict in favour of the plaintiff, it requires the clearest case to support the conclusion that, for legal purposes there is no evidence at all or that the jury could not reasonably accept such evidence as exists or act upon it'.[65]

Kirby J further held that, in the absence of direct expert evidence to prove negligence, an inference of liability based on factual circumstances, if warranted, should be drawn in a manner which is as favourable as possible to the plaintiff. His Honour continued with the following rationale:

> 'Where inferences may reasonably be drawn within the experience properly attributed to a jury of lay people, it must be assumed for the present purpose that the jury would draw the inferences available in a way favourable to the plaintiff. Although it is sometimes said by judges that the evidence proved is equally consistent with the presence and absence of negligence, experienced judges, with much knowledge of jury trials, have observed that it is "a very exceptional case" in which a judge, upon that ground, would direct a verdict for the defendant and deprive the plaintiff of the jury's verdict'.[66]

Having stated the law, Gaudron, Kirby and Callinan JJ concluded that the jury could have drawn a reasonable inference from the following facts that the second respondent doctor, Dr Jensen, had breached his duty of care by failing to perform an angiogram on the appellant:

---

64 Ibid 276-277 (Gaudron J), 293 (Kirby J) and 311 (Callinan J).
65 Ibid 293.
66 Ibid.

i) The opinion of the neurosurgeon for the appellant that a subarachnoid haemorrhage usually follows a significant blow to the head;[67]

ii) The persistent signs and symptoms displayed by the appellant on admission to hospital were consistent with a cause other than trauma;[68]

iii) The result of the CT scan revealed an unusually large amount of blood in the left ventricle;[69]

iv) There was evidence that the risks of angiogram were relatively slight, and that it would almost certainly have revealed the true condition.[70]

3.3 CRITICISMS OF THE DECISION IN *NAXAKIS*

The decision in *Naxakis* represents the common law position on the standard of care expected of doctors in the areas of diagnosis and treatment in Australia. As shown in the preceding analysis, the Australian High Court in *Naxakis* went beyond merely rejecting the *Bolam* test. The Court also took the similar approach as in *Goodes* and *Albrighton* of questioning the accepted practice of the medical profession. This section provides critique of the judgments of the High Court justices in *Naxakis* by reference to established legal principles and academic literature.

3.3.1 Failure to provide clear and predictable mechanism for evaluating expert medical opinion

One of the major weaknesses of *Naxakis* is the failure of the Australian High Court justices to proffer an unambiguous and predictable mechanism to facilitate the evaluation of expert medical opinion. Of the four judges in *Naxakis* who dealt with the issue of standard of care, only Gaudron J articulated a definite principle for the evaluation of expert medical opinion. In *Rogers*, Gaudron J had called for the need to scrutinise medical opinion on the basis of its 'reasonableness of precautionary measures'.[71] That statement was reiterated by her Honour in *Naxakis*.[72] The other judges, McHugh, Kirby and Callinan JJ, were rather cryptic on the exact methodology with which the courts should evaluate the reasonableness of clinical conduct or medical opinion. What seems clear is that the three justices based their decision on the

67 Ibid 277 (Gaudron J) and 295 (Kirby J).
68 Ibid 295 (Kirby J) and 311 (Callinan J).
69 Ibid 277 (Gaudron J) and 311 (Callinan J).
70 Ibid 312 (Callinan J).
71 *Rogers* (1992) 175 CLR 479, 493.
72 *Naxakis* (1999) 197 CLR 269, 276.

reasonableness of adopting an angiogram as an alternative diagnosis. On this basis, Corbett argues that such reasoning is consistent with the approach of Gaudron J to assess the feasibility of taking precautionary steps to avoid serious injuries.[73] Despite this commentary, the Court in *Naxakis* was arguably not sufficiently explicit to provide clear guidance on how the court may adjudicate clinical decisions of diagnosis and treatment.

Even if *Naxakis* stands as an authority requiring the courts to evaluate the sufficiency of precautionary steps, there remains an ambiguity as to the extent to which medical practitioners should take preventive actions. In *Naxakis* the Australian High Court did not seem to take into account the fact that the burst aneurism that was sustained by the appellant was an 'unusual injury'.[74] Neither did it call for the need to weigh the inconvenience that might be caused to the appellant patient against the necessity to adopt alternative diagnoses or treatment.[75] It has been argued that the judgment of Gaudron J, in particular, was effectively asserting that 'doctors should always test for all possible causes of any particular symptoms' at all costs.[76] In the absence of any clear assessing criteria, medical practitioners are left with no concrete and predictable guidance as to what actions or omissions might make them liable for negligence.

3.3.2 The Australian medical profession may be vulnerable to negligence suits

A worrying fact for the medical profession is the pronouncement of the Australian High Court in *Naxakis* that the court, or the jury, may infer liability where there is no direct medical opinion which indicates negligence. Except for McHugh J, who identified a responsible body of medical opinion from one expert testimony, the remaining three High Court justices chose to leave the case to the jury to make a finding of negligence based on circumstantial evidence and inference. The more controversial aspect of the decision in *Naxakis*, however, is the judgment of Gaudron J who endorsed a 'common sense' approach to infer liability from facts. The use of this term in the legal context can mislead because the

---

73 Angus Corbett, 'Regulating Compensation for Injuries Associated with Medical Error', (2006) 28 S*ydney Law Review* 259, 286.

74 Ibid.

75 There was a possibility that the appellant might suffer further brain injury if he was to undergo further diagnostic tests. Research has shown that patients suffering from head injury may sustain additional harm if they are subjected to extensive head movements. See especially The Association of Anaesthetists of Great Britain and Ireland, 'Recommendations for the Transfer of Patients with Acute Head Injuries to Neurosurgical Units' (May 2006), Section III, 4.

76 Julian Morris, 'Insuring Against Negligence: Medical Indemnity in Australia', (2002) 18(3) *Policy* 10, 12.

concept is obscure and vague.[77] Nonetheless, the wording was clarified extra-curially as an expression that requires judges and juries to exercise their 'personal sense of wisdom and reasonableness'.[78]

Academics scholars Adeney and Gunson defend the approach of drawing inference in medical negligence cases as a method to avoid 'medical uncertainty and in many cases to implement a policy of benevolence to the plaintiff'.[79] They argue that the reliance on inference was to provide flexibility in the courts' reasoning process because there is no fixed rule on how it should be drawn. As such, the courts can use inference-drawing as a means to do justice when and where the need arises.[80] On the other hand, Skene cautions that *Naxakis* has the ramification of exposing medical practitioners to an increased risk of liability for negligence.[81] The alarming message that *Naxakis* has sent to the medical profession, Skene argues, is that injured patients could still succeed in their negligence suits even though they may only have one medical expert or no direct medical opinion at all to support their case.[82]

The sanction by Gaudron and McHugh JJ in *Naxakis* to infer liability based on commonsense and indirect medical evidence respectively arguably creates a greater chance for injured patients to file medical negligence suits. Injured patients may or may not succeed in proving liability for medical negligence in courts. Nonetheless, the fear by doctors that they may be vulnerable to medical negligence suits may arguably subject them to unnecessary pressure whilst treating patients. The High Court in *Naxakis* might have taken a benevolent approach to the injured patient. That approach arguably might have been adopted at the expense of the interests of the Australian medical profession in general.

3.3.3 The decision in Naxakis is theoretically and practically flawed

Finally, it may be argued that the decision in *Naxakis* that justifies an inference of liability from facts other than direct medical opinion in clinical disputes is untenable both practically

---

77 Jane Stapleton, 'Factual Causation', (2010) 38 *Federal Law Review* 467, 469.

78 Justice Keith Mason, 'Fault, Causation and Responsibility: Is Tort Law Just An Instrument of Corrective Justice', (2000) 19 *Australian Bar Review* 201, 211.

79 Elizabeth Adeney, 'The Challenge of Medical Uncertainty: Factual Causation in Anglo-Australian Toxic Tort Litigation', (1993) 19 *Monash University Law Review* 23, 42. See also John Gunson, 'Turbulent Causal Waters: The High Court, Causation and Medical Negligence', (2001) 9 *Torts Law Review* 53, 62.

80 Ibid.

81 Loane Skene, 'Withdrawing Cases from Juries After *Naxakis v Western General Hospital*', (2000) (November) *Law Institute Journal* 78, 79.

82 Ibid 81.

and theoretically. In medical negligence trials, the testimony of physicians is both necessary and of paramount importance in practical medical negligence litigation. This is because the facts of any given case will provide no indication of what other ordinary skilled practitioners would have or would not have done under similar circumstances.[83] More importantly, the reasoning in *Naxakis* goes against the conceptual distinction drawn by the majority in *Rogers* between disclosure of risks, and diagnosis and treatment. The nature of the doctor-patient relationship in diagnosis and treatment requires that the courts, when adjudicating both aspects of the doctors' duty of care, rely solely or primarily on expert medical testimony.[84]

Furthermore, in stating that the courts could infer liability from facts other than direct medical opinion, the High Court justices in *Naxakis* failed to reconcile the pronouncement with the doctrine of *res ipsa loquitur*.[85] The rule, in general terms, means 'the thing speaks for itself'. It allows the courts to infer liability for negligence where there is significant circumstantial evidence but direct proof may be lacking.[86] As far as actions of medical negligence are concerned, the principle of *res ipsa loquitur* has been commonly used in overt cases. For instance, where a foreign substance is left in the patient's body at the end of a surgical operation[87] and a healthy part of the body remote from the field of surgery is injured.[88] In these situations, the requirement for expert evidence is dispensed with simply because it is a common knowledge that such consequence would not have occurred unless the doctors in question had been negligent.[89]

In more complex medical disputes of diagnosis and treatment, the courts have generally declined to apply the doctrine of *res ipsa loquitur* unless the claims of negligence

---

83 Donald Chalmers and Robert Schwartz, '*Rogers v Whitaker* and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure', (1993) 1 *Medical Law Review* 139, 152.

84 *Rogers* (1992) 175 CLR 479, 491.

85 *Res ipsa loquitur* was not evoked in *Naxakis*. The application of this doctrine is subject to the satisfaction of three criteria:

i) There must be an absence of explanation of the occurrence that caused the injury;
ii) The incident was of such a kind that does not ordinarily occur without negligence; and
iii) The instrument or agency that caused the injury was under the control of the defendant.

See especially *Schellenberg v Tunnel Holdings Pty Ltd* (2000) 200 CLR 121, 134 (Gleeson CJ and McHugh J) (*Schellenberg*).

86 (*Schellenberg*) (2000) 200 CLR 121, 133 (Gleeson CJ and McHugh J). See also *Anchor Products Ltd v Hedges* (1966) 115 CLR 493, 500-501 (Windeyer J).

87 *Mahon v Osborne* [1939] 2 KB 14.

88 *Cassidy v Ministry of Health* [1951] 2 KB 343.

89 *MacDonald v Pottinger* [1953] NZLR 196.

are supported by expert evidence.[90] The rationale for this approach is that cases of such nature often involve asserted errors in medical judgment and miscalculation of clinical risks.[91] These technical issues are understandably outside the knowledge and expertise of the courts to comprehend let alone to form any opinion on negligence in the absence of any assistance from medical experts.[92]

3.3.4 The preferable approach to Naxakis

The shortcomings of the decision in *Naxakis* may be rectified by a number of qualifications. One important aspect of *Naxakis* that needs to be qualified is with regard to the role of expert medical opinion. *Naxakis* has established that the courts or jury may determine the issue of liability based on all available evidence. However, judges or jury, due to their lack of medical expertise, may not be able to decide on this issue unless they are assisted by expert medical opinion. In this regard, it should be made clear that expert medical opinion is influential, if not determinative, of the issue of liability for negligence. The issue of liability should only be left to the courts or jury where there is direct medical evidence which indicates liability for negligence.

The second aspect of *Naxakis* that requires qualification relates to the mechanism for evaluating expert medical opinion. In *Naxakis*, most High Court justices took the approach of evaluating expert medical opinion on the basis of sufficiency of precautionary measures. The analysis in the preceding paragraphs shows that an unreasonable obligation to take precautionary measures may be imposed on the medical profession if there is no qualification placed on this approach. Hence, it is suggested that factors such as convenience and costs should be taken into account in determining whether a defendant has breached his or her duty of care in failing to take sufficient preventive steps to avoid injury.

---

90 *Australian Capital Health Authority v Moorby* [1997] NSWCA 32 (25 June 1997) (Priestley, Beazley JJA and Dunford AJA). See also Carolyn Sappideen and Prue Vines, *Fleming's The Law of Torts* (Thomson Reuters (Professional) Australia, 10th ed, 2011) 364.

91 Scarlett Reid, '*Res Ipsa Loquitur*: A Chameleon in Medical Negligence Cases', (1999) 7 *Journal of Law and Medicine* 75, 79.

92 James Lavery, 'The Rise and Rise of *Res Ipsa Loquitor* in Medical Negligence Litigation', (1998) 7 *Australian Health Law Bulletin* 17, 19.

3.4 CONCLUSION

This chapter examined the current Australian position of the common law principle relating to the standard of care of doctors in diagnosis and treatment. It also highlighted the various legal issues in the law and how they have impacted on the law of medical negligence in Australia and beyond.

What the chapter demonstrates is that Australian courts have disapproved of the *Bolam* test in the areas of diagnosis and treatment as well as the doctor's duty to provide advice on material risks. Nonetheless, the legal position as established by the High Court in *Naxakis* remains patchy. Most, if not all, the justices of the High Court have adopted different reasoning to arrive at their decisions. Hence, it is difficult to gauge a clear testing mechanism to assist judges in the lower courts to evaluate expert medical opinion. It is equally hard for medical practitioners to interpret the standard of reasonable care and skill that is expected of them given that the High Court in *Naxakis* did not spell out the relevant assessing factors. As for injured patients, their solicitors will probably have to advise filing negligence suits in the courts and see how the judge in each case applies the decision in *Naxakis*. However, concrete empirical studies are needed to draw a direct link between the decision in *Naxakis* and the increase in medical negligence litigation in Australia, if any.

The more important question that stems from the analysis in this chapter, however, is whether the law is fair and just in the context of the doctor-patient relationship. It is true that the Australian courts have shifted the pendulum away from the medical profession when determining the standard of care in diagnosis and treatment. However, it appears that the Australian common law position is not entirely patient-oriented. There is no explicit statement in the decision of *Naxakis* that the interests of a patient to receive a particular diagnosis and treatment should be taken into consideration. Under the English and Singaporean versions of the *Bolitho* principle, the courts are at least required to evaluate the standard of reasonableness from the perspective of the benefits that a diagnostic test or a medical treatment will provide *vis-a-vis* the risks it will pose to the patient.

As far as the Australian medical profession is concerned, the High Court in *Naxakis* appears to have gone too far in allowing the courts to determine the issue of breach of duty of care when there is no direct medical evidence to support an injured patient's case. Some scholars rationalise the decision of *Naxakis* with the Australian High Court's benevolent

approach to a seriously injured appellant who lacked adequate direct evidence to at least have his case considered by jury. However, such an explanation could hardly be reconciled with the conceptual bases that underpin the doctor-patient relationship in diagnosis and treatment. In fact, the medical profession has good reason to be concerned about its legal status following the decision in *Naxakis*. *Naxakis* is not only ambiguous and uncertain, it may also easily enable injured patients to establish liability for negligence against defendant doctors.[93] Coincidentally, the decision also came at a time when many high risk specialists were confronted with drastic increases in medical indemnity premiums.[94] However, it remains to be proven whether the decision in *Naxakis* has had any real impact on the medical insurance industry and rates of medical negligence litigation in Australia.

---

93 These concerns resonate the widely held public perception in Australia at that time that the common law principles of negligence in general were unclear, unpredictable and became too easy for injured patients to establish liability for medical negligence: See Panel of Eminent Persons, *Review of the Law of Negligence: Final Report* (2002) x[1.4(a) and (b)].

94 This issue is elucidated in great length in Section 4.2 of Chapter 4 of this thesis.

CHAPTER 4
THE MEDICAL INDEMNITY CRISIS IN AUSTRALIA

4.1 INTRODUCTION

It is widely accepted in Australia that the medical indemnity crisis, which occurred in the early years of this century, precipitated legislative reforms in medical negligence law.[1] The crisis most notably referred to the imminent collapse of Australia's largest medical defence organisation, United Medical Protection (UMP), and the steep rise in medical indemnity premiums that affected doctors in rural and regional areas who practised high risk specialities. Essentially naming the common law as one of the major causes of the crisis, the Australian Commonwealth Government established the Ipp Review Committee[2] to review the legal principle that was applicable in medical negligence cases.

This chapter analyses the background facts leading to the establishment of the Ipp Committee to review the law of medical negligence in Australia. It evaluates the medical indemnity crisis and question whether the common law principles of the standard of care in diagnosis and treatment had, in actual fact, contributed to the drastic increase in medical indemnity premiums in the early 2000s. This chapter also examines the extent to which the Australian Commonwealth Government addressed the real causes of the crisis. In this regard, special emphasis is given to the Government's effort to assess the real causes of the crisis and the establishment of the Ipp Committee to conduct the law review. One pivotal conclusion from the analysis is that there is no cogent evidence pointing the common law principles relating to the standard of care in diagnosis and treatment as one of the contributing factors to the medical indemnity crisis in Australia. It is argued that although the Ipp Committee was set up with good intentions, it was rather a reform strategy that aimed to provide short-term solutions with the view to gaining political support.

4.2 THE MEDICAL INDEMNITY CRISIS – WHAT WAS IT?

One of the early signs of the medical indemnity crisis was the drastic increase in medical indemnity premiums. It was reported that medical indemnity premiums in Australia increased

---

1 Loane Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) 1.

2 Hereafter referred to as the 'The Ipp Committee'.

at an average rate of 13 per cent from 1995 onwards, and the largest annual increase was in 2002, when the average premium rose nearly 50 per cent.[3]

The increase in premiums sparked a very strong response from Australian doctors, particularly those practiced in high risks areas such as obstetrics. In 1999/2000 the yearly indemnity premiums for obstetricians across Australia ranged from AUD$11,050 to AUD$41,400[4] and these figures continued to rise in 2000/2001 and 2001/2002.[5] It was reported in the media that many obstetricians in rural and regional Australia had threatened to withdraw from their practice due to their inability to cope with the unexpected increase in the medical indemnity premiums.[6] Understandably, these specialists served only a handful of patients and did not make enough money from their few patients to cover their indemnity burden. Back in 2000, the then President of the Australian Medical Association had issued the following salutary warning:

> '…We have reached a stage where clinicians in a number of fields are obliged to carry an unrealistic premium burden…anecdotally we are aware that many obstetricians are leaving obstetrics. One of the first group to 'down tools' is the rural GP obstetricians...'.[7]

The pressure on medical indemnity premiums was further intensified by the imminent collapse of Australia's largest medical defence organisation, UMP.[8] In 2002, UMP went into provisional liquidation as a result of its failure to satisfy the requirement of the Australian Prudential Regulation Authority to fund estimated future claims from its reserves.[9] The impending winding up of UMP brought turmoil to Australian medical practitioners. When UMP was declared provisionally insolvent in April 2002, approximately 60 per cent of Australian doctors and up to 90 per cent of medical practitioners in New South Wales and

---

3 Insurance Statistics Australia Ltd, 'Medical Indemnity Report: An Analysis of Premium and Claim Trends for Medical Indemnity Insurance in Australia from 1995 to 2005' (Medical Indemnity Industry Association of Australia, 21 August 2006) 5.

4 Quoted in Senate Community Affairs References Committee, Parliament of Australia, *Rocking the Cradle: A Report into Childbirth Procedures* (1999) 181.

5 Nadine Rofail, 'Rural Doctors May Stop Delivering Babies', *Australian Current Law News* (Brisbane), 23 April 2001.

6 Andrew White and John Kerin, 'Medical Insurer Faces Closure', *The Australian* (Sydney), 24 April 2002.

7 Dr Kerryn Phelps, 'Tort Law Reform' (Unpublished address to a seminar, Sydney, 12 February 2000).

8 Loane Skene and Harold Luntz, 'Effects of Tort Law Reform on Medical Liability', (2005) 79 *Australian Law Journal* 345, 346.

9 Special Report, 'What Brought UMP Down', *Medical Observer* (Sydney), 31 May 2002, 20.

Queensland were left without any insurance cover.[10] The supply shortage of medical indemnity insurance following the imminent collapse of UMP inevitably led to rises in the premiums charged by other competitors[11] in the medical indemnity market.[12] In order to prevent medical practitioners from ceasing practice due to lack of insurance cover, the Australian Commonwealth Government stepped in to salvage the situation by a series of measures. These included guaranteeing UMP's obligations and passing a package of legislation to save UMP and other medical insurers from liquidation as well as to provide a national scheme for medical indemnity.[13]

4.3 WHAT CAUSED THE MEDICAL INDEMNITY CRISIS IN AUSTRALIA?

There were many available theories explaining the medical indemnity crisis in Australia. Among the causes that were identified by the Australian Commonwealth Government were: the 11 September 2001 terrorist attacks in New York, the provisional liquidation of UMP, the increasing compensation payments for medical negligence cases by the courts and the steep rise in medical negligence litigation in Australia.[14] The following section analyses the latter factor as it is relevant to the examination of the issue of the standard of care in diagnosis and treatment in this thesis.

4.3.1 The trend of medical negligence claims in Australia

There had been mixed reports regarding the growing trend of medical negligence claims in Australia, at least for the ten-year period prior to the medical indemnity crisis. Some empirical research indicated a steep rise in the number of medical malpractice claims, whilst other findings suggested only a stable growth. A 2001 analysis by Trowbridge Consulting

---

10 Kumaralingam Amirthalingam, 'Anglo-Australian Law of Medical Negligence – Towards Convergence?', (2003) 11 *Torts Law Journal* 117, 130-131.

11 As at 2001, there were seven organisations which offered medical indemnity insurance cover in Australia. They were: UMP, Medical Defence Association of Victoria, Medical Defence Association of Western Australia, Medical Defence Association of South Australia, Medical Indemnity Protection Society, Medical Protection Society of Tasmania and St Paul and Macquarie Underwriting. See, eg, Kerrie Chambers, 'Medical Indemnity – Is There a Crisis? Is There a Solution', (2002) 11(2) *Australian Health Law Bulletin* 13, 14.

12 Harold Luntz, 'Medical Indemnity and Tort Law Reform', (2003) 10 *Journal of Law and Medicine* 385, 386.

13 *Medical Indemnity Agreement (Financial Assistance-Binding Commonwealth Obligations) Act 2002* (Cth); *Medical Indemnity Act 2002* (Cth); *Medical Indemnity (IBNR Indemnity) Contribution Act 2002* (Cth)*; Medical Indemnity (Consequential Amendments) Act 2002* (Cth).

14 Other contributory factors included the falling investment returns due to a downturn in financial markets and the heavy underwriting losses on medical indemnity policies in the previous decades. See, eg, The Treasury, Commonwealth of Australia, *Available and Affordable: Improvements in Liability Insurance Following Tort Law Reform in Australia* (Attorney-General's Department, 2006) 1.

based on selected data provided by the UMP and Medical Defence Associations in Victoria, South Australia and Western Australia suggested a drastic increase in claims rates from 1991 to 2001.[15] Using an index measure, Trowbridge Consulting concluded that overall claims frequency in Australia had increased 2.5 times from 1991 to 2001.[16] According to Trowbridge Consulting, frequency claims increased dramatically in the early 1990s and continued to rise over the late 1990s but at a lower level. The analysis went on to conclude that 'each of the Medical Defence Organisations contributing to the study has shown a similar increase'.[17]

It is unclear whether these findings are accurate. This is because data from individual Australian Medical Defence Organisations gave a less alarming conclusion than the collective analysis of Trowbridge Consulting. The Medical Defence Association National Annual Report 2001, for instance, stated that although there had been a significant increase in the total case load from 1991 to 2001, there was 'a levelling off in claims'.[18] In addition, the United Medical Protection Annual Report for 1999-2000 and 2000-2001 indicated only a modest increase in the number of claims, from 4,432 to 4,961.[19] Furthermore, the Medical Defence Association of South Australia Annual Report 2000-2001 measured 'claims frequency per hundred members' and concluded that the claims frequency had been fairly static from 1995 to 2001, notably between 2.4 to 3.0 claims per one hundred members.[20]

In fact, the Trowbridge Consulting contention that Australia was experiencing a sharp increase in medical negligence claims had been challenged by others. A report prepared by the Legal Process Reform Group of the Australian Health Ministers Advisory Council (AHMAC) conceded that there were rise in the number of claims for the past 10 years before the medical indemnity crisis but urged caution in interpreting the data.[21] However, the AHMAC report stated that the increased claims may have been caused by a variety of external reasons, such as a significant increase in the number of doctors in the affected

---

15 Gillian Harrex, Keran Johnston and Estelle Pearson, 'Medical Indemnity in Australia' (A presentation to the Institute of Actuaries of Australia XIII General Insurance Seminar, Trowbridge Consulting, November 2001).

16 Ibid.

17 Ibid.

18 Quoted in the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group (Chair: Marcia Neave), *Responding to the Medical Indemnity Crisis: An Integrated Reform Package* (2002) 16-17[3.18].

19 Ibid 17[3.20].

20 Ibid 17[3.19].

21 Ibid 15[3.9].

jurisdictions,[22] the expansion of the provision of Medicare services by 66 per cent and an increase of 76 per cent of hospital admissions nationally.[23] In an inquiry conducted by the Victorian Parliament Law Reform Committee in 1997, it was stated that the rise in medical negligence claims in Australia prior to the medical indemnity crisis was a false alarm:

> 'The Committee has found that there is evidence of a widespread fear of litigation among doctors generally. However, there is no evidence of a significant increase in medical litigation. The shortage of doctors in some areas of practice has not been shown to be a consequence of any rise in the cost of obtaining professional indemnity insurance. Rather the Committee has received extensive evidence to the effect that the shortage of doctors in rural areas, for example, is due to other social and economic factors'.[24]

An empirical study conducted by Ted Wright and commissioned by the Law Council of Australia[25] also painted a different picture than that of Trowbridge Consulting. This research analysed personal injury claims,[26] including medical malpractice disputes which were filed in the district courts and the supreme courts in all Australian states and territories between 1995 and 2002. From the analysis of the collected data, Wright concluded that generally there 'was no evidence of a general increase' in personal injury litigation during the eight-year period.[27] The only state where there was a clear rising trend in claim numbers was South Australia.[28] In Western Australia[29] and Tasmania,[30] there was a sharp decline in 2000 and 2001 although claim numbers in both jurisdictions rose rapidly in the late 1990s. The litigation rates in New South Wales,[31] Queensland,[32] Victoria[33] and Northern Territory[34] was reported to be stable between 1995 and 2002. In the Australian Capital Territory, the trend of

---

22 Ibid 15[3.12].
23 Ibid 18-19[3.25].
24 Parliament of Victoria Law Reform Committee, *Legal Liability of Health Service Providers: Final Report* (1997) 230[9.68].
25 Ted Wright, 'National Trends in Personal Injury Litigation: Before and After "Ipp"' (Law Council of Australia, 26 May 2006).
26 This study excluded work injury and road accident claims.
27 Ted Wright, above n 25, 29.
28 Ibid 23.
29 Ibid 21-22.
30 Ibid 25.
31 Ibid 15-16.
32 Ibid 19-20.
33 Ibid 18.
34 Ibid 28.

litigation was reported to be declining during the same period.[35] Based on these data, there is arguably no convincing evidence to suggest that Australia was experiencing a medical negligence litigation crisis prior to 2002.

4.4 MEDICAL NEGLIGENCE CLAIMS AND THE COMMON LAW STANDARD OF CARE IN DIAGNOSIS AND TREATMENT IN AUSTRALIA

There was a dearth of empirical research in Australia which sought to establish a correlation between the success rates of medical litigation against doctors between the 1990s and early 2000s and the common law development of the medical standard of care. This issue has thus far been addressed by anecdotal evidence. The Australian medical profession has argued that the revised standard of care, which represented a shift from the traditional *Bolam* test, produced greater success rates against defendant doctors in medical negligence litigation.[36] These concerns notably referred to the High Court decisions in *Rogers v Whitaker*[37] and *Naxakis v Western General Hospital*,[38] which rejected the *Bolam* test in disclosure of risks and in both diagnosis and treatment respectively.[39] Conversely, some Australian medical defence organisations stated that of those cases which were litigated, there were high success rates in defending their members.[40] It should be noted, however, that this latter study is not wide-ranging enough as it did not cover all the medical defence organisations in Australia. In this regard, the reliability of its conclusion remains to be proven. Nonetheless it may be concluded that a direct correlation between the success rates in favour of plaintiff patients and the case law development in Australia on the standard of care in medical negligence cases has not been established by hard evidence.[41]

4.5 THE LAW REFORM ON MEDICAL NEGLIGENCE IN AUSTRALIA

This section analyses the reform process of medical negligence law in Australia after the medical indemnity crisis. It examines the Trowbridge Report and the establishment of the Ipp

---

35 Ibid 26-27.

36 Quoted in the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group, above n 18, 62-63[6.23].

37 (1992) 175 CLR 479 (*Rogers*).

38 (1999) 197 CLR 269 (*Naxakis*).

39 The decisions in *Rogers* and *Naxakis* were examined Sections 3.2.3 and 3.2.6 of Chapter 3 respectively.

40 Quoted in the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group, above n 18, 62-63[6.23].

41 Ibid.

Committee, both of which formed the basis for the review of the Australian common law principle in medical negligence.

4.5.1 The Trowbridge Report

The major statistical report that provided the backbone of tort law reform in Australia, and which subsequently led to the establishment of the Ipp Review Committee, was the Trowbridge Report.[42] This actuarial report was commissioned by the Australian Commonwealth Treasury and its aim was to develop practical measures to resolve the public liability[43] and medical indemnity crises which happened simultaneously.

The Trowbridge Report proposed a review of the law of general negligence in Australia following the public liability and medical indemnity crises.[44] Overall, it offered three reasons for the recommendation. First, the Report noted that there was a gradual 'stretching' of the interpretation of negligence by judges.[45] This statement was reported to be based on an extra-curial commentary by James Spigelman CJ of the New South Wales Supreme Court in early 2002.[46] Spigelman CJ's main argument is that the developments of the law of general negligence in Australia had become too favourable to claimants and there was an urgent need for what his Honour called 'a more principled approach' to redress the imbalance.[47] Secondly, the Report observed that there were problems of expansion in the size of negligence claims as well as uncertainty in the claims outcome and it saw tort reform as a means of solving both problems.[48] Thirdly, the Report argued that there was a mismatch between the current state of the law of negligence and the expectations of the community in

---

42 Trowbridge Consulting, 'Public Liability Insurance: Practical Proposals for Reform' (May 2002).

43 The analysis of the public liability crisis is beyond the scope of this chapter. Essentially, the public liability crisis referred to two important incidents. The first was the collapse of HIH, Australia's largest personal injury indemnity insurer, in 2001. The second was the drastic increase in insurance premiums for public authorities, non-for profit organisations and the tourism industry which offered high risk recreational and sporting activities. Insurance premiums for these activities were soaring at the rates of double, triple or even quadruple increment. For certain activities, insurance coverage was not given at all. As a result, many recreational or sporting events had to be cancelled as the affected public authorities or businesses could not afford the insurance costs or did not have the insurance coverage that was required to conduct those events. See Chief Justice James Spigelman, 'Negligence and Insurance Premiums: Recent Changes in Australian law', (2003) 11 *Torts Law Journal* 291 for an illuminative analysis of the public indemnity crisis and its possible causes in Australia.

44 Peter Cane, 'Reforming Tort Law in Australia: A Personal Perspective', (2003) 27 *Melbourne University Law Review* 649, 657-658.

45 Trowbridge Consulting, above n 42, iv and 26.

46 Chief Justice James Spigelman, 'Negligence: The Last Outpost of the Welfare State', (2002) 76 *Australian Law Journal* 432, quoted in Trowbridge Consulting, above n 42, 26.

47 Chief Justice James Spigelman, above n 46, 433-434.

48 Trowbridge Consulting, above n 42, 12.

terms of the balance between cost and that which the community regarded as legitimate negligence deserving of compensation by the wrongdoers.[49]

4.5.2 The Ipp Committee

The Ipp Committee was set up in response to the Trowbridge Report's recommendation that the law review be carried out by a 'specific expert panel'.[50] The Ipp Committee appointed a 'Panel of Eminent Persons' in early July 2002 to conduct the review. The Panel consisted of a sitting appeal court judge, David Ipp JA, after whom the committee was named, an academic lawyer, a clinical professor of surgery and a senior member of local government. This composition was to reflect 'community representation', as proposed by the Trowbridge Report.[51] The main term of reference of the Ipp Committee was to reform the law of negligence in Australia with the specific 'objective of limiting liability and quantum of damages arising from personal injury and death'.[52] Under the heading of professional negligence, the Ipp Committee was required to develop reform options that the standard of care in, *inter alia*, medical negligence cases to conform to 'accepted practice' of the medical profession at the time of the 'negligent act or omission'.[53] The Panel commenced its work in late July 2002.[54] The final report of the Ipp Committee was submitted to the Commonwealth Assistant Treasure and Minister of Finance on 30 September 2002.[55]

4.6 COMMENTARY

The following section provides commentary on the medical indemnity crisis in Australia, the Australian Commonwealth Government's response to the crisis and the establishment of the Ipp Committee to conduct the review of the common law medical negligence following the crisis.

4.6.1 The Medical Indemnity crisis

The medical indemnity crisis in Australia arguably might have been exaggerated. One message that the media in Australia sought to convey was the adverse impact of the crisis on

---

49 Ibid 26-27.
50 Ibid iv.
51 Ibid 27. The panel members were Justice of Appeal David Ipp, Peter Cane, Donald Sheldon and Ian Macintosh.
52 Panel of Eminent Persons, *Review of the Law of Negligence: Final Report* (2002) ix.
53 Ibid, Term of Reference 3(d), 37.
54 Peter Cane, above 44, 665.
55 Ibid.

the delivery of high risk health services in regional and rural areas. There was, however, a lack of cogent evidence adduced to suggest that any Australian doctors had ceased practice as a result of the medical indemnity crisis. This scepticism was expressed by the Governor of Tasmania, Peter Underwood, who openly stated in his address to the State branches of Australian insurers that he was not aware of any doctors who had wound down their practices due to inability to pay medical indemnity premiums.[56] Hence, it may be argued that the hue and cry of the medical profession over the crisis were merely rhetorical threats that did not translate into actual cessation of practice by its members.

Contrary to the view that the Australian medical profession was the biggest victim as a result of the drastic increase in medical indemnity premiums in early 2000s, it instead became one of the beneficiaries in the aftermath of the crisis. After the Australian Commonwealth Government had put in place a national scheme for medical indemnity following the crisis, the media also reported massive protests by hundreds of obstetricians and general practitioners in Sydney and Melbourne in mid 2003 over the uncertainties in the medical indemnity arrangements.[57] At the time, the President of the Royal Australasian College of Surgeons, Mr Kingsley Faulkner, released the results of a survey of 750 surgeons over the age of 55 and concluded that about 15 per cent of those in private practice would cease practice if the uncertainties were not resolved.[58] As the protests and threats by the medical profession escalated, the pressure from the medical profession ultimately forced the Government to negotiate with the Australian Medical Association.[59] A series of negotiations eventually led to the passing of a number of pieces of legislation to impose regulatory supervision on medical defence organisations in Australia to ensure that there would be affordable insurance premiums in the future.[60] In the end, it seemed that the Australian medical profession had much to gain from the crisis as it somewhat speeded up the resolution of the profession's long-standing problem of high insurance premiums.

---

56 The address was published in an article titled, Peter Underwood, 'Is Ms Donoghue's Snail in Mortal Peril?', (2004) 12 *Torts Law Journal* 39, 41-42.

57 Susie O'Brien, 'Doctors Lash Out at Delay', *Herald Sun* (Melbourne), 5 May 2003.

58 Kingsley Faulkner, 'Surgeons Set to Quit Over Cover', *The Australian* (Sydney), 8 May 2003.

59 Harold Luntz, 'The Australian Picture', (2004) 35 *Victoria University of Wellington Law Review* 879, 889.

60 *Medical Indemnity (IBNR Indemnity) Contribution Act 2002* (Cth); *Medical Indemnity Amendment Act 2003* (Cth); *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth); *Medical Indemnity (Prudential Supervision and Product Standards (Consequential Amendments Act 2003* (Cth); *Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003* (Cth).

4.6.2 The response of the Australian Commonwealth Government to the crisis

The Australian Commonwealth Government arguably might have failed to conduct a wide-ranging investigation into the factors that triggered the medical indemnity crisis. Even before the legal inquiry by the Ipp Committee commenced, the Government had concluded that the medical indemnity crisis was largely attributed to, among others, the principle relating to the standard of care in diagnosis and treatment under the common law. This is evident from the term of reference of the Ipp Committee, which required its Panel members to 'examine a method for the reform of the common law with the objective of limiting liability... arising from personal injury and death'.[61] On the face of it, this term of reference had its merits. The rejection of the *Bolam* test in favour of the principles in *Rogers* and *Naxakis* means that judges, not the medical profession, would decide the final outcomes of medical negligence cases.[62] These developments, to use the words of James Spigelman J, indicate a 'stretching' of the standard of care in favour of injured patients in medical litigation.[63]

Many critics, however, have argued that poor financial management of the insurance industry was to blame for the drastic increase in medical indemnity premiums in the early 2000s. It had been argued that Australian medical defence organisations had for many years taken advantage of the lack of regulatory supervision to underprice indemnity premiums so as to obtain market share.[64] This practice inevitably led to shortage of funds within the organisations to allocate adequate reserves to pay for incurred, but not reported, claims. The 11 September 2001 terrorist attacks further compounded the situation as the event caused investment sentiment in the insurance industry to decline considerably.[65] Most insurers, including the Australian medical defence organisations, derive substantial earnings on investments.[66] A reduction in capital due to a combination of these factors meant that medical defence organisations in Australia had to increase indemnity premiums substantially in order to meet insurance claims. The possibility that the crisis might have been caused, among others, by the shortcomings within the medical indemnity industry was not fully explored by the Government before establishing the Ipp Committee.

---

61 Panel of Eminent Persons, above n 52, ix.

62 The principles as enunciated in *Rogers* and *Naxakis* were examined in Sections 3.2.3 and 3.2.6 of Chapter 3 respectively.

63 Chief Justice James Spigelman, above n 46, 433.

64 Peter Underwood, above n 56, 41-42.

65 Rob Davis, 'The Tort Reform Crisis', (2002) 25(3) *University of New South Wales Law Journal* 865, 870.

66 Peter Cashman, 'Tort Reform and the Medical Indemnity Crisis', (2002) 25(3) *University of New South Wales Law Journal* 888, 890.

The Australian Commonwealth Government's handling of the medical indemnity crisis seemed to show an imbalance in the consideration of competing interests in favour of the medical profession. Throughout the period of the medical indemnity crisis, the medical profession had the full attention of the Government to ensure it did not lose out as a result of the soaring medical indemnity premiums. As part of the Government's intervention to resolve the crisis, medical defence organisations were subject to regulatory supervision to ensure that they had sufficient reserves to fund insurance claims. This measure safeguarded against significant fluctuation of medical indemnity premiums in the future. Furthermore, the Government initiated the proposed reform to the standard of care under the common law to ensure that the medical profession ultimately decided what should be the acceptable practice. Regrettably, what was left unaddressed by the Government, through the Trowbridge Report and legal inquiry by the Ipp Committee, was the interests of plaintiff patients in medical disputes. In particular, there was no analysis of the extent to which the proposed changes to the common law would affect the rights of patients injured as a result of the action or omission of doctors.

4.6.3 The establishment of the Ipp Committee

The establishment of the Ipp Committee following the medical indemnity crisis in Australia might have been politically driven.[67] Above all, the proposed legal review was spearheaded by the Australian Commonwealth Treasury Minister rather than the Attorney-General. Moreover, the Trowbridge Report, which proposed the establishment of the Ipp Committee, was commissioned by the Commonwealth Treasury. The financial resources that funded the entire review process were jointly pooled by the Australian State and Commonwealth governments. These factors show that the governments of the day had a stake in the proposed law reform.

There were, in hindsight, good reasons for the Australian Commonwealth and State governments to take a great interest in leading the review of the law of medical negligence. Given the seriousness of the medical indemnity crisis, the respective Commonwealth and State governments were concerned about how the general public perceived them and what steps they would take to resolve the problems.[68] Should UMP be wound up, there would be

---

67 Peter Cane, above n 44, 667.

68 Justice of Appeal David Ipp, 'The Politics, Purpose and Reform of the Law of Negligence', (2007) 81 *Australian Law Journal* 456, 456.

substantial loss of jobs and the medical indemnity market would be in turmoil. The threats of cessation of practice by medical practitioners in rural and regional areas also became a talking point in the media and the public demanded answers. In short, the stakes of the medical indemnity crisis were just too high for governments of the day to ignore and a failure to act accordingly might risk losing votes and, hence, political power.[69]

The problem with political intervention in the legal inquiry of the Ipp Committee was that it eventually ended up as a quick fix process mainly to achieve short-term goals rather than addressing long-term legal problems. One aspect of this concern was the allotted time within which the panel members of the Ipp Committee had to finalise recommendations. The Trowbridge Report suggested that the panel be given 'a short time frame (say three months)' to complete its work.[70] The criticism that the entire review process was conducted with the intention to achieve short term goals is also evident in the terms of reference of the Ipp Committee. Under the principal term of reference, the primary task of the Ipp Committee was to devise a reform method that would achieve 'the objective of limiting liability and quantum of damages arising from personal injury and death'.[71] This term of reference was read as requiring the Ipp Committee only to provide answers to specific problems, namely the expansion of liability and increased size of claims in actions for medical malpractice, rather than to conduct a general review of the law of medical negligence in Australia.[72] Under the broad remit of the principal term of reference, there were other smaller terms of reference, which revealed the governments' underlying motive to only address the immediate problems at hand in the face of the crisis.[73] For instance, concerns about increased levels of medical negligence disputes were translated into a term of reference to develop reform options that would enable the medical profession to be the final arbiter of the issue of standard of care.[74] This term of reference was arguably too restrictive and did not reflect a commitment by the respective Australian Commonwealth and State governments' commitment to engage in a larger and broader national reform of the law of medical negligence that would otherwise provide a long-term solution to the crisis.[75]

---

69 Ibid.
70 Trowbridge Consulting, above n 42, 27.
71 Panel of Eminent Persons, above n 52, 26.
72 Peter Cane, above n 44, 667.
73 Ibid 668.
74 Panel of Eminent Persons, above n 52, Term of Reference 3(d), x.
75 See Harold Luntz, 'Reform of the Law of Negligence: Wrong Questions – Wrong Answers', (2002) 25(3) *University of New South Wales Law Journal* 836, 836.

4.7 CONCLUSION

This chapter has examined the medical indemnity crisis, its causes and the extent to which the Australian governments, both State and Commonwealth, addressed the real causes of the crisis. A significant finding of the analysis is that there is no cogent evidence suggesting that the common law principle of medical negligence had contributed to the medical indemnity crisis. On this basis, the justification for initiating the legal reform based on the occurrence of the crisis alone was far from convincing.

Another major argument in this chapter is that the Australian Commonwealth Government to adopt a wide-ranging investigation into the real reasons that triggered the crisis. Instead of conducting in-depth enquiry into the financial management of medical defence organisations in Australia, the governments established the Ipp Committee to review the common law which took years to develop. Although it has been argued in a previous chapter of this thesis that there are many criticisms levelled at case law development concerning the standard of care in medical diagnosis and treatment in Australia,[76] the legal review of the common law immediately after the occurrence of the crisis was arguably a knee-jerk reaction that failed to address the real causes of the problem.

This chapter has also argued that the review process of the Ipp Committee was politically motivated. The nature of the establishment of the Ipp Committee and time frame which this review body had to complete its work show that the governments of the day aimed to find a quick fix solution to the crisis. The lack of credible basis for the terms of reference on medical negligence also added criticisms to the Australian Commonwealth Government's handling of the crisis. There is no doubt that the legislation that imposes regulatory supervision on medical defence organisations and the proposed reform to the common law medical standard of care would ensure affordable insurance premiums for doctors and protect the interests of the medical profession. However, it remains to be seen whether the crisis could repeat itself in the near future given that a thorough analysis of the crisis was not conducted.

[76] These criticisms were illuminated in Section 3.3 of Chapter 3.

CHAPTER 5
THE AUSTRALIAN MODIFIED *BOLAM* TEST

5.1 INTRODUCTION

From 2002 to 2004, six Australian states codified the test for determining medical standard of care in the areas of diagnosis and treatment in their respective *Civil Liability Acts*.[1] The formulation, commonly referred to as the modified *Bolam* test,[2] was designed to protect the medical profession in the aftermath of the medical indemnity crisis. In a previous chapter of this thesis, the possible causes of the medical indemnity crisis in Australia were analysed.[3] This chapter focuses on analysing the legislative background to the test. It seeks to question the defensibility of the statutory enactment in terms of its practical application and in the wider context of the doctor-patient relationship in medical malpractice cases of diagnosis and treatment.

There are two major extrinsic materials to the statutory enactment, the Final Report of the Ipp Review Committee[4] and the Australian states' *Hansard*. The former sets out the proposed legal changes and the rationale behind its recommendations. States parliamentary debates, on the other hand, provide the reasoning for the statutory implementation of the modified *Bolam* test. Contrary to the proposal of the Ipp Review Committee[5] for a uniform and consistent approach to the law reform, it is shown that there are material discrepancies in the codification of the modified *Bolam* test by the six Australian State jurisdictions. In this regard, reference is made to the States' *Hansard* to explore the reasoning behind the different versions of the legislative reform.

This chapter argues that the implementation of the modified *Bolam* test was a hasty legislative exercise that lacked detailed legal and empirical research. Furthermore, the test

---

1 The term '*Civil Liability Acts*' refers to the various pieces of state legislation which implement the modified *Bolam* test under different names, namely *Civil Liability Act 2002* (NSW); *Civil Liability Act 2003* (Qld); *Civil Liability Act 1936* (SA); *Civil Liability Act 2002* (Tas); *Wrongs Act 1958* (Vic); *Civil Liability Act 2002* (WA).

2 This term was used by leading Australian medico-legal scholars Skene and Luntz. See, eg, Loane Skene and Harold Luntz 'Effects of Tort Law Reform on Medical Liability', (2005) 79 *Australian Law Journal* 345, 351.

3 See Sections 4.2 and 4.3 of Chapter 4.

4 Panel of Eminent Persons, *Review of the Law of Negligence: Final Report* (2002). Hereafter referred to as the 'Report'.

5 Hereafter referred to as 'the Ipp Committee'.

itself is difficult to apply. This problem, it is argued, is attributable to the existence of some ambiguous terms under the test that find no practical guidance from extrinsic evidence to the statutory enactment. It is also contended that although the legislative changes are meant to safeguard doctors against unnecessary negligence suits, they were implemented at the expense of the interest of injured patients in medical negligence disputes. Finally, it is argued that the operation of the modified *Bolam* test is unsatisfactory as the common law principle was reintroduced by judges for determining whether a plaintiff has discharged his or her burden of proof of medical negligence. This, it is argued, is contrary to the legislation intention of the test and may cause a rise in medical negligence litigation in Australia.

5.2 THE REVIEW OF THE LAW OF MEDICAL NEGLIGENCE IN AUSTRALIA BY THE IPP COMMITTEE

In early July 2002, the Ipp Committee was tasked to reassess the legal principles of negligence under the common law, which included medical negligence. Under the heading of medical negligence, the Ipp Committee was to develop a *Bolam* type[6] evidentiary test that makes reference to 'generally accepted practice" of the medical profession for determining the standard of care in, *inter alia*, diagnosis and treatment. That obligation was specifically spelt out in the Ipp Committee's Term of Reference 3(d):

> 'develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accords with the generally accepted practice of the relevant profession at the time of the negligent act or omission'.[7]

The Ipp Committee, in its preliminary review process, called for public submissions. These written submissions were important because they formed part of the Ipp Committee's public consultation process. At the end of this process, 100 written submissions were shortlisted, the parties of which represented a cross section of the Australian community.[8] They ranged from senior judges, leading barristers and academics, representatives of legal, medical and insurance bodies, accounting, actuarial firms as well as social justice groups.[9]

---

6 The elements of the *Bolam* test were discussed in Section 2.2.5 of Chapter 2.

7 Panel of Eminent Persons, above n 4, x.

8 The written submissions can be retrieved at <http://www.revofneg.treasury.gov.au/submissions.asp>.

9 Panel of Eminent Persons, above n 4, 33[1.43].

The written submissions, among others, consisted of various suggestions and justifications for the proposals. The following analysis focuses on the recommendations and arguments made by nine interest groups which had been vocal in debating medical indemnity and advocating reform to the law of medical negligence in Australia.[10]

In summary, the relevant proposals put forward by these interest groups can be divided into three distinct categories: the return of the *Bolam* test in its original form,[11] the preservation of the status quo under the common law principle as it stood in Australia prior to the proposed law reform,[12] and the introduction of the qualified *Bolam* test as articulated by Lord Browne-Wilkinson in the House of Lords case of *Bolitho v City and Hackney Health Authority*.[13]

5.2.1 Reintroduction of the original Bolam test in Australia

Four organisations from the medical fraternity and the insurance industry urged the Ipp Committee to reintroduce the *Bolam* test in its original form in Australia. They were the Australian Medical Association (AMA), the Insurance Council of Australia, the Australian Doctors' Fund/Council of Procedural Specialists and the United Medical Protection (UMP).

One of the main justifications for reversing the legal position back to the *Bolam* test in its original form was that the formulation, which referred to common medical practices as the yardstick for the standard of care, would provide certainty to the medical profession.[14] In essence, the *Bolam* test enables the actions or omissions in medical disputes to be judged against commonly accepted medical practices, which the doctors are aware of, rather than by any arbitrary standard which the practitioners had no hope of attaining.[15]

Apart from the argument of certainty, there was also the suggestion that only the medical profession could appreciate the reality of clinical practice. The AMA expressed the

---

10 Australian Medical Association (Submission 055); Australian Plaintiff Lawyers Association (Submission 042); Law Council of Australia (Submission 033); Insurance Council of Australia (Submission 018); Australian Doctors' Fund/Council of Procedural Specialists (Submission 001); Australian Council of Profession (Submission 023); Australian Dental Association (Submission 017); Ramsay Health Care Ltd (Submission 030); United Medical Protection (UMP) (Submission 011).

11 Section 2.4.1 of Chapter 2 illuminated the interpretation of the *Bolam* test in its original form.

12 See Section 3.2.6 of Chapter 3.

13 [1998] AC 232 (*Bolitho*). See Section 2.6 of Chapter 2 for an analysis of the English *Bolitho* principle.

14 Australian Doctors' Fund/Council of Procedural Specialists (Submission 001) 13.

15 Ibid.

concern, based on the experience of its members, that the courts had in many cases ignored the constraints and limitations that doctors had to confront in the course of their duties.[16] Among the practical problems were stressful working conditions, the split-second life-and-death decisions made in a clinical environment and financial constraints in medical practice which inevitably reduce attainable standards.[17] The AMA suggested that the *Bolam* test was only replaceable until and unless judges had had a reasonable understanding of the complexity of medical decision-making and the whole clinical context in which diagnosis or treatment is carried out.[18]

The organisations that supported the reintroduction of the *Bolam* test in its original form recognised the shortcomings of the test, which in the past had produced outcomes that mostly favoured doctors in medical litigation. However, they defended the test by attributing the problem to the inherent weaknesses in the adversarial system and the procedural framework which failed to safeguard against bias or misleading expert opinion.[19] In the adversarial system, it is inevitable that parties in medical disputes would adduce opinion evidence that only supports their own case. According to the AMA, such practice had enabled medical experts of litigants to use various tactics to withhold opinion evidence in a legitimate way even without the knowledge of the opposing parties or the courts.[20] Hence, even were the Ipp Committee to recommend a test that allowed the courts to have the final say on the issue of the standard of care, they would not have been able to deliver any just outcomes in medical disputes.[21]

Two medical interest groups, the AMA and the UMP, recommended procedural reform to the application of the original *Bolam* test. They emphasised that the proposed reform should address the need to provide greater objectivity in the evaluation of expert medical opinion.[22] One way to solve the practical weaknesses of the *Bolam* test was to empower the courts to appoint independent experts who were accredited by Specialist Medical Colleges in Australia. The use of independent medical experts, the AMA argued, would provide more reliable medical opinion and greater likelihood of consensus opinion

16 Australian Medical Association (Submission 055) 7.
17 Ibid 4.
18 Ibid 7.
19 Australian Medical Association (Submission 055) 6; UMP (Submission 011) 3.
20 Australian Medical Association (Submission 055) 9.
21 Ibid 6.
22 Ibid.

than litigant chosen experts.[23] The UMP, on the other hand, proposed amendments to procedural rules to allow judges to refer to clinical guidelines that were developed by specialist medical colleges in the evaluation of the expert evidence.[24] However, neither of the organisations highlighted any potential problems that were associated with the use of court-appointed expert witnesses nor clinical guidelines in medical negligence litigation in Australia.

5.2.2 Rejection of the original Bolam test in favour of either the Australian common law principle or the English Bolitho principle

Four influential medical and legal representatives believed the *Bolam* test in its original form was no longer appropriate in the assessment of clinical negligence. They were the Australian Plaintiff Lawyers Association (APLA), the Law Council of Australia, the Ramsay Health Care Ltd[25] and the Australian Dental Association.

Some highly persuasive arguments were put forward by the Law Council of Australia, the Ramsay Health Care Ltd and APLA for rejecting the original *Bolam* test. The Council of Australia contended that the original *Bolam* test could potentially allow medical practices that were flawed, convenient to the medical profession and unjustifiable to patients to set the legal standard of care.[26] The absence of judicial scrutiny under the test would also encourage insularity and complacency in the medical profession at the expense of improved quality of health care services in the long run.[27] APLA, on the other hand, suggested that the medical practitioners be scrutinised in the same manner as other individuals and professionals through the court process.[28] In the opinion of APLA, judges, who often decided cases involving complex technical issues with the assistance of experts, were equally capable of determining the appropriate standard of care in negligence cases dealing with diagnosis and treatment.[29] Permitting the medical profession to dictate the outcome of medical disputes, APLA contended, also went against the community desire for equality before the law. Hence, there

---

23 Ibid.
24 UMP (Submission 011) 3.
25 By way of background, Ramsay Health Care Ltd is one of the leading private hospitals in Australia. It owns and operates 23 private hospitals across major cities and regional areas in 5 Australian states.
26 Law Council of Australia (Submission 033) 22.
27 Ibid.
28 Australian Plaintiff Lawyers Association (Submission 042) 27.
29 Ibid.

was no valid ground to accord the medical profession any special privilege in clinical negligence cases under the law.[30]

The four organisations that rejected the original *Bolam* test were equally split on the type of formulation that should be adopted by the Ipp Committee as a substitute. APLA and the Ramsay Health Care Ltd suggested the status quo under Australian common law, allowing judges to be the final arbiters of the standard of care in diagnosis and treatment,[31] as decided by the Australian High Court decision in *Naxakis v Western General Hospital*.[32] In the views of APLA and the Ramsay Health Care Ltd, the courts, as the final forum to whom litigants sought assistance to resolve their disputes, were the appropriate body to make decisions in all types of clinical negligence cases.[33] They argued that the limited expertise that judges face in the adjudication of medical negligence cases could be complemented by the assistance of expert testimony.[34] The other two interest groups, the Law Council of Australia and the Australian Dental Association preferred the English *Bolitho* principle.[35] This test was justified as a means to limiting the application of the original *Bolam* test.[36] It was also defended as a less stringent formulation for the medical profession than the common law position under the case of *Naxakis* because it gave defendant doctors the leeway to prove that their actions or omissions had a 'logical basis'.[37]

Despite the disagreement on the exact formulation that should be chosen, the four interest groups nonetheless reached a consensus that the courts should give considerable weight to expert medical opinion to avoid imposing unrealistic standards on the medical profession.[38] Interestingly, none of these organisations addressed the problem of skewed expert evidence in medical litigation as a result of handpicking witnesses. The Australian Dental Association, which preferred the English *Bolitho* principle, proposed that the courts should not reject an expert opinion which was represented by a significant body of the

---

30 Ibid.

31 Australian Plaintiff Lawyers Association (Submission 042) 25; Ramsay Health Care Pty Ltd (Submission 030) 15-16.

32 (1999) 197 CLR 269 (*Naxakis*). An analysis of the decision in *Naxakis* was given in Section 3.2.6 of Chapter 3.

33 Australian Plaintiff Lawyers Association (Submission 042) 27; Ramsay Health Care Pty Ltd (Submission 030) 15-16.

34 Australian Plaintiff Lawyers Association (Submission 042) 27; Ramsay Health Care Pty Ltd (Submission 030) 15.

35 Law Council of Australia (Submission 033) 22; Australian Dental Association (Submission 017) 2.

36 Law Council of Australia (Submission 033) 22.

37 Australian Dental Association (Submission 017) 2.

38 Ramsay Health Care Pty Ltd (Submission 030) 15; Australian Dental Association (Submission 017) 2.

medical profession unless this opinion was illogical or unreasonable.[39] The rationale underlying this suggestion was the importance of peer review in professional practice. The Australian Dental Association revealed that within the medical and dental professions, peer review is constantly delivered by the appropriate assessing body, without fear or favour, to ensure quality of health services. In the context of medical negligence litigation, the Australian Dental Association stated that peer review is reflected in the use of expert witnesses.[40] The Association, however, did not elaborate on the term 'significant'. Neither did it provide any explanation as to how the requirement for 'significant body of medical opinion' was to be assessed.

5.3 THE RECOMMENDATIONS OF THE FINAL REPORT OF THE IPP COMMITTEE

The Report consisted of 61 reform proposals to the law of negligence in Australia, all of which were finalised on 30 September 2002.[41] Out of the 61 recommendations, 5 specifically dealt with the standard of care as expected of doctors in the areas of disclosure of medical risks, diagnosis and treatment. Most significantly, it called for all its recommendations to be codified in a single statute in each Australian State and Territory:

> '*A national response*
>
> **Recommendation 1**
>
> The Panel's recommendations should be incorporated (in suitably drafted form) in a single statute that might be styled the *Civil Liability (Personal Injuries and Death) Act* ('the Proposed Act') to be enacted in each jurisdiction.'[42]

The Report's recommendations on the standard of care in medical negligence cases comprised of a mixture of reinstatement of the common law principle and substantive changes to the existing common law.

---

39 Australian Dental Association (Submission 017) 2.
40 Ibid.
41 Panel of Eminent Persons, above n 4, 1-24.
42 Ibid 1.

5.3.1 Disclosure of risk

The Report recommended reinstatement of the common law principle with regard to issue of disclosure of risk. The Report proposed that the principle as enunciated by *Rogers* and affirmed in *Rosenberg v Percival*[43] be codified in legislation. The Report classified a doctor's obligation to give advice into proactive duties and reactive duties respectively.[44] A proactive duty requires that a medical practitioner discloses information to patients about the risks of medical treatment, as a reasonable person in the patients' position would want to be given before consenting to the treatment.[45] The doctor would be under no obligation under the proactive duty to give information about obvious risks, including matters that are patent or of common knowledge.[46] On the other hand, a reactive duty demands that a doctor provides information about the risks inherent in a proposed medical treatment which the doctor knows or ought to know a patient would attach significance in deciding whether or not to undergo the treatment.[47] In short, the reactive obligation relates to 'information that the patient has asked for or otherwise communicated a desire to be given.'[48]

5.3.2 Diagnosis and Treatment

The Report proposed a major overhaul to the test for determining negligence in medical diagnosis and treatment. It recommended the following test for statutory enactment:

> 'A medical practitioner is not negligent if the treatment[49] provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.'[50]

The crux of this recommended test was its emphasis on peer review.[51] However, the Report did not proffer adequate guidance as to facilitate the adjudication of medical expert's opinion.

---

43 (2001) 205 CLR 434.

44 Panel of Eminent Persons, above n 4, Recommendation 7(a), 2.

45 Ibid, Recommendation 7(b), 2.

46 Ibid, Recommendations 7(d) and (e), 3.

47 Ibid, Recommendation 7(f), 3.

48 Ibid 52[3.65].

49 The Report defined the word 'treatment' as including diagnosis, the prescribing of medications and the carrying out of medical procedures. See especially Panel of Eminent Persons, above n 4, 37[3.1].

50 Panel of Eminent Persons, above n 4, Recommendation 3, 41-42.

51 Ibid 40[3.16].

In particular, it did not define the terms 'widely', 'significant' and 'respected medical practitioners' and how the requirements should be determined.

5.5.3 Proposed procedural reforms on the use of agreed or court-appointed medical experts

The Report also suggested procedural reforms on the use of medical expert witnesses in medical negligence litigation. One of the related recommendations was the use of agreed or court-appointed experts in appropriate jurisdictions on a 'trial basis' for three years.[52] Under the proposal, any medical expert who was to be called to give testimony must be approved by the parties in litigation.[53] If the litigants could not reach a final agreement on the appointment of a particular expert, the judge would be empowered to select one or more witnesses from a list of experts which had been agreed upon by both parties.[54] In situations where the parties could not reach any consensus on the list of witnesses, the judge could appoint the expert on their behalf.[55] All parties would be entitled to cross-examine the experts appointed under the recommendation.[56] The Report stated that the proposal for expert evidence was not conclusive, conceding that it had been unable to provide a detailed exposition on how the system would work due to insufficient time.[57]

5.4 EXPLANATIONS OF THE RECOMMENDATIONS

The Report aimed to achieve three objectives from its recommended formulation.[58] One was to prevent reliance on localised medical practices that were developed in isolation from the mainstream medical activity. This could be met with the requirement that the medical experts' opinion be 'widely held'. In addition, the condition that the opinion should be supported by a 'significant number' of medical practitioners in the field could filter out idiosyncratic opinions. Finally, the aim of the Report to ensure that expert medical opinion relied upon had a sound basis was underscored by the additional criterion of 'respectability' in the status of medical experts.[59]

---

52 Ibid 55[3.79].
53 Ibid 56[3.81(b)].
54 Ibid 56[3.81(f)(ii)].
55 Ibid 56[3.81(f)(iii)].
56 Ibid 56[3.81(c)].
57 Ibid 55[3.81(g)].
58 Ibid 40[3.15].
59 Ibid.

The Report explained the extent to which expert testimony should influence the outcome of medical disputes in cases of both disclosure of risks and diagnosis and treatment. It stated that expert opinion on provision of advice was not determinative in deciding the amount of information that doctors should disclose to their patients.[60] This was because issues pertaining to the disclosure of risks by doctors and the giving of consent to medical treatment by patients were not matters of medical expertise. Rather, they involved wider questions about the relationship between doctors and patients and the right of individuals to decide their own fate. It would be more appropriate for judges to adjudicate over these matters.[61] By contrast, the more complex nature of medical diagnosis and treatment required the courts to defer to expert medical opinion for setting the appropriate standard of care in these two branches of the doctors' duty of care.[62] Litigants would be precluded from calling medical expert witnesses of their own accord to ensure that the courts were not advised by bias or skewed testimony.[63]

5.5 JUSTIFICATIONS FOR THE PROPOSED MODIFIED *BOLAM* TEST IN DIAGNOSIS AND TREATMENT

The Report justified its departure from the Term of Reference 3(d) on the grounds that its requirements were too restrictive. The main problem was the condition of 'generally accepted practice' which, the Report stated, did not allow for 'genuine difference of opinion'.[64] Another difficulty was that the term 'generally accepted practice' gave no scope for judges to admit expert opinion on new or novel medical procedures.[65] The implication of this latter setback was that doctors would not dare to adopt novel practices for fear of liability for negligence, thus hampering the proper development of cutting edge clinical techniques.[66]

The Report also rejected the original *Bolam* test in its recommendations.[67] The Report's major objection to the *Bolam* test was that the formulation requires the medical profession, not the courts, to set the standard of reasonable care in diagnosis and treatment.[68] The other concern was that the test had allowed the opinion of a small body of medical

60 Ibid 45[3.37].
61 Ibid.
62 Ibid 40[3.16].
63 Ibid 55 and 56[3.74 and 3.80].
64 Ibid 40[3.13].
65 Ibid.
66 Ibid.
67 Ibid 39-40[3.11].
68 Ibid 38[3.6].

practitioners to set the standard of reasonableness.[69] The opinion of a minority of experts may be 'extreme' and confined to a small locality or held by practitioners working in a similar institution.[70]

The Report aimed for a proposal that placed the courts as the ultimate arbiters of the standard of care in diagnosis and treatment.[71] In this regard, the Report preferred a model that was similar to English *Bolitho* principle. It, however, did not adopt the principle in *Bolitho* in its entirety. Instead, it introduced an 'irrational' proviso to the recommended principal provision cited above: a judge may reject a 'widely accepted' opinion if the judge considers that the opinion is 'irrational'.[72] The 'irrational' proviso was intended to empower the courts to exercise control over clinical decision-making of diagnosis and treatment in 'very exceptional cases'.[73] In addition, the adjudication of the 'irrational' proviso should reflect 'the expectation of the Australian community'.[74] The Report did not elucidate the terms 'irrational' and 'very exceptional cases'. Neither did it elaborate on the notion of community expectation, a collateral standard which is pivotal to the application of the 'irrational' proviso. Another advantage of the proviso is that it gives judges guidance as to when the opinion of medical experts may be overruled, an element which is lacking in the Australian common law position.[75]

The Report also proffered reasons for its recommendations for agreed or court-appointed expert. The proposals aimed to address two problems in the system of expert evidence. The first was the issue of witnesses 'consciously or sub-consciously slant [sic] their testimony to favour the party who retains them'.[76] The Report accepted that the setback was contributed by the inherent weakness of the adversarial trial process which failed to provide safeguards against biased experts.[77] The existence of these 'bias [sic] experts' was stated to be

---

69 Ibid 39[3.8].
70 Ibid 39[3.8] and 40[3.11].
71 Ibid 38[3.6].
72 Ibid 41[3.18].
73 Ibid 42[3.24].
74 Ibid.
75 Ibid 4[3.17]. This criticism was raised in the analysis of the Australian High Court decision in *Naxakis* under Section 3.3.1 of Chapter 3.
76 Ibid 54[3.74].
77 Ibid.

rampant in medical litigation where some doctors even devoted their time entirely to giving expert opinion in the courts.[78]

Another problem that the Report sought to resolve was the widespread practice of parties in disputes dispensing with the presence of expert witnesses in the courts, with their opinion confined to expert reports and no cross-examination taking place.[79] Although the Report acknowledged that the practice would reduce delays and costs in the litigation process, it criticised the practice as 'contrary to the accepted tenets of the adversarial system'.[80] It would also mean judges would have to 'choose between competing views contained in the expert report'.[81] The mechanism of court-appointed experts would ensure that judges see and hear the witnesses and compel the litigants to cross-examine the appointed experts. However, the Report qualified that the problems in expert evidence were not a common phenomenon across Australia.[82] Hence, it did not recommend a national reform, but on a three-year trial basis, with subsequent evaluation, in jurisdictions where the problems were recognised as 'serious'.[83]

5.6 THE STRENGTHS OF THE REPORT'S PROPOSED MODIFIED *BOLAM* TEST

The Report stated that its recommended test would provide safeguards to the interests of the medical profession, patients and the wider Australian community.[84] Since judges can only reject a 'widely held' opinion in 'very exceptional cases', medical practitioners who follow mainstream clinical practices would be protected against negligence suits.[85] In addition, doctors who work at the cutting edge of medical practice would not be excluded from the suggested formulation as the test would allow differences of clinical opinions.[86] Judges would not be allowed to adjudicate between the opinions.[87]

---

78 Ibid.
79 Ibid 54[3.76].
80 Ibid.
81 Ibid.
82 Ibid 55[3.79].
83 Ibid.
84 Ibid 42[3.24].
85 Ibid.
86 Ibid 42[3.23].
87 Ibid 42[3.22].

With regard to the interests of the broader community, the Report justified that the recommended test would provide clarity and certainty in the law. The consistency and unambiguous nature of the proposal would have a positive impact on the price of medical indemnity insurance, hence benefiting the general public.[88] There was, however, no mention as to how the proposed rule would serve the interest of patients, particularly those who are involved in medical negligence disputes.

5.7 IMPLEMENTATION OF THE REPORT'S RECOMMENDATIONS AT THE STATE JURISDICTIONS

All the Australian states have responded to the Report's call for legislative reform to the standard of care in diagnosis and treatment. The New South Wales Parliament was the first to codify the modified *Bolam* test under its *Civil Liability Act 2002* (NSW)[89] on 22 November 2002. This was followed by Queensland,[90] Tasmania,[91] Western Australia,[92] Victoria[93] and South Australia.[94] The Australian Territories chose not to implement the Report's proposed test. Northern Territory took the decision to maintain the legal position as established by *Naxakis* whilst the Australian Capital Territory statutorily qualified the common law.[95]

5.7.1 A general overview of the implementation at State jurisdictions

One important observation of the statutory implementation of the modified *Bolam* test by the States is that it has not been consistent. As far as the form of the legislation is concerned, Tasmania, Queensland, New South Wales and South Australia have named their respective statutes the *Civil Liability Act*.[96] The South Australian *Civil Liability Act* was dated 1936 as a result of the renaming of its *Wrongs Act 1936* (SA) by the *Law Reform (Ipp*

---

88 Ibid 42[3.21].

89 As amended by the *Civil Liability Amendment (Personal Responsibility) Act 2002* (NSW). The amending Act came into operation on 6 December 2002.

90 *Civil Liability Act 2003* (Qld). This Act was enacted on 3 April 2003 and the provisions relating to the modified *Bolam* test took effect retrospectively on 2 December 2002.

91 *Civil Liability Amendment Act 2003* (Tas). All the provisions in this Act commenced on 4 July 2003.

92 *Civil Liability Amendment Act 2004* (WA). The provisions under this Act came into operation retrospectively on 1 December 2003.

93 *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic). The statutory provisions on the standard of care in clinical diagnosis and treatment were among the majority provisions that took effect on 3 December 2003.

94 *Law Reform (Ipp Recommendations) Act 2004* (SA). This Act was effective on 1 May 2004.

95 These are explained in Sections 5.8 and 5.9 of this chapter.

96 *Civil Liability Act 2002* (Tas); *Civil Liability Act 2002* (NSW); *Civil Liability Act 2002* (WA); *Civil Liability Act 2003* (Qld).

Recommendations) Act 2004 (SA). Victoria, on the other hand, chose to maintain its *Wrongs Act 1958* (Vic) without changing the name of that Act.

There is, in addition, a lack of uniform take up of a group of material words in the Report's recommended test in most jurisdictions. Among the States which have implemented the modified *Bolam* test, only the Queensland Parliament framed an almost identical provision to the Report's recommendation. Section 22(1) of the *Civil Liability Act 2003* (Qld) provides that a professional, including a medical practitioner, is not negligent if:

> '... it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice'.[97]

As to the locality of 'widely accepted' opinion, four States, with the exception of Western Australia and Queensland, qualified the requirement to only 'in Australia'.[98] The term 'respected practitioners in the field' only appears in the Queensland and Victorian legislation.[99] None of the *Hansards* from the State Parliaments provide any information on the material distinctions of the different wording in the statutory provisions.

The other significant discrepancy lies in the stipulation which authorises judges to reject a 'widely accepted' opinion. Four Australian states, New South Wales, Queensland, South Australia and Tasmania implemented the 'irrationality' qualification as proposed by the Report.[100] The term 'irrational' was not defined in any of the States' legislation and was intentionally left by the legislatures to judicial interpretation in due course.[101] Nonetheless, it

---

97 The corresponding provision under Section 5PB(1) of the *Civil Liability Act 2002* (WA) is similar to Section 22(1) of the *Civil Liability Act 2003* (Qld), except that the former has omitted 'a significant number of respected practitioners in the field'. Section 5PB(1) of the *Civil Liability Act 2002* (WA) states that:

> 'An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice'.

98 *Civil Liability Act 2002* (NSW) Section 5O(1); *Civil Liability Act 2002* (Tas) Section 22(1); *Wrongs Act 1958* (Vic) Section 59(1); *Civil Liability Act 1936* (SA) Section 41(1).

99 *Wrongs Act 1958* (Vic) Section 59(1).

100 *Civil Liability Act 2002* (NSW) Section 5O(2); *Civil Liability Act 1936* (SA) Section 41(2); *Civil Liability Act 2002* (Tas) Section 22(2); *Civil Liability Act 2003* (Qld) Section 22(2).

101 Queensland, *Parliamentary Debates*, Legislative Assembly, 11 March 2003, 367 (R J Welford, Attorney General and Minister of Justice).

has been stated in parliamentary debates that 'irrationality' would be assessed against the 'normal bounds of community expectation'.[102] It is also clear from the parliamentary debates that the proviso was designed to make it 'much harder for the court to disregard' the opinion of medical experts as compared with the position of the common law.[103]

5.7.2 Departure from the 'irrational' proviso

The States of Victoria and Western Australia did not adopt the 'irrational' proviso. Instead, both jurisdictions implemented an 'unreasonable' caveat in their legislation.[104] The statutes of neither State define the scope of unreasonableness and how it should be interpreted. The only assistance given by the Victorian Parliament was that the 'unreasonable' requirement would give more discretion to the courts to overrule peer professional opinion than the 'irrational' proviso.[105] A South Australian legislator has said that the introduction of the 'unreasonable' proviso in the *Wrongs Act 1958* (Vic) was a result of extensive lobbying by 'a very significant and politically strong group in the legal profession'.[106] Contrary to this allegation, the Victorian legislature offered two reasons for rejecting the 'irrational' proviso. One was that the criterion had not been tested in Australian jurisdictions.[107] The other reason concerned the ambiguity of the term 'irrational' as its dictionary definition includes meanings such as 'illogical', 'absurd' or 'unreasonable'.[108]

The 'unreasonable' provisos under the Victorian and Western Australian legislation contain one material difference. The former authorises judges to dismiss a widely accepted opinion that is considered 'unreasonable'.[109] The latter, structured upon the principle of *Wednesbury* unreasonableness, enables the courts to reject a widely held opinion if it is 'so unreasonable that no reasonable health professional in the health professional's position could have acted or omitted to do...'.[110] This public law doctrine of *Wednesbury* unreasonableness

---

102 Ibid.

103 New South Wales, *Parliamentary Debates*, Legislative Assembly, 23 October 2002, 5766 (Robert Carr, Premier of New South Wales, Minister for the Arts and Minister for Citizenship).

104 *Wrongs Act 1958* (Vic) Section 59(2); *Civil Liability Act 2002* (WA) Section 5PB(4).

105 Victoria, *Parliamentary Debates*, Legislative Council, 30 October 2003, 1856 (C A Strong, the Chair of the Legislative Committee, Member of Parliament for Higinbotham).

106 South Australia, *Parliamentary Debates*, House of Assembly, 23 February 2004, 1359 (Chapman, Member of Parliament for Bragg).

107 Victoria, *Parliamentary Debates*, Legislative Council, 30 October 2003, 1857 (Lenders, Minister for Finance of the State of Victoria).

108 Victoria, *Parliamentary Debates*, Legislative Council, 30 October 2003, 1857 (C A Strong).

109 *Wrongs Act 1958* (Vic) Section 59(2).

110 *Civil Liability Act 2002* (WA) Section 5PB(4).

was derived from the English House of Lords case of *Associated Provincial Picture Houses Ltd v Wednesbury Corporation*.[111] In the context of medical negligence cases concerning diagnosis and treatment, the principle was applied by Dillon LJ in the Court of Appeal decision in *Bolitho v City and Hackney Health Authority*:

> 'In my judgment, the court could only adopt the approach of Sachs L.J. and reject medical opinion on the ground that the reasons of one group of doctors do not really stand up to analysis, if the court, fully conscious of its own lack of medical knowledge and clinical experience, was none the less clearly satisfied that the views of that group of doctors were *Wednesbury* unreasonable, i.e views such as no reasonable body of doctors could have held'.[112]

As regards the discretion of the courts to reject a widely accepted opinion, it has been noted that the Western Australian proviso is more restricted than its comparable 'unreasonable' proviso under the *Wrongs Act 1958* (Vic). The effect of the Western Australian model was said to resemble the application of the *Bolam* test in its original form:

> '... this Bill deals with... the application of the *Bolam* test to health professionals... The *Bolam* test seeks to take us back to what the law was some years ago. It worked very well. It is a very fair and reasonable test, and it provides for certainty...'.[113]

5.7.3 Reinstatement of the Bolam Jurisprudence in the Modified Bolam Test

Despite the myriad versions of the modified *Bolam* test implemented by the six Australian states, all the State jurisdictions unanimously reinstated some of the common law principles of the *Bolam* test. Among them was the principle that the standard of care in diagnosis and treatment must be determined according to what an ordinary competent doctor would have

---

111 [1948] 1 KB 223. See Section 2.6.2 of Chapter 2 for an explanation of the principle of '*Wednesbury* unreasonableness'. In the House of Lords decision in *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410, Lord Diplock likened '*Wednesbury* unreasonableness' as the 'irrationality' ground for judicial review of public administrative body's decisions.

112 (1993) 4 Med LR 381, 392. A more detailed analysis of the Court of Appeal decision in *Bolitho v City and Hackney Health Authority* (1993) 4 Med LR 381 was given in Section 2.6.2 of Chapter 2.

113 Western Australia, *Parliamentary Debates*, Legislative Council, 19 August 2004, 5220 (Nick Griffiths, Minister for Housing and Works).

done at the time of the incident, not a later date.[114] This principle was intended to prevent judges from passing hindsight judgment.[115] All the comparable statutes also allow for differences in expert opinions.[116] Any one of the widely accepted opinions may be admitted as evidence to support a defendant doctor's case, provided that the opinion does not contravene the 'irrational' or 'unreasonable' proviso.

5.8 THE JUSTIFICATIONS FOR NOT IMPLEMENTING THE REPORT'S RECOMMENDATION IN THE AUSTRALIAN TERRITORIES

Two main reasons may be gleaned in the *Hansards* of the Territories for refusing to statutorily implement the Report's proposal on the standard of care in medical diagnosis and treatment. One was that the Territories were not convinced that the common law principle relating to the standard of care of doctors had contributed to the medical indemnity crisis. The Australian Capital Territory Parliament, for instance, pointed to the empirical study conducted by the Legal Process Reform Group of the Australian Health Ministers Advisory Council (AHMAC) in 2002, showing that the crisis might have been caused by external reasons within the medical indemnity industry, and that no legislative reform was needed to replace the common law.[117] Similarly, the Northern Territory Parliament took the view that the reform package which addressed the medical indemnity crisis should take into account the findings of not only the Report but also that of the 2002 report of AHMAC.[118]

The other reason was that the Report's proposed test on the standard of care in diagnosis and treatment favoured the medical profession at the expense of the interests of injured patients. The proposed test, in the words of the then Chief Minister of the Australian

---

114 *Civil Liability Act 2002* (NSW) Section 5O(1); *Civil Liability Act 1936* (SA) Section 41(1); *Civil Liability Act 2002* (Tas) Section 22(1); *Civil Liability Act 2003* (Qld) Section 22(1); *Wrongs Act 1958* (Vic) Section 59(1); *Civil Liability Act 2002* (WA) Section 5PB(1).

115 South Australia, *Parliamentary Debates*, House of Assembly, 16 February 2004, 1187 (K O Foley, Deputy Premier of South Australia).

116 *Civil Liability Act 2002* (NSW) Section 5O(3); *Civil Liability Act 1936* (SA) Section 41(3); *Civil Liability Act 2002* (Tas) Section 22(3); *Civil Liability Act 2003* (Qld) Section 22(3); *Wrongs Act 1958* (Vic) Section 59(3); *Civil Liability Act 2002* (WA) Section 5PB(3).

117 Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 September 2002, 3155 (Jon Stanhope, Chief Minister, Attorney-General, Minister for Community Affairs and Minister for the Environment of the Australian Capital Territory), quoting the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group (Chair: Marcia Neave), *Responding to the Medical Indemnity Crisis: An Integrated Reform Package* (2002) 66[6.41 and 6.42]. See also Section 4.3.1 of Chapter 4 for an analysis of the external reasons identified by AHMAC.

118 Northern Territory, *Parliamentary Debates*, House of Assembly, 27 November 2002, Parliamentary Record No. 9 (Peter Toyne, Minister for Justice and Attorney General) < http://notes.nt.gov.au/lant/hansard/hansard9.nsf/WebFullTextTranscript/270727FE049F987D69256C990006076F?opendocument>.

Capital Territory, enabled doctors 'to get together and decide for themselves if one of the colleagues has been negligent'.[119] It was further stated by the Chief Minister of the Australian Capital Territory that:

> 'Unlike some other Australian jurisdictions, my government has chosen a path that will not exclude genuine plaintiffs from exercising their rights to seek redress for [medical] negligent conduct...'.[120]

The major advantage of the common law position on the standard of care of doctors, the Chief Minister stated, was that it provided 'a fair balance between the role the courts play as independent decision makers and the role of medical experts who give evidence'.[121]

5.9 DISTINCTIVE FEATURES IN THE APPLICATION OF THE COMMON LAW IN THE AUSTRALIAN TERRITORIES

The application of the common law principle of the standard of care in diagnosis and treatment in the Australian Capital Territory and Northern Territory contains two notable distinctions. One relates to procedural changes on the use of expert witnesses in medical negligence litigation. In the Australian Capital Territory, the appointment of a single agreed or a single court-appointed expert is made after the commencement of personal injury proceedings, including medical negligence litigation.[122] The appointment of additional court-appointed experts remains within the discretion of the court.[123] Under this system, which was not implemented in Northern Territory, litigants agree on one witness,[124] selected from a list of medical experts as approved by the Australian College of Surgeons.[125] If no agreement is

---

119 Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 September 2002, 3156 (Jon Stanhope).

120 Ibid, 24 June 2003, 2245 (Jon Stanhope).

121 Ibid, 24 September 2002, 3156 (Jon Stanhope).

122 *Civil Law (Wrongs) Act 2002* (ACT) Sections 85(1) and 86(1) read together with Division 2.12 of the *Civil Procedures Rules 2006* (ACT). The State of Queensland also statutorily introduced the system of a single agreed or a single court-appointed expert in civil proceedings at the Supreme Court, which also included medical negligence cases. The main difference between the models in Queensland and the Australian Capital Territory is that the appointment of this expert in Queensland is made before the commencement of legal proceedings. See Sections 8.4.2 and 8.4.3 of Chapter 8 for an analysis of the reform models in Queensland and the Australian Capital Territory.

123 *Civil Law (Wrongs) Act 2002* (ACT) Section 86(2).

124 *Civil Law (Wrongs) Act 2002* (ACT) Section 85(1).

125 Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 June 2003, 2246 (Jon Stanhope).

reached, the court appoints an expert on the parties' behalf.[126] In either instance, the parties share the cost of this single expert equally or as otherwise agreed by them or ordered by the court.[127] The use of this expert aims to resolve the problem of partisan expert medical opinion brought about by the system of litigant-appointed experts.[128] Its purpose is also to reduce costs as litigants share the cost of one medical expert, as opposed to each of them appointing at least one expert.[129]

The other distinction lies in substantive principle.[130] In 2003 statutory provision was introduced in the Australian Capital Territory requiring the single agreed or the single court-appointed expert to inform the court whether the diagnosis and treatment in question was 'in accordance with an opinion widely held by a significant number of respected practitioners in Australia in the relevant field'.[131] The introduction of this statutory provision was a result of lobbying by the Australian Medical Association (AMA), as revealed in the second reading speech of the Hon Jon Stanhope, the Chief Minister of the Australian Capital Territory:

> 'I might say, and add, Mr Speaker, for the information of members, that this particular amendment was negotiated by the government with the AMA and is essentially akin to the modified *Bolam* test which the medical profession were seeking as an alternative to the position that the government proposes...'.[132]

The emphasis on the number of medical experts expressing similar opinions under the statutory provision in the Australian Capital Territory is arguably a modification of the common law position. As stated in a previous chapter, the Australian High Court in *Naxakis* held that the issue of medical negligence in the areas of diagnosis and treatment may be determined by the court where there is only one body of expert medical opinion or, in certain circumstances, indirect medical evidence.[133] This reform also brings the application of the common law in the Australian Capital Territory closer to the modified *Bolam* test in the

---

126 *Civil Law (Wrongs) Act 2002* (ACT) Section 86(1).
127 *Civil Law (Wrongs) Act 2002* (ACT) Section 90.
128 Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 June 2003, 2246 (Jon Stanhope).
129 Ibid.
130 Ibid.
131 *Civil Law (Wrongs) Act 2002* (ACT) Section 87(4).
132 Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 21 August 2003, 3011 (Jon Stanhope).
133 See Sections 3.2.6 of Chapter 3 for an analysis of the decision in *Naxakis*.

Australian states, except without a statutory proviso stating when judges may reject expert medical opinion.

5.10 AN ASSESSMENT OF THE IMPLEMENTATION OF THE AUSTRALIAN MODIFIED *BOLAM* TEST

The implementation of the modified *Bolam* test is a novel step in the development of the law of medical negligence in Australia. Fundamentally, the test for determining the standard of care in diagnosis and treatment in Australia can no longer be regarded as largely a common law field. The crystallisation of the law would also mean that the doctor-patient relationship in both aspects of the doctor's duty of care would now be subject to the additional theoretical and practical issues of statutory scope and interpretation. Against this backdrop of originality in the legislative reform, this section, however, puts forward several criticisms at the Australian modified *Bolam* test and its bases.

5.10.1 Flawed review and legislative process

The Ipp Committee arguably did not undertake adequate scrutiny of the information it gathered. The Report stated that there was a 'widely held' perception in the Australian community that the principles of the law of negligence, including that of medical negligence, were 'unclear' and 'unpredictable' and that it has become 'too easy' for plaintiffs to establish liability against doctors.[134] The Ipp Committee did, during its review process, gather written submissions from various interest groups. These written submissions, as the previous sections of this chapter demonstrated, were largely self-serving and devoid of independence. There was also a lack of full analysis in the written submissions of the assumptions that the common law principle was uncertain, ambiguous and led to outcomes that were favourable to plaintiffs in medical negligence disputes.

The Ipp Committee recognised the shortcomings in its inquiry.[135] The Report revealed that the vast majority of the assertions in the written submissions were based on anecdotal evidence and the panel members were unable to test the reliability of the assertions with any empirical evidence.[136] To make the review process justifiable, the Report stated that the underlying objective of the proposed law reform was not to ascertain the truthfulness or

134 Panel of Eminent Persons, above n 4, 25[1.4(a) and (b)].
135 Ibid 32[1.38].
136 Ibid.

otherwise of those perceptions, but instead to address the 'general belief in the Australian community that there is an urgent need' to reform the law of negligence.[137]

The issue of lack of thorough assessment of information is arguably not confined to the review process of the Ipp Committee itself. It is also evident in the recommendations of the Ipp Committee. Instead of structuring the reform proposals on hard evidence, the Report stated that all the recommendations were based on three simplistic steps: perusing the written submissions, conducting research, and finally, relying on the somewhat vague 'collective sense of fairness' of its Panel members.[138]

The short period of time allotted to the Ipp Committee to complete the legal inquiry might have been the main reason why it was unable to verify the assumptions on which the law review was based. Several members of the public, through their written submissions, had criticised the limited time frame and urged the Ipp Committee to seek more time rather than constraining itself to the three-month deadline.[139] The Ipp Committee, however, did not take heed of the advice, stating that it was able to recommend 'some principled and soundly-based options' within the time allotted to it.[140]

The State Parliaments, on the other hand, also did not undertake a wide-ranging inquiries and assessment as to whether the principles of medical negligence under the common law were flawed. As the records of the parliamentary debates show, none of the legislators produced any reports to challenge the perceptions that the law of medical negligence was 'uncertain', or that the legal principle had been unfairly applied against defendant doctors. The State Parliaments also did not conduct any independent assessment to consider the feasibility of an alternative mode of reform that might help to address the medical indemnity crisis. In Victoria, evidence had previously suggested that its Parliament had failed to conduct adequate discussion and consultation with the relevant interested parties before passing the *Wrongs and Other Acts (Law of Negligence) Bill* (Vic). The Hon C A Strong quoted the comments of the Common Law Bar Association (Victoria) in the Victorian Legislative Council:

---

137 Ibid 26[1.6].
138 Ibid 32[1.38].
139 Ibid 31[1.31].
140 Ibid 32[1.37].

'I am indebted to the Common Law Bar Association for a very full, well-thought-out and clear critique of this bill. Under the heading "Process" it states:

> 'Given that the government asserts that the "key aim of the bill" is to provide 'improved clarity and guidance' in relation to the principles of negligence, one would have thought that the first step taken by the government would be to engage in wide-ranging discussion and consultation with all interested parties before implementing a bill which sought to allegedly "codify" the law of negligence. On any view such an enterprise is a difficult and far-reaching exercise that requires considerable thought, time and effort. Rather, the government has engaged in a rushed, inadequate and unfair process of so-called consultation with members of interested groups'.[141]

The State Parliaments seemed desperate to implement the Report's recommended *Bolam* test, as though it was the only solution to the crisis. Less than two months after the Report was released on 2 October 2002, the New South Wales Parliament legislated the modified *Bolam* test. The corresponding provisions of the test in other States, such as Western Australia and Queensland that were enacted in subsequent years, had nonetheless been given retrospective effect.[142] Such speedy implementation of the test was commended by politicians. For instance, the Queensland Parliament prided itself for having 'responded quickly and decisively to the insurance crisis'.[143] Although most of the evidence before the Ipp Committee was anecdotal, the then Premier of New South Wales, Robert Carr, was reportedly hailing the statutory enactment, among others, on medical negligence, a 'triumph for common sense'.[144] The politicians and the legislators obviously did not regard the dearth of hard evidence to substantiate the implementation of the modified *Bolam* test as a real problem.

---

141 Victoria, *Parliamentary Debates*, Legislative Council, 26 November 2003, 1844 (C A Strong).

142 *Civil Liability Act 2003* (Qld). The Act was enacted on 3 April 2003. However, the provisions on the test for deciding the standard of care in diagnosis and treatment, *inter alia*, took effect retrospectively on 2 December 2002. The corresponding *Civil Liability Amendment Act 2004* (WA) also came into operation retrospectively on 1 December 2003.

143 Queensland, *Parliamentary Debates*, Legislative Assembly, 11 March 2003, 366 (R J Welford).

144 New South Wales, *Parliamentary Debates*, Legislative Assembly, 23 October 2002, 5764 (Robert Carr).

5.10.2 The modified Bolam test jeopardises the interests of injured patients in medical disputes

The modified *Bolam* test was arguably implemented at the expense of injured patients' interests in medical negligence disputes. It is clear from the extrinsic evidence to the statutory enactment of the modified *Bolam* test that the 'irrational' and *Wednesbury* 'unreasonable' provisos are meant to make it onerous for plaintiffs to convince the courts that a 'widely accepted' opinion is negligent.[145] A Western Australian legislator even stated that injured patients would have an uphill task to commence medical negligence proceedings in the courts:

> '... it seems to me that under those proposed subsections it will be virtually impossible for a plaintiff to mount a case... I believe that premiums should certainly decrease because I cannot see that a plaintiff in any situation will be able to successfully argue his case in court. That is disturbing. This is not quality legislation'.[146]

Even assuming that injured patients could file medical negligence suits, their interests would not be given sufficient consideration by the courts. Unlike the English and Singaporean *Bolitho* principles,[147] the 'irrational' and 'unreasonable' provisos impose no obligation on judges to consider whether the benefits of adopting the medical procedure in question outweigh the risks to the patients. If there should be any such balancing analysis, it would have been at the discretion of medical expert witnesses.

5.10.3 The test lacks practical guidance from the State legislators

The statutory provisions for the modified *Bolam* test are arguably devoid of clarity and practical guidance to facilitate application by judges. One of the key requirements under the modified *Bolam* test that was left undefined by State legislators is the term 'widely accepted'. In the context of litigation, it is unclear how judges would construe a 'widely accepted' opinion. Should judges gather statistics from formal surveys of respectable medical bodies?[148]

---

145 Ibid 5766.

146 Western Australia, *Parliamentary Debates*, Legislative Council, 19 August 2004, 5228 (John Fischer, Minister for Mining and Pastoral).

147 There are, however, a number of distinctions between the English and Singaporean *Bolitho* principles. See Section 2.9 of Chapter 2 for an analysis of these distinctions.

148 Kathy Sant, 'A New *Bolam* Test?', (2004) 64 *Precedent* 20, 22.

Alternatively, would judges be required to make reference to medical literature and practice guidelines, or simply calculate the number and ratio of medical experts who are called in the trials?[149] The application of the requirement for 'widely accepted' is also problematic in the case of cutting-edge treatment or diagnosis where the number of medical doctors who adopt new medical techniques is understandably low.

The State legislators also did not provide clear guidance to assist judges to decide whether an opinion may be considered 'irrational' or 'unreasonable'. The Report and second reading speeches of the Queensland Parliament stated that the proviso should be judged against 'community expectation'.[150] A reference to 'community expectation' is arguably vague and ambiguous. On the one hand, there is the community of plaintiff patients in medical negligence disputes whose interests are in conflict with that of the defendant doctors and their insurers, the latter of whom aim to reduce the costs of negligence.[151] There is also, on the other hand, the expectation of the greater Australian community to see that the legal system compensates victims in medical negligence cases according to the severity of the injuries and the degree of fault committed by the doctors.[152]

In view of this ambiguity, two fundamental questions were arguably left unaddressed by the respective State legislators in implementing the 'irrational' and 'unreasonable' provisos. One was the expectation of the Australian community in relation to legislation that was meant to protect the medical profession. The other was whether judges should take into account the interest of parties beyond the medical disputes, say, the insurers or that of the larger Australian public. In common law, it is a rarity for judges to consider the interests of those who are not parties to the disputes before them.[153] Justice Michael McHugh, a judge of the High Court of Australia, has extra-curially commented that the open-ended notion of 'community expectation' might herald a 'changing paradigm of the common law', requiring judges to consider the concerns of those who do not have direct interest in medical disputes.[154] This comment might be helpful. It is, however, regrettable that this guidance was

149 Ibid.

150 Panel of Eminent Persons, above n 4, 42[3.24]; Queensland, *Parliamentary Debates*, Legislative Assembly, 11 March 2003, 367 (R J Welford).

151 Joanna Davidson, 'Reform of the Law of Negligence: Balancing Costs and Community Expectations', Foreword, (2002) 25(3) *University of New South Wales Law Journal* 808, 808.

152 Ibid.

153 Justice Michael McHugh, 'Introduction: Sydney Law Review Torts Special Issue', (2005) 27 *Sydney Law Review* 385, 391.

154 Ibid.

given neither by the Ipp Committee nor the respective State legislators, both of whom were entrusted to implement a clear and predictable test for determining the standard of care in the areas of medical diagnosis and treatment.

5.11 THE AUSTRALIAN MODIFIED *BOLAM* TEST IN PRACTICE

There is currently no Australian High Court decision concerning the interpretation of the modified *Bolam* test in medical negligence cases of diagnosis and treatment. A number of recent Australian Court of Appeal and Supreme Court cases, however, have provided some guidance as to how the test should be construed and applied. These important cases are found mainly in the states of New South Wales and Victoria.

The most important case to date is arguably the New South Wales Court of Appeal decision in *Dobler v Halverson*.[155] *Dobler* is significant because of its pronouncement that the Australian modified *Bolam* test is merely a defence to liability for medical negligence rather than an outright abolitition of the common law position under the decision in *Naxakis*. The appellant in *Dobler* was a general practitioner who allegedly failed to refer the respondent patient to an electrocardiogram (ECG) or to a cardiologist in view of his heart condition. The respondent later suffered from cardiac arrest and hypoxic brain damage. The issue before the Court was whether the appellant had breached his duty of care under Section 5O of the *Civil Liability Act 2002* (NSW).[156] In particular, the Court was asked to consider the operation and impact of this statutory provision on burden of proof.

The arguments of the opposing parties were of great interest and they are worth noting in this analysis. The appellant submitted that Section 5O of the *Civil Liability Act 2002* (NSW) defined the content of the standard of care. On this view, the appellant argued that the respondent patient must discharge the burden of proof to show that his omission was not an accepted practice widely supported by a significant number of medical practitioners in Australia. In support of these arguments, the appellant referred to Section 5 of the *Civil Liability Act 2002* (NSW) which defines 'negligence' to mean 'failure to exercise reasonable care and skill'. This definition, the appellant contended, also applied to Section 5O of the Act.

---

155 (2007) 70 NSWLR 151 (*Dobler*).

156 This provision states, *inter alia*, that a doctor is not liable for negligence if his or her action or omission is supported by an opinion widely accepted by other competent medical professionals in Australia, unless the court considers that the opinion is irrational.

The respondent, however, argued that S5O of the Act was more properly considered as a special defence to medical negligence. In line with this argument, the respondent instead must prove that the requirements under Section 5O of the Act were satisfied.

The Court of Appeal, consisting of Giles JA, Basten JA and Ipp JA,[157] unanimously held that Section 5O of the Act provides a defence to medical negligence.[158] The Court cited two extrinsic materials to support this interpretation. One was Paragraph 3.22 of the Report which states that the modified *Bolam* test 'provides a defence for any medical practitioner whose treatment...'.[159] The other was the *Hansard* which also stated that legislative provision was 'an additional defence to alleged professional negligence'.[160] This interpretation of S 5O means that the plaintiff bears the burden of proving negligence. Once this burden is discharged, the defendant doctor must satisfy the court that the requirements under S 5O are met.[161]

The more important part of the Court of Appeal decision in *Dobler*, however, was that Section 5O of the Act does not completely replace the principle in *Rogers*, or *Naxakis* as the principle applies in the areas of medical diagnosis and treatment. Giles JA, who delivered the judgment of the Court in *Dobler*, stated that the standard of care as claimed by a plaintiff:

> '... will be that determined by the Court with guidance from evidence of acceptable professional practice unless it is established (in practice, by the defendant) that the defendant acted according to professional practice widely accepted by (rational) peer professional opinion...'.[162]

In *Dobler* the Court found that the respondent had established an initial case of negligence and the appellant doctor had failed to prove that the criteria under Section 5O of the Act were satisfied.

---

157 Ipp JA was one of the panel members in the Ipp Committee.

158 See also the New South Wales Court of Appeal decision in *Sarian v Elton* [2011] NSWCA 123 (19 May 2011) [159] and the dicta of Rares J in the recent Federal Court case of *Wingecarribee Shire Council v Lehman Brothers Australia Ltd (in liq)* [2012] FCA 1028 (21 September 2012) [1113].

159 *Dobler* (2007) 70 NSWLR 151, 168.

160 Ibid. The Court quoted the second reading speech of Robert Carr, Premier of New South Wales, Minister for the Arts and Minister for Citizenship. See New South Wales, *Parliamentary Debates*, Legislative Assembly, 23 October 2002, 5766.

161 *Dobler* (2007) 70 NSWLR 151, 167.

162 Ibid 168.

The decisions in *Dobler* have since been reaffirmed by a number of Australian lower court cases. In *Braikoulias v Karunaharan*[163] and *King v Western Sydney Local Health Network*,[164] it was held by the Supreme Courts in Victoria and New South Wales respectively that the determination of the standard of care under the Australian modified *Bolam* test involves three main steps:

1. A plaintiff discharges the legal burden to prove negligence under the common law standard of care as expressed in *Naxakis*;
2. If the court finds that the burden is discharged, the defendant is to be found negligent unless he or she can establish that the defence as provided by the modified *Bolam* test applies.
3. The court determines whether the 'irrational' or 'unreasonable' proviso should apply.

5.12 A CRITIQUE OF THE APPLICATION OF THE AUSTRALIAN MODIFIED *BOLAM* TEST

The analysis of *Dobler* and a number of Australian Supreme Court cases shows that *Naxakis* is still relevant, at least in relation to proving negligence by a plaintiff in a medical dispute concerning issues of diagnosis and treatment.[165] The modified *Bolam* test is only applicable when determining whether a defendant doctor has discharged his or her burden of disproving negligence.[166] Whilst these cases rightfully affirm the burden of proof in medical negligence cases at common law,[167] it is argued that the reintroduction of the decision in *Naxakis* in establishing liability for negligence by a plaintiff is unwarranted. The assessment of the Ipp Report and the states' *Hansards* in previous sections of this chapter has demonstrated that the modified *Bolam* test was meant to replace the common law completely in medical negligence cases concerning diagnosis and treatment.[168] Neither extrinsic material has indicated the relevance of *Naxakis* in discharging the burden of proof by a plaintiff.

---

163 [2012] VSC 272 (12 June 2012).

164 [2011] NSWSC 1025 (7 September 2011) [111].

165 See also Bill Madden, 'Three Dimension of the Standard of Care in Professional Negligence Cases', (2008) 4(8) *Australian Civil Liability* 89, 93.

166 See also Harold Luntz, David Hambly, Kylie Burns, Joachim Dietrich and Neil Foster, *Torts Cases and Commentary* (Lexis Nexis Butterworths Australia, 6th ed, 2009) 431.

167 See eg, *Naxakis* (1999) 197 CLR 269, 281 (McHugh J).

168 See Sections 5.3 and 5.7 of this chapter.

The adverse implication of *Dobler* is that it may encourage more injured patients to commence legal proceedings against doctors, thereby causing a rise in medical negligence litigation. It has been argued in a previous chapter that a plaintiff may easily prove negligence under the principle in *Naxakis*.[169] There is no doubt that the ultimate standard of care will be determined by the application of the modified *Bolam* test. These patients may not be interested in pursuing the litigation fully. They may, however, use these court actions as strategies for negotiating out-of-court settlements with doctors whose reputation may have been adversely affected by the litigation. The better approach than in *Dobler*'s is to state that a plaintiff discharges his or her burden of proving negligence by solely relying on expert medical opinion. The role of the court is to determine which side of the expert opinion satisfies the requirements of the modified *Bolam* test. This suggested interpretation is arguably more in tandem with the legislative intent of the test.

5.13 CONCLUSION

The adoption of the modified *Bolam* test by the Australian states means that it is now more difficult to hold doctors liable for negligence in the spheres of diagnosis and treatment in the jurisdictions. The implementation of the test may no doubt reduce medical disputes and, hence, prevent another wave of medical indemnity crisis. Nonetheless, the drastic approach of jettisoning the common law principle is arguably overshadowed by the question as to whether the reform is indeed necessary and justifiable. Neither the Report nor the State Parliaments produced any cogent evidence which drew a direct linkage between the application of the common law principle of the standard of care in both diagnosis and treatment and the medical indemnity crisis. The State legislatures also failed in their task to make good use of the time and resources that were available to them to conduct thorough research and assessment before making the decision to overhaul the law. This problem was compounded by the lack of coordination and consultation among the States to bring uniform changes to the standard of care in diagnosis and treatment in Australia.

Prior to the implementation of the modified *Bolam* test, the High Court of Australia had developed one standard of care to be applied to all the States and Territories. As a result of the legislative reform, there are now three different applicable standards of care in diagnosis and treatment in the Australian states: three different versions of the test that carry

[169] See Section 3.3.2 of Chapter 3.

the ‘irrational’, *Wednesbury* ‘unreasonable’ and the ‘unreasonable’ provisos respectively. This is in addition to two different versions of the standard of care in diagnosis and treatment under the common law as implemented in the Australian Capital Territory and Northern Territory. This development, not only reflected a lack of consultation among the Australian State and Territories jurisdictions in the law reforms, but also fell short of a momentous change in the law.

At this juncture, one should focus only on how the modified *Bolam* test could strike a balance between protecting the interests of defendant doctors and serving the wellbeing of injured patients. In this respect, the role of judicial interpretation becomes pivotal, given that the legislature intentionally left a few key requirements in the test undefined. However, it is doubtful how far judges can stretch the parameters of the law since the analysis of this chapter revealed that the respective State legislatures did not give due consideration to the interests of injured patients. The problem is compounded by the lack of guidance in the Report and the States’ *Hansards* to enable judges to decipher the material wording of the test. There is also the question of how judges would gather credible information on the notion of ‘community expectation’ when considering the ‘irrational’ and ‘unreasonable’ caveats under the statutory provisions. In this regard, an onerous responsibility has been unfairly placed on the courts to interpret a test which is, on balance, indefensible in its practical application as well as in the context of the doctor-patient relationship in clinical disputes concerning diagnosis and treatment.

The interests of patients and defendant doctors aside, analysis of recent cases in this chapter had demonstrated an unsatisfactory development in the application of the modified *Bolam* test. The main concern is the reintroduction of the principle in *Naxakis* in the determination of a plaintiff’s case for medical negligence, as established by the New South Wales Court of Appeal in *Dobler* and a series of Supreme Court cases. These cases do not alter the adjudication of the ultimate standard of care in cases concerning medical diagnosis and treatment. They may, however, bring about a rise in medical negligence litigation with plaintiffs easily establishing their initial claims for liability, and later tactically use these outcomes as a means of negotiating out-of-court settlement with defendant doctors. An Australian High Court decision is therefore necessary for clarifying whether the modified *Bolam* test should equally be applied when evaluating expert medical opinion adduced by plaintiffs in medical negligence cases concerning diagnosis and treatment.

CHAPTER 6
THE *BOLAM* TEST IN MALAYSIA

6.1 INTRODUCTION

The Malaysian legal system is founded on English common law.[1] Prior to gaining independence from the United Kingdom in 1957, English common law had already been statutorily introduced in the Federation of Malaya[2] through the *Civil Law Ordinance 1956* (Federation of Malaya). This legislation continued to be in force after Malaysia was declared an independent state in 1957, except that it was renamed the *Civil Law Act 1956* (Malaysia) and subsequently revised to incorporate two more states, Sabah and Sarawak.[3] The *Civil Law Act 1956* aside, Malaysian courts have always in practice been ready to consider English case law and examine its appropriateness in developing domestic jurisprudence.[4] This practice has been judicially confirmed in the Privy Council[5] decision in *Jamil bin Harun v Yang Kamsiah*[6] where it was noted that:

> 'Their Lordships do not doubt that it is for the courts of Malaysia to decide, subject always to the statute law of the Federation, whether to follow English case law. Modern English authorities may be persuasive, but are not binding. In determining whether to accept their guidance the courts will have regard to the circumstances of the States of Malaysia and will be careful to apply them only to

---

1 Michael Rutter, *The Applicable Law in Singapore and Malaysia* (Malayan Law Journal, 1st ed, 1989) 460-465.

2 The Federation of Malaya is the name given to a federation of 11 States which existed from 31-1-1948 until 16-9-1963. The 11 states comprised of 9 Malay States and two of the British Straits Settlement, Penang and Malacca. The Federation became independent on 31-8-1957 and was reconstituted as Malaysia with the addition of Singapore, Sabah and Sarawak in 1963. Singapore left Malaysia to become an independent state on 9-8-1965 for political reasons.

3 The revised version of this legislation took effect on 1 April 1972. Section 3(1) imports all subjects of English common law and equity into all Malaysian States. In two States of Sabah and Sarawak, however, judges are also allowed to apply English statutes under Section (3)(1)(b)&(c) of the *Civil Law Act 1956*. It should be noted that the importation of the English laws in Malaysia under Section 3(1) of the *Civil Law Act 1956* is subject to cut-off dates. The cut-off dates in the States in West Malaysia, Sabah and Sarawak (both are located in East Malaysia) are 7-4-1956, 1-12-1951 and 12-12-1949 respectively. All subsequent developments in England after these dates are not included.

4 Cyrus Das, 'Recent Developments in the Common Law and their Reception in Malaysia' (Paper presented at the Conference on the Common Law in Asia, University of Hong Kong, 15-17 December 1986).

5 Appeals to the Privy Council in the United Kingdom ceased in Malaysia in 1985. The abolition took place in two stages, firstly criminal and constitutional matters in 1978 and then followed by civil cases in 1985. Since 1985, the Federal Court has become the highest appellate court in Malaysia.

6 [1984] 1 MLJ 217.

> the extent that the written law permits and no further than in their view it is just to do so.[7]

The evolution of the legal system of a country is closely related with the nation's history and culture.[8] With the process of transplantation of the common law of England in Malaysia, it may be of interest to see whether the English characteristics of the legal principles have been unaltered or have been subjected to changes to suit local conditions.[9] In the Court of Appeal decision in *Nyali Ltd v Attorney-General*,[10] Denning LJ spoke of the process of transplantation of English common law in foreign jurisdictions with the following intriguing observation:

> '... just as with an English oak, so with the English common law: you cannot transplant it to [another] continent and expect it to retain the tough character which it has in England. It will flourish indeed, but it needs careful tending. So with the common law. It has many principles of manifest justice and good sense which can be applied with advantage to peoples of every race and colour all the world over: but it has also many refinements, subtleties and technicalities which are not suited to other folk. These off-shoots must be cut away'.[11]

In the case of the *Bolam* test, Malaysian judges had adopted this English common law principle since the 1960s as the basis for determining the standard of care in cases concerning issues of medical diagnosis and treatment. This chapter traces the historical development of the *Bolam* test in Malaysia prior to 2006[12] and examine how its internal bases were treated in this jurisdiction. Using the English oak as the metaphor for the *Bolam* test, it is shown that there were three discernible categories into which the treatment of the test fell between the 1960s and 2006. To use the words of Denning LJ in *Nyali*, a majority of appellate court authorities simply 'transplanted' the test in Malaysia without changing its original characteristics. There were, on the other extreme, a number of lower courts decisions which

---

7 Ibid 219 (Lord Scarman, during argument).

8 Bruce McPherson, *The Reception of English Law Abroad* (Supreme Court of Queensland Library, 1st ed, 2007) 2.

9 Alan Watson, *Legal Transplants* (University of Georgia Press, 2nd ed, 1993) 20.

10 [1956] 1 QB 1 (*Nyali*).

11 Ibid 16-17.

12 The year of 2006 marked the important Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun* [2007] 1 MLJ 593 which reviewed the legal status of the *Bolam* test in medical negligence cases in Malaysia. This seminal decision is examined fully in Section 7.2.4 of Chapter 7.

'discarded the English oak', refusing to apply the test. In between these two categories of cases, there were a small number of appellate and lower court authorities which adopted a 'cut away its offshoots' approach by placing certain qualifications on the test. These latter cases, it is argued, gave the Malaysian *Bolam* test some important characteristics that are distinctive from its original English version. In spite of this discrepancy, the vast majority of Malaysian cases maintained the original characteristics that the test had received in the United Kingdom. This chapter explores the reasons why the original version of the *Bolam* test reigned in Malaysian courts for almost four decades.

6.2 ENGLISH OAK ON MALAYSIAN SOILS – PURE TRANSPLANT

There are three leading Malaysian appellate court decisions which adopted a 'pure transplant' approach to the English *Bolam* test in Malaysia. These precedents were widely cited by judges in subsequent medical negligence cases dealing with issues of diagnosis and treatment and, hence, can be considered as significant. Two of the earliest Malaysian cases were the Privy Council decision in *Chin Keow v Government of Malaysia*[13] the Federal Court case of *Swamy v Matthews*.[14] The subsequent Court of Appeal in *Dr Chin Yoon Hiap v Ng Eu Khoon*[15] reaffirmed this approach in the late 1990s.

6.2.1 Chin Keow v Government of Malaysia

Chin Keow is a leading decision in the area of negligent treatment. It reinstated the important element of the *Bolam* test: that the yardstick of determining liability for medical negligence is that of an ordinary competent practitioner exercising a particular skill. The doctor in *Chin Keow* treated a patient suffering from a small ulcer on her right ankle and swollen glands in her thigh with a penicillin injection. The medical practitioner did not inquire whether the patient was sensitive to the drug. Three years prior to this treatment, the patient had been given a similar injection from which she suffered adverse reactions. The patient died within an hour of having been administered with the penicillin injection.

In determining the issue of breach of duty of care in relation to liability for medical negligence, the Malaysian High Court had to determine whether the patient should have been

[13] [1967] 2 MLJ 45 (*Chin Keow*).
[14] [1968] 1 MLJ 138 (*Swamy*).
[15] [1998] 1 MLJ 57 (*Chin Yoon Hiap*).

asked about her allergy to penicillin. During the trial, it was not disputed that other medical practitioners would have probed into the medical history of the patient on penicillin treatment because the drug had proved fatal in a number of cases. The defence of the doctor, however, was that the omission to inquire about the allergy of patients to penicillin was part of his routine practice where he had done an average of one hundred injections each day with no mishaps. The trial judge applied the *Bolam* test and held the doctor negligent on the basis of the available medical evidence which pointed to the necessity to inquire about the deceased's past allergy to penicillin injection.

The doctor appealed the decision of the trial judge to the Federal Court on the grounds that the trial judge's finding of negligence was not based on cogent medical evidence.[16] The Federal Court agreed, stating that all supporting medical opinion should have derived from experts of the highest standing or corroborated by medical literature written by 'distinguished medical men'.[17] The Federal Court did not refer to the *Bolam* test. Instead, it distinguished the facts in the present case with that in the English Court of Appeal case of *Roe v Minister of Health*.[18] The Federal Court stated that in *Roe*, the trial judge's decision was based on the opinion of a number of medical witnesses 'of the highest professional standing' in their fields.[19] Comparatively, the doctor in the present case was more experienced in the knowledge of penicillin injection than all the medical witnesses 'put together'.[20]

Madam Chin Keow, the deceased's mother, took her last resort to appeal the decision of the Federal Court in the Privy Council in London. She posed the legal question whether the Federal Court erred in rejecting the trial judge's findings of negligence. The Privy Council unanimously allowed the appeal on the grounds that Federal Court was wrong in its reasoning that doctors were judged against the highest professional expertise. [21] The legal standard, the Privy Council stated, is that of an 'ordinary competent practitioner' or an average doctor who professes and exercises a particular skill.[22] On the facts, the Court held that the trial judge's

16 *Government of Malaysia v Chin Keow* [1965] 2 MLJ 91, 92 (Federal Court).
17 Ibid 94.
18 [1954] 2 QB 66 (*Roe*).
19 *Government of Malaysia v Chin Keow* [1965] 2 MLJ 91, 94.
20 Ibid 96.
21 The panel members of the Privy Council comprised of Viscount Dilhorne, Lord Hodson, Lord Guest, Lord Upjohn and Lord Hugh Wooding.
22 *Chin Keow* [1967] 2 MLJ 45, 47.

findings of liability which were based on the standard practice of the medical profession satisfied the test.

6.2.2 Swamy v Matthews

The Federal Court decision in *Swamy* was one of the earliest appellate court decisions on Malaysian soils which applied the English *Bolam* test in *verbatim*. This decision is distinctive because instead of referring to *Chin Keow* it relied on a number of English precedents[23] prior to the case of *Bolam v Friern Hospital Management Committee*.[24] The facts of *Swamy* also dealt with the issue of negligent medical treatment. The appellant in *Swamy* suffered from an itch on his hands and legs and sought medical treatment from the second respondent doctor. The doctor was uncertain of his diagnosis, suspecting the disease to be either ringworm or psoriasis. The doctor treated the appellant with three doses of arsenical drug by way of injections on separate occasions. The first two injections consisted of heavy doses while the third was of reduced dosage. After the third injection, the appellant's hands and legs became paralysed and he claimed that the injury was caused by the administration of the arsenical drug.

The Federal Court had to consider whether the paralysis of the appellant was attributable to the arsenical drug and if so, whether the doctor was negligent in injecting three separate doses of the drug into the appellant. Medical opinions were divided on these matters, two of which supported the patient and one of which was in favour of the doctor. The Federal Court held the doctor not negligent by a majority of two to one.[25] The majority judgment was delivered by Barakbah LP[26] where his Honour relied on an aged-old English decision of *Lanphier*[27] to support the Court's reasoning.[28] In *Lanphier* Tindal CJ stated that all professionals undertake to exercise 'a fair, reasonable and competent degree of skill', not the

---

23 They were *Lanphier v Phipos* (1838) 173 ER 581; (1838) 8 Car & P 475 (*Lanphier*) and *Hatcher v Black* [1954] CLY 2289 (*Hatcher*).

24 [1957] 2 All ER 118 (*Bolam*).

25 The majority of the justices of the Federal Court in *Swamy* consisted of Barakbah LP and Azmi J. Ong Hock Thye J dissented.

26 The position of Lord President of the Federal Court was created in 1963, the year when Sabah, Sarawak and Singapore joined the Malaya Federation to form Malaysia. The Lord President was the head of the judiciary in Malaysia. The title of Lord President was renamed Chief Justice of the Federal Court in 1994. The office of Chief Justice of the Federal Court is followed by President of the Court of Appeal, the Chief Judge of the High Court in Malaya and the Chief Judge of the High Court in Sabah and Sarawak.

27 (1838) 173 ER 581; (1838) 8 Car & P 475.

28 To whom Azmi J concurred.

highest professional standard.[29] This principle of law was interpreted by Barakbah LP in *Swamy* as follows:

> 'A man or woman who practices a profession is bound to exercise the care and skill of an *ordinary competent practitioner* in that profession – be it the profession of an accountant, a banker, a doctor, solicitor or otherwise.'[30] *(Emphasis added)*

In light of this principle, their Honours accepted the medical evidence of the doctor's sole expert that the arsenical drug did not cause the paralysis of the appellant and the three injections of the drug was an acceptable practice of the medical profession.

6.2.3 Dr Chin Yoon Hiap v Ng Eu Khoon

Whilst *Chin Keow* and *Swamy* reinstated the *Bolam* test in Malaysia, the subsequent Court of Appeal in *Chin Yoon Hiap* reaffirmed that its interpretation in this jurisdiction was the same as in the United Kingdom prior to 1997. *Chin Yoon Hiap* was a case that addressed the issues of negligent medical diagnosis and treatment. In this case, the plaintiff Ng Eu Khoon was born prematurely in late 1975. As a premature baby, he was kept in an incubator with oxygen therapy for approximately one month. A few months after having been discharged from the hospital, Ng began to experience defects in his vision and his father brought this matter to the attention of the appellant doctor, Dr Chin Yoon Hiap. Dr Chin did not provide any medical treatment, advising that Ng's defective vision would improve gradually. Years later, Ng's condition worsened and he was later totally blind. Consultations with eye specialists indicated that he was suffering from retrolental fibroplasias.[31]

Having attained the age of majority when legal action was still enforceable,[32] Ng filed a suit for medical negligence in the High Court against Dr Chin alleging, *inter alia*, that the medical practitioner had failed to inform his parents about the defect so that an ophthalmologist could have been consulted for an early diagnosis of the ailment. Medical

---

29 *Lanphier* (1838) 173 ER 581, 583; (1838) 8 Car & P 475, 479.

30 [1968] 1 MLJ 138, 139.

31 Retinopathy of Prematurity, previously known as Retrolental Fibroplasias, is an eye disease that affects prematurely-born babies. It may lead to blindness in serious cases.

32 The age of majority in Malaysia, as defined by Section 3(1) of the *Age of Majority Act 1971* (Malaysia), is eighteen years old.

experts of both opposing parties agreed that retrolental fibroplasias was not curable and as such an early ophthalmic examination served no purpose.[33] Conversely, a consultant ophthalmologist who testified for Ng stated that retrolental fibroplasias could have been detected, even in its earliest stage.[34] The trial judge preferred this latter evidence over the overwhelming expert medical opinion that retrolental fibroplasias could not be treated.[35] The judge took the view that by taking the step of enabling an early diagnosis of the medical condition, such as informing Ng's parents about his medical condition, measures could have taken to prevent the onset of retrolental fibroplasias.[36]

Dr Chin appealed the findings of negligence of the High Court in the Court of Appeal on the grounds that they were not based on the medical evidence that there was no treatment for retrolental fibroplasias. The three member of the Court of Appeal[37] addressed this issue with the application of the *Bolam* test. In affirming the *Bolam* test, the Court cited the case of *Chin Keow* and a series of English precedents which formed the legal foundation of the *Bolam* test.[38] Of particular significance was the reliance of the Court on two English House of Lords decisions in *Maynard v West Midlands Regional Health Authority*[39] and *Whitehouse v Jordan*[40] which established the *Bolam* test in the United Kingdom.[41] The case of *Maynard*, in particular, established the principle that the courts are not allowed to choose one medical opinion over another when evaluating expert evidence in medical negligence cases concerning issues of diagnosis and treatment.[42] In light of these authorities, the Court of Appeal relied on the medical evidence that retrolental fibroplasias was incurable.[43] It also took into consideration the undisputed expert medical opinion that an early ophthalmic diagnosis would not have made any difference to Ng's medical condition. Based on this medical testimony, the Court of Appeal held that the appellant, Dr Chin, did not breach his

33 *Chin Yoon Hiap* [1998] 1 MLJ 57, 72 (As quoted by Abdul Malek Ahmad JCA who delivered the judgment of the Court of Appeal).
34 Ibid 71 (As quoted by Abdul Malek Ahmad JCA).
35 Ibid 64 (As quoted by Abdul Malek Ahmad JCA).
36 Ibid. There is no indication from the judgment of the Court of Appeal as to which legal principle the trial judge had applied for arriving at this conclusion.
37 They consisted of Gopal Sri Ram, Chan Nyarn Hoi and Abdul Malek Ahmad JJCA.
38 For instance *Hunter v Hanley* [1955] SC 200 (*Hunter*) and *Rich v Pierpoint* (1862) 176 ER 16; [1862] 3 F & F 35 (*Rich*).
39 [1985] 1 All ER 635 (*Maynard*).
40 [1981] 1 All ER 267.
41 Both English House of Lords cases were cited for the first time in the record of the Malaysian appellate court decisions dealing with issues of medical negligence of diagnosis and treatment.
42 [1985] 1 All ER 635, 639 (Lord Scarman).
43 *Chin Yoon Hiap* [1998] 1 MLJ 57, 73.

duty of care because even if he had informed the first respondent's parents, the result 'would have come to nothing'.[44]

6.2.4 Conclusion

Chin Keow, *Swamy* and *Chin Yoon Hiap* are the major appellate court decisions which interpreted and applied the *Bolam* test in its original form. Over the years, these authorities were relied on by a vast majority of lower courts as the legal basis for applying the *Bolam* test when deciding the standard of care in negligence cases regarding issues of diagnosis and treatment.[45]

6.3 CUTTING AWAY THE OFFSHOOTS OF ENGLISH OAK – THE MALAYSIAN WAY

In some instances efforts were made by Malaysian judges to place certain qualifications on the *Bolam* test, particularly on the extent to which judges could make findings of liability for medical negligence. The High Court case of *Elizabeth Choo v Government of Malaysia*[46] and the subsequent Federal Court decision in *Kow Nam Seng v Nagamah*[47] are two examples that illustrate how the *Bolam* test was adapted in Malaysia.

6.3.1 Elizabeth Choo v Government of Malaysia

The High Court case of *Elizabeth Choo* was concerned with the issue of medical diagnosis. This decision is significant because its reasoning laid a foundation for the subsequent ruling

---

44 Ibid.

45 *Hong Chuan Lay v Dr Eddie Soo Fook Mun* [2006] 2 MLJ 218, 220 (Court of Appeal) affirmed the application of the *Bolam* test by the High Court in *Hong Chuan Lay v Dr Eddie Soo Fook Mun* [1998] 7 MLJ 481, 496 (an alleged misdiagnosis of the plaintiff's numbness in his fingers. This led to subsequent surgical operations on cervical spine that brought about partial paralysis of the plaintiff's legs and his failure to maintain urinary and bowel control); *Udaya Kumar A/L Karuppusamy v Penguasa Hospital Daerah Pontian* [2004] 2 MLJ 661, 685 (High Court) (delayed treatment of a fever and as a result of which the first plaintiff was mentally retarded); *Asiah Bte Kamsah v Dr Rajinder Singh* [2002] 1 MLJ 484, 492 (High Court) (a caesarean operation on the plaintiff which eventually led to brain damage) and *Dr K S Sivananthan v Government of Malaysia* [2001] 1 MLJ 35, 44 (High Court) (internal fixation of the plaintiff's fractured leg which later resulted in leg amputation); *Abdul Rahman Bin Abdul Karim v Abdul Wahab Bin Abdul Hamid* [1996] 4 MLJ 623, 634 (High Court) (a surgery conducted by a traditional eye healer which resulted in loss of vision in the plaintiff's right eye); *Mariah Bte Mohamad (Administratrix of the Estate of Wan Salleh Bin Wan Ibrahim, Deceased) v Abdullah Bin Daud (Dr Lim Kok Eng, Third Parties*) [1990] 1 MLJ 240, 243 (High Court) (failure to conduct a computer axial tomogram (CAT) scan to examine the extent of the deceased's brain injury).

46 [1970] 2 MLJ 171 (*Elizabeth Choo*).

47 [1982] 1 MLJ 128 (*Kow Nam Seng*).

in the Federal Court decision in *Kow Nam Seng*. The plaintiff in *Elizabeth Choo* suffered from piles and was admitted to hospital to remove them. The second defendant doctor performed sigmoidoscopic[48] under a general anaesthesia with the intention of examining the lining of the plaintiff's colon. During the course of the diagnostic procedure, the plaintiff sustained a perforation of her colon. The plaintiff suffered nervous shock as a result of the perforation and did not undergo piles operation. She commenced legal action for medical negligence against the second defendant doctor.

The main issue in the High Court was whether the second defendant doctor was negligent when performing the sigmoidoscopy examination. The second defendant adduced several bodies of medical opinion in support of the view that sigmoidoscopy performed under anaesthesia was the recognised practice at the material time. This overwhelming medical evidence was in stark contrast to only one medical opinion adduced by the plaintiff. The plaintiff's expert stated that the diagnostic procedure should be carried out without anaesthesia because this would enable the patient to forewarn the doctor of any pain. The trial judge Raja Azlan Shah J[49] applied the *Bolam* test and stated that the practice conducted by the second defendant doctor was not in itself negligent. His Honour stated that:

> '... The principle of law is well established that a practitioner cannot be held negligent if he treads the well-worn path; he cannot be held negligent if he follows what is the general and approved practice in the situation with which he is faced...'.[50]

Nonetheless, his Honour further qualified this statement of law:

> '... It was stated by [counsel] for the plaintiff that the courts are always reluctant to find negligence against a medical man. With respect that proposition cannot be true. To say the least, I am no advocate of the right of medical men occupying

---

48 Sigmoidoscopic is a minimal invasive diagnostic test where a flexible tube is inserted into a patient's rectum and slowly guides it into the colon. The tube is called a sigmoidoscope. The scope transmits an image of the inner part of the colon so the doctor can carefully examine the lining of the colon.

49 Raja Azlan Shah J was elevated to the Federal Court in 1973, three years after the decision in *Elizabeth Choo*. In 1979, his Honour was made the youngest ever Lord President of the Federal Court of Malaysia.

50 *Elizabeth Choo* [1970] 2 MLJ 171, 172. In stating this principle, Raja Azlan Shah J did not refer to the Privy Council decision in *Chin Keow*. Rather, his Honour relied on the cases of *Bolam*, *Hunter* and *Vancouver General Hospital v MacDaniel* (1934) 152 LT 56.

> a position of privilege. They stand in the same position as any other man. Their acts cannot be free from restraint; where they are wrongfully exercised by commission or default, it becomes the duty of the courts to intervene...'.[51]

Following this statement, Raja Azlan Shah J went on to consider whether the second defendant doctor had wrongfully conducted the sigmoidoscopy examination. On this issue, his Honour accepted the evidence of the doctor's expert that the plaintiff had had bicornuate uterus.[52] This medical condition, the expert testified, may have contributed to the 'slight perforation' that the plaintiff sustained.[53] In conclusion, the High Court held that the second defendant doctor was not negligent although it was not disputed that the plaintiff's perforation of her colon was sustained during the pre-operative examination.

6.3.2 Kow Nam Seng v Nagamah

The reasoning in *Elizabeth Choo* later found favour in the subsequent Federal Court decision in *Kow Nam Seng*.[54] However, the Court further extended the authority of the courts to make findings of negligence without relying on expert medical opinion, but only in limited circumstances. The case of *Kow Nam Seng* related to the issue of negligent medical treatment. The second respondent in this case sustained minor fractures to his leg in a road accident and was admitted to hospital. Two doctors in the hospital, the third and fourth respondents,[55] applied a complete plaster cast to the second respondent's leg. The application of the plaster caused inadequate blood circulation in the affected leg and led to gangrene, necessitating the amputation of the leg.

The key issue in the Federal Court was whether the third and fourth respondent doctors was negligent in providing medical treatment to the second respondent. Different medical opinions were adduced on the types of plaster that should have been applied to the second respondent's leg. The experts for both doctors stated that the standard medical practice in Malaysia was to apply a complete cast. In contrast, the second respondent's expert

---

51 *Elizabeth Choo* [1970] 2 MLJ 171, 172. Raja Azlan Shah J relied on the English case of *Rich* (1862) 176 ER 16, 19; [1862] 3 F & F 35, 40 where Erle CJ held that it was the jury, not the medical profession, which had the final say in the issue of the standard of care in medical negligence cases.

52 Bicornuate uterus is a female genital malformation where two 'horns' form at the upper part of the uterus.

53 *Elizabeth Choo* [1970] 2 MLJ 171, 173.

54 [1982] 1 MLJ 128.

55 The appellant in this case was the driver of a motor vehicle which hit the second respondent's car.

was of the opinion that a partial plaster cast could have been applied in the circumstances because a complete plaster carried a high risk of inadequate blood circulation. In determining this issue, the Court approved the cases of *Bolam* and *Elizabeth Choo* but referred neither to *Chin Keow* nor *Swamy*. Applying the *Bolam* test, the Court ruled that since a complete cast was a widely accepted medical practice in Malaysia, the choice of the treatment was not in itself negligent.

The Federal Court,[56] however, took the issue of liability further by considering whether the third respondent doctor had wrongfully applied the complete plaster cast to the second respondent's leg. The Court accepted the medical opinion of the second respondent's expert that if a patient suffered from pain after a complete plaster cast had been applied, the cast must be split. This was because, this expert testified, the inability of the patient to move his or her toe was an indication of an advanced state of inadequate blood circulation. On the facts, there was evidence that the second respondent did complain to both doctors of 'severe pain' in his leg; the complete plaster cast 'became too tight' and his toe 'became immobile' and 'turned cold'.[57] Having evaluated all this evidence, the Court stated that 'even a layman could appreciate' the direct correlation between the injury suffered by the second respondent in the hospital and the complete cast that was applied by both doctors.[58] The Federal Court therefore held that the third and fourth respondent doctors had failed to discharge their duty in the application of the complete cast on the second respondent's leg.

Finally, the Court considered whether the failure of both doctors to give post-operative treatment shortly after realising the second respondent's leg injury which was brought about by the application of the complete cast was also negligent. There was no direct medical evidence on this issue. The Court instead took into account a number of items of circumstantial evidence and arrived at the conclusion that both medical practitioners were negligent. This evidence included: the omission of both doctors to monitor the second respondent's response to the application of a complete cast, the delay in the administration of

---

56 The Court consisted of Lee Hun Hoe CJ, Sulaiman FCJ and Salleh Abas FCJ. The unanimous judgment of the Court was delivered by Salleh Abas FCJ.

57 *Kow Nam Seng* [1982] 1 MLJ 128, 131.

58 Ibid.

remedial medical treatment to repair the damage done to the second respondent's leg and the weak excuse given by the doctor that this delay was due to his busy working schedule.[59]

6.3.3 Conclusion

The Federal Court decision in *Kow Nam Seng* is the only appellate court decision which has notably 'cut away the offshoots' of the *Bolam* test to enable judges to make findings of negligence. This, however, gave the *Bolam* test in Malaysia certain characteristics that are distinctive from its original English version. Following *Kow Nam Seng*, judges could avoid the strict application of the *Bolam* test by rejecting standard medical diagnostic and treatment procedures if indirect expert medical opinion indicated that they were wrongfully exercised by default or omission.[60] Findings of negligence may also be made by the courts in the absence of expert medical opinion where the issues involved are straightforward or within the comprehension of a layperson.[61]

In spite of the existence of the qualifications that were placed on the *Bolam* test by the Federal Court in *Kow Nam Seng*, they were rarely taken up by subsequent lower court cases. Some cases did not refer to *Kow Nam Seng*, preferring instead to rely either on *Chin Keow*, *Bolam* or a series of English decisions prior to *Bolam*.[62] Even if *Kow Nam Seng* was cited, lower court judges merely treated it as affirming the *Bolam* test.[63] As is shown in the following section of this chapter, of the few trial judges who analysed *Kow Nam Seng* differently, they used this Federal Court decision as the basis for not applying the *Bolam* test.

6.4 DISCARDING THE ENGLISH OAK IN MALAYSIA

In the late 1990s the Malaysian High Court rejected the *Bolam* test in the areas of medical diagnosis and treatment. Two cases were of particular importance due to their influence in the

---

59 Ibid.

60 Ibid 130-131.

61 Ibid 131. See also Kumaralingam Amirthalingam, 'Judging Doctors and Diagnosis the Law: *Bolam* Rules in Singapore and Malaysia', [2003] *Singapore Journal of Legal Studies* 125, 142.

62 See *Mariah Bte Mohamad (Administratrix of The Estate of Wan Salleh Bin Wan Ibrahim, Deceased) v Abdullah Bin Daud (Dr Lim Kok Eng, Third Parties*) [1990] 1 MLJ 240, 243 (High Court) (failure to conduct a computer axial tomogram (CAT) scan to examine the extent of the deceased's brain injury); *Abdul Rahman Bin Abdul Karim v Abdul Wahab Bin Abdul Hamid* [1996] 4 MLJ 623, 634 (High Court) (a surgery conducted by a traditional eye healer resulting in loss of vision in the plaintiff's right eye).

63 See for instance *Inderjeet Singh a/l Piara Singh v Mazlan Bin Jasman* [1995] 2 MLJ 646, 653 (High Court) (failure to diagnose the plaintiff's ruptured urethra and subsequent administration of wrong treatment which led to urinary infection).

subsequent development of the law in Malaysia: *Kamalam a/p Raman v Eastern Plantation Agency*[64] and *Foo Fio Na v Hospital Assunta*.[65]

6.4.1 Kamalam a/p Raman v Eastern Plantation Agency

The facts of *Kamalam* related to the issue of negligent medical treatment. Mr Dinasan had collapsed in his work place due to a stroke. He had a history of hypertension. In an unconscious state, Dinasan was taken to the clinic of his employer and was examined by the second defendant doctor. The doctor prescribed medication for his existing hypertension but did not diagnose any other condition. A few days later, Dinasan was found bleeding profusely from the nose and mouth and then became unconscious. He passed away in the hospital one day later, and it was subsequently found that he was suffering from a stroke prior to his death.

There were two important issues concerning liability for medical negligence against the second defendant doctor: whether the second defendant doctor had prescribed inappropriate drugs to Dinasan and whether the doctor was under a duty to refer him to the hospital for specialist treatment. There were conflicting medical opinions on both matters. Two medical experts for Dinasan's wife, the first plaintiff, testified that the symptoms displayed by Dinasan constituted an impending stroke. They stated that in the circumstances, it was imperative for the second defendant doctor to take precautionary measures such as leaving Dinasan to rest for a while in the clinic and then referring him to a cardiologist in the hospital. The expert for the second defendant doctor, on the other hand, took the view that Dinasan did not display any warning signs of an impending stroke and the stroke suffered prior to his death may have occurred suddenly. According to this expert, there was no reason to prescribe Dinasan drugs specifically for stroke and neither was the second defendant doctor under an obligation to transfer him to the hospital.

The trial judge Richard Talalla J did not apply the *Bolam* test when addressing the issue of negligence. His Honour opined that the Federal Court in *Kow Nam Seng* did likewise, stating that the justices in *Kow Nam Seng* neither addressed the *Bolam* test nor applied it.[66] Richard Talalla J further endorsed the dicta of the majority justices in the Australian High

---

64 [1996] 4 MLJ 674 (*Kamalam*).

65 [1999] 6 MLJ 738 (*Foo Fio Na*) (High Court).

66 *Kamalam* [1996] 4 MLJ 674, 690.

Court case of *Rogers v Whitaker*[67] which affirmed the departure of the *Bolam* test in cases of medical diagnosis and treatment:

> 'In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill...But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade... Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied (see *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 562-563 (case of medical treatment). See also *E v Australian Red Cross Society* (1991) 27 FCR 310 ...'.[68]

In line with this passage, Richard Talalla J stated that the test for determining the standard of care in issues of negligent treatment was similar to that in general negligence cases:

> '... I should emphasise that while due regard will be had to the evidence of medical experts, I do not accept myself as being restricted by the establishment in evidence of a practice accepted as proper by a responsible body of medical men skilled in that particular art to finding a doctor is not guilty [sic] of negligence if he has acted in accordance with that practice. In short, 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, unshackled, on the ordinary principles of the law of negligence and the overall evidence.'[69]

Having evaluated all the evidence, his Honour concluded that the second defendant should have referred Dinasan to a specialist hospital and the failure to do so was tantamount to a breach of his duty of care.[70] This evidence included medical literature concerning the necessity to probe the medical history of Dinasan which the second defendant failed to do;[71]

---

67 (1992) 175 CLR 479 (*Rogers*).
68 Ibid 487. This passage was quoted by Richard Talalla J in *Kamalam* [1996] 4 MLJ 674, 687.
69 *Kamalam* [1996] 4 MLJ 674, 690.
70 Ibid 698.
71 Ibid 693-694.

high readings of Dinasan's blood pressure when he was under the care of the second defendant;[72] Dinasan's long history of hypertension and having been a heavy smoker;[73] the fact that the second defendant sent Dinasan home on medical leave instead of admitting him to hospital; and the opinion of both the first plaintiff's experts that admitting Dinasan to the hospital would have prolonged his life.[74]

6.4.2 Foo Fio Na v Hospital Assunta (High Court)

The Federal Court in *Kow Nam Seng* was again relied on by another High Court case of *Foo Fio Na*[75] for departing from the *Bolam* test when addressing the issues of negligent medical treatment.[76] Of particular significance was the striking similarity between the interpretations of *Kow Nam Seng* in this case, and that in *Kamalam*. Having cited the ruling in *Kow Nam Seng*, the trial judge, Mokhtar Sidin J, in *Foo Fio Na* explained that:

> 'It is clear from the principle above [of *Kow Nam Seng*] that the determination of whether a doctor is negligent or not is for the court to determine based entirely on the evidence of each case...'.[77]

The importance of the High Court decision in *Foo Fio Na* rests on two aspects. One was its findings on the issues of negligent medical treatment, which was based on a total departure from the *Bolam* test. The second was its subsequent appeals in the Court of Appeal and the Federal Court. The Court of Appeal ruled the High Court erred for not applying the *Bolam* test. A final appeal to the Malaysian Federal Court in 2006 resulted in the endorsement of the findings of the High Court and the case of *Kamalam*. Following the decision of the Federal Court, there was a major shift away from the *Bolam* test in the determination of the standard of care in diagnosis and treatment in Malaysian lower court cases. These issues are considered in the next chapter of this thesis.

---

72 Ibid 691.

73 Ibid 694.

74 Ibid 697.

75 The High Court decision in *Foo Fio Na* is analysed fully in Section 7.2.1 of Chapter 7.

76 There were two other High Court cases which applied the principle as articulated by the Australian High Court in *Rogers*, namely *Tan Ah Kau v Government of Malaysia* [1997] 2 CLJ (Supplementary) 168 and *Hong Chuan Lay v Dr Eddie Soo Fook Mun* [1998] 7 MLJ 481. However, the application of the principle in both cases was confined to issues of failure to disclose risk. The *Rogers* principle, as it is applied in the context of the doctor's duty to warn the patient, was elaborated in Section 3.2.3 of Chapter 3.

77 *Foo Fio Na* [1999] 6 MLJ 738, 766 (High Court).

6.4.3 Conclusion

The rejection of the 'English oak' in both High Court decisions in *Kamalam* and *Foo Fio Na* in the late 1990s and early 2000s was akin to the development in Australia prior to the case of *Rogers*. As was demonstrated in a previous chapter, a number of Australian Supreme Court decisions departed from the *Bolam* test in the areas of medical treatment and diagnosis in the late 1970s and 1980s.[78] Despite this common feature, the reliance on the decision in *Rogers* by the trial judge in *Kamalam* was arguably extraordinary as there had not been any highest court decision which endorsed this part of the Australian common law in the Malaysian medical negligence cases. Although both the High Court cases of *Kamalam* and *Foo Fio Na* are the minority of cases which did not apply the *Bolam* test, their existence added uncertainty to the legal status of the test in the late 1990s and the early 2000s.

6.5 AN ASSESSMENT OF THE REASONS FOR RETAINING THE BOLAM TEST IN MALAYSIA PRIOR TO 2006

Several reasons had been given by judges for adopting and maintaining the English characteristics of the *Bolam* test in Malaysia, although the occasions in which these justifications were given were rare. One of the earliest statements recorded within the court process is found in the judgment of Barakbah LP in *Swamy*. Drawing on the reasoning of Denning LJ in *Hatcher*,[79] Barakbah LP expressed the fear that a legal standard that is higher than that of an ordinary competent doctor would lead to the following consequence:

> 'It would mean that a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body – perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body...'.[80]

---

78 For instance *Goode v Nash* (1979) 21 SASR 419 (diagnosis) and *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 (surgical treatment). Both cases were examined in Sections 3.2.1 and 3.2.2 of Chapter 3 respectively.

79 The justification for applying the *Bolam* test was stated by Denning LJ in *Hatcher* [1954] CLY 2289 as follows:

> '... In a hospital when a person was ill and came in for treatment, no matter what care was used there was always a risk; and it would be wrong and bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community...'.

80 *Swamy* [1968] 1 MLJ 138, 140.

From this passage, it was clear that the adoption of the *Bolam* test in Malaysia aimed to achieve two main purposes: protecting the doctors, and preventing them from placing their interests before that of the patients so as to avoid medical negligence claims.[81]

Even in the early 2000s, the Malaysian judiciary continued to defend the retention of the *Bolam* test in the name of safeguarding the interests of the doctors and the patients. This was so even though jurisdictions such as the United Kingdom and Australia had respectively qualified and rejected the *Bolam* test in the areas of diagnosis and treatment on the grounds that the test was too protective of the medical profession.[82] This judicial policy was affirmed by Gopal Sri Ram JCA,[83] albeit extra-curially. At the Second National Medico-Legal Conference in the capacity of a Court of Appeal judge in Kuala Lumpur in 2000, Gopal Sri Ram JCA noted that uniformity in the application of legal principles among the English Commonwealth jurisdictions is only appropriate in the commercial context, where there is a need to treat business transactions the same way across borders.[84] In the area of medical negligence disputes, Gopal Sri Ram JCA took the view that the applicable legal principle should bring about benefits to the doctors and the patients.[85] According to his Honour, giving the medical profession the final say on the legal standard of care, as the *Bolam* test does, could safeguard against the reluctance of the doctors to venture into new medicine at the expense of hampering the future advancement of medical science.[86]

The rationale for supporting the *Bolam* test in its original form in Malaysia arguably lacked a well-balanced analysis of its adverse implications. For instance, there were concerns that the *Bolam* test could potentially allow medical practices that were flawed, convenient to the medical profession and unjustifiable to patients to set the legal standard of care. There

---

81 This is the interpretation given by Yeo to this passage of Barakbah LP in *Swamy*. See Stanley Yeo Meng Heong, 'The Standard of Care in Medical Negligence Cases', (1983) 25 *Malaya Law Review* 32, 34.

82 See Section 2.6 of Chapter 2 and Section 3.2.6 of Chapter 3 for an analysis of the common law positions on the standard of care in diagnosis and treatment in the United Kingdom and Australia respectively.

83 Gopal Sri Ram JCA was also one of the sitting judges in the Court of Appeal decision in *Chin Yoon Hiap*. His Honour was elevated to the Federal Court in April 2010 and retired in February 2011.

84 The edited version of this paper was published as Justice of Appeal Gopal Sri Ram, 'The Standard of Care: Is the *Bolam* Principle Still The Law?', [2000] 3 *Malayan Law Journal* lxxxi, lxxxviii.

85 In support of this contention, Gopal Sri Ram JCA cited the judgment of Lord Lloyd in the Privy Council decision in *Invercargill City Council v Hamlin* [1996] 1 All ER 756, 764.

86 Justice of Appeal Gopal Sri Ram, above n 84, lxxxviii-lxxxix. The advantages of the *Bolam* test in safeguarding against the spectre of defensive medicine and ensuring the proper development of medical science had also been advocated by Denning LJ in *Roe* [1954] 2 QB 66, 83. These policy considerations were discussed in Section 2.2.4 of Chapter 2.

were also the fears that the absence of judicial intervention in the application of the test might encourage insularity and complacency in the medical profession at the expense of long-term improvement in the quality of medical service.[87] These matters should have been addressed in the judicial reasoning for retaining the *Bolam* test in Malaysia.

A preferable approach to applying the *Bolam* test in Malaysia may have been to confer upon judges limited authority to reject the standard practice of the medical profession as unreasonable, such as in cases like *Elizabeth Choo* and *Kow Nam Seng*. In this regard, the following statements of Raja Azlan Shah J in *Elizabeth Choo* should have been decisive in determining the standard of care in cases concerning medical diagnosis and treatment. His Honour stated that the practice of the medical profession:

> '... cannot be free from restraint; where they are wrongfully exercised by commission or default, it becomes the duty of the courts to intervene'.[88]

In the light of this passage, the main issue would have been to what extent the courts should be allowed to reject the accepted practice of the medical profession. Both *Elizabeth Choo* and *Kow Nam Seng* have provided instances in which judges may be able to do so. However, both cases, particularly *Kow Nam Seng*, should have provided clearer guidance on the situations in which the courts might be allowed to intervene, so that arbitrary standards would not have been imposed on the medical profession.

6.6 CONCLUSION

This chapter analysed the development of the *Bolam* test in Malaysia during the period between the 1960s and 2006. It examined the manner in which the internal bases of this English common law principle were treated in medical negligence cases concerning issues of diagnosis and treatment in Malaysia. The analysis demonstrated that there were essentially three discernible ways in which the *Bolam* test was applied in Malaysia. In a small number of precedents, the test had been subjected to some 'cutting away of its offshoots', with certain qualifications to enable the courts to make findings of negligence. In a minority of lower

---

87 These criticisms were expressed by the Law Council of Australia in pursuant to the review of the law on the standard of care in medical negligence cases by the Ipp Review Committee. They were elaborated in Section 5.2.2 of Chapter 5.

88 [1970] 2 MLJ 171, 172.

court decisions, the *Bolam* test was 'discarded', in which trial judges refused to apply it. However, the majority of Malaysian court decisions during the period of analysis simply did not change its English characteristics. This state of the law is unsatisfactory as there was a lack of consistency and certainty in the application of the *Bolam* test.

The analysis revealed that the cases that rejected the *Bolam* test, notably the Malaysian High Court decisions in *Kamalam* and *Foo Fio Na*, began to appear in the late 1990s. Legal trends of a similar nature were also recorded in other common law jurisdictions during the same period. In 1997, the English House of Lords in *Bolitho v City and Hackney Health Authority*[89] qualified the *Bolam* test to enable the courts to reject expert medical opinion concerning issues of diagnosis and treatment if they are satisfied that the opinion does not have a 'logical basis'.[90] Two years later, the Australian High Court in *Naxakis v Western General Hospital*[91] held that the *Bolam* test should no longer be applied in cases that dealt with issues of diagnosis and treatment.[92]

In view of these developments, the real issue for Malaysia is whether the *Bolam* test should be retained in the twenty-first century. This question was addressed in late 2006 when the Federal Court in *Foo Fio Na v Dr Soo Fook Mun*[93] was asked to consider whether the *Bolam* test should be applied in 'all aspects of medical negligence cases'.[94] This important decision is examined in the next chapter of this thesis. The analysis shows that the Federal Court failed to provide a clear legal principle for deciding the standard of care in medical negligence cases concerning issues of diagnosis and treatment.

---

89 [1998] AC 232 (*Bolitho*).

90 See Section 2.6 of Chapter 2 for an analysis of the English *Bolitho* principle.

91 (1999) 197 CLR 269.

92 The decision in *Naxakis* was examined in Section 3.2.6 of Chapter 3.

93 [2007] 1 MLJ 593.

94 This was the legal question posed to the Federal Court for seeking special leave to appeal. A more detailed analysis of this legal question is given in Section 7.2.3 of Chapter 7.

CHAPTER 7
THE CURRENT LEGAL POSITION IN MALAYSIA

7.1 INTRODUCTION

The Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun*[1] is the key authority on medical standard of care in Malaysia. The significance of this seminal case lies in the review by this Court of the *Bolam* test in medical negligence cases. After years of mixed judicial views regarding its application by previous Federal Courts and the uncertainty over its application at the courts below,[2] the Federal Court in *Foo Fio Na* finally ruled in 2006 that the *Bolam* test was no longer relevant in 'all aspects of medical negligence cases'. Most explicitly, the Federal Court redefined the manner in which the standard of care of doctors in disclosure of risks was determined. Adopting the Australian High Court decision in *Rogers v Whitaker*,[3] the Federal Court expressly held that doctors are duty bound to inform patients who are of sound mind and understanding of all risks that are associated with a proposed medical treatment. According to this approach, the Federal Court held that it is the courts, not the medical profession, which will ultimately decide whether that duty has been breached.

In Malaysia, the importance of *Foo Fio Na* was recognised almost immediately after the Federal Court judgment was pronounced. In major local daily newspapers, the decision was hailed as a case that raised 'the standards for medical practitioners'[4] and it would be 'easier for litigants to prove negligence against doctors' than in the past.[5] The Malaysian Bar Council even went on the record for suggesting 'the demise of *Bolam* principle: *Foo Fio Na v Dr Soo Fook Mun*', when reporting the decision on its website.[6]

This chapter examines the significance of *Foo Fio Na* and what it stands for in relation to the standard of care in medical negligence cases concerning diagnosis and treatment. The analysis consists of three essential parts. The first part discusses the litigation

---

1 [2007] 1 MLJ 593.

2 Sections 6.2, 6.3 and 6.4 of Chapter 6 elaborated this criticism.

3 (1992) 175 CLR 479 (*Rogers*).

4 Chelsea Ng, 'Court Punctures Docs' Defence', *The Star* (Online), 30 December 2006 <http://www.thestar.com.my/news/story.asp?file=/2006/12/30/nation/16445027&sec=nation>.

5 V. Anbalagan, 'Now Easier to Win Suits Against Specialists', *New Straits Times* (Online), 30 December 2006 <http://malaysianmedicine.wordpress.com/2006/12>.

6 The Malaysian Bar, *Demise of Bolam Principle: Foo Fio Na v Dr Soo Fook Mun & Assunta Hospital* (3 February 2007) <http://www.malaysianbar.org.my/content/view/8271/27>.

of *Foo Fio Na* at the first instance stage, namely the High Court, the Court of Appeal and finally the Federal Court. The second part critiques the Federal Court judgment in *Foo Fio Na*. Contrary to the affirmative conclusion of the Malaysian Bar Council that the *Bolam* jurisprudence had ceased to be relevant in medical negligence cases, this chapter argues that the Federal Court in *Foo Fio Na* did not provide a clear principle for adjudicating the issue of the standard of care in diagnosis and treatment. This latter contention is examined from three perspectives: the judgment of the Federal Court in *Foo Fio Na*, scholarly commentaries and lower courts cases which had applied *Foo Fio Na* in medical malpractice litigation of diagnosis and treatment.

The final analysis in this chapter explores options for reform to the law relating to the standard of care in diagnosis and treatment in Malaysia. This chapter advocates legislative reform to replace the common law. It contends that statutory reform is the more flexible and effective way to address the ambiguity in the Federal Court decision in *Foo Fio Na*, and the prolonged uncertainty in this area of medical negligence law in Malaysia.[7] As far as the substance of the proposed legislative changes is concerned, this chapter proposes the adoption of a test that is similar to the English qualified *Bolam* test as enunciated by the English House of Lords in *Bolitho v City and Hackney Health Authority*.[8] The underlying intention of this proposal is to place the Malaysian medical jurisprudence in diagnosis and treatment in line with other major jurisdictions such as the United Kingdom, six Australian states and Singapore.

7.2 THE LITIGATION OF *FOO FIO NA*

This part of the chapter examines the court proceedings in *Foo Fio Na*. It first highlights the tragic circumstances of the case and the nature of the pleadings. The trial of the case took place in the High Court. The case later went through two levels of appeal, the Court of Appeal and the Federal Court.

---

7 This latter issue was elaborated through an analysis of cases prior to the Federal Court decision in *Foo Fio Na*. See Sections 6.2, 6.3 and 6.4 of Chapter 6.

8 [1998] AC 232 (*Bolitho*).

Hearings at the Federal Court in Malaysia, as the law requires, comprise of two stages.[9] The first involves the application for leave to appeal.[10] Having granted the leave, the Federal Court will, in a later date, proceed to hear the substantive appeal which seeks to resolve questions of law. The decisions of *Foo Fio Na* in both stages of the appeal proceedings at the Federal Court are analysed.

7.2.1 The Malaysian High Court[11]

On 11th July 1982, the plaintiff, Miss Foo, was injured when a car in which she was a passenger hit a tree. She was then admitted to the first defendant hospital, Hospital Assunta. At the time of her admission, the plaintiff was able to move all her limbs and walked unassisted into the emergency room only with some pains in her neck. The next morning, Miss Foo was examined by the second defendant doctor, Dr Soo, an orthopaedic surgeon, who informed her that two vertebrate bones on her neck had dislocated. The second defendant administered traction treatment. The treatment was halted after two days because the surgeon decided that it was unsuccessful.

The second defendant instead performed a close manipulation procedure under anaesthetic[12] as an alternative treatment. The procedure was again considered unsuccessful. Subsequently, the second defendant recommended open surgery on the plaintiff's neck. The surgical operation involved grafting bone and inserting a wire loop to move the dislocated vertebrae to their original positions. The surgery was performed on 19 July 1982. One day after the operation, the plaintiff became paralysed. On 5 August 1982, more than two weeks after the first surgical operation, a neurosurgeon was called in to conduct a myelogram test[13] on the plaintiff in the presence of the second defendant. The test revealed that the wire loop

---

9 All appeals from the Court of Appeal to the Federal Court of Malaysia require special leave. Section 96(a) of the *Courts of Judicature Act 1964* (Malaysia) provides that special leave will be granted if there is 'a question of general principle decided for the first time' or 'a question of importance upon which further argument and a decision of the Federal Court would be to public advantage'.

10 The same procedure applies in Australia. Under Section 35(2) of the *Judiciary Act 1903* (Cth), all appeals to the High Court of Australia requires special leave. Under Section 35A of the Act, special leave will only be granted where 'a question of law of public importance arises' or 'where the interests of the administration of justice require consideration by the Australian High Court'.

11 *Foo Fio Na v Hospital Assunta* [1999] 6 MLJ 738 (High Court).

12 This procedure is used to improve articular and soft tissue movement using specifically controlled release, manipulation and mobilisation techniques while the patient is under moderate to deep sedation using monitored anesthesia.

13 A myelogram test is a type of radiographic examination that uses contrast medium to detect pathology of the spinal cord, including the location of a spinal cord injury. The procedure often involves injection of contrast medium into cervical or lumbar spine, followed by several X-rays projections.

was pressing on the plaintiff's spinal cord. On the same day, the plaintiff was taken into the operating theatre to remove the wire loop. This second operation was performed successfully by the second defendant. Following the second operation, however, the plaintiff was only able to move her hands and her legs remained irreversibly paralysed.

In 1987 the plaintiff filed a suit in the Malaysian High Court against, *inter alia*, the second defendant for medical negligence. In her legal action, Miss Foo claimed that the doctor was negligent in performing the first surgical operation which caused the paralysis. She also alleged that the second defendant had failed to inform her of the risks of paralysis in the first open surgery despite her having asked about the dangers and possible adverse consequences. Finally, the plaintiff claimed that the second defendant had failed to take immediate remedial action to rectify her paralysis.

The issue before the trial judge, Mokhtar Sidin J, was whether the second defendant had exercised reasonable care and skills in the field of orthopaedics. On the issue of the duty to disclose risks related to the first surgery, the plaintiff gave evidence that she had asked the second defendant of 'the dangers of the surgery and if anything untowards could happen to her'.[14] However, she alleged that the second defendant doctor did not advise her of the risks of paralysis as well as the nature and procedure of the surgery. The only information the surgeon gave to the plaintiff was that the operation 'was only a minor one'.[15] The second defendant did not call any witnesses to contradict this evidence.

In respect of the alleged negligent first surgical operation, the plaintiff and the second defendant doctor each called a medical expert to testify. The expert witness for the plaintiff, Dr Arumugasamy, gave evidence that the first surgical operation was conducted prematurely. This Malaysian medical expert testified that, in the circumstances, he would have proceeded with conservative treatment as the initial treatment, namely traction and wearing of a cervical collar on the neck to reduce the pain. This expert was of the opinion that the traction treatment should have been continued for months in order to gauge whether the plaintiff was responding to the treatment. He gave this evidence after examining the plaintiff and her X-rays. His opinion on continuous traction treatment for a prolonged period was also

14 *Foo Fio Na* [1999] 6 MLJ 738, 748.
15 Ibid 751.

corroborated by leading medical literature, the authenticity of which was not disputed by the second defendant doctor.

The second defendant's expert witness, Dr Myles Gibson, was a neurosurgeon from the United Kingdom. In his evidence, Dr Gibson expressed a different opinion that the timing of the first surgical operation was appropriate. According to his testimony, the dislocation of the two vertebrae in the plaintiff's neck, if left untreated, would have developed progressive weakness, including paralysis, of all four limbs sooner rather than later. Dr Gibson, however, did not conduct any medical check up on the plaintiff nor did he analyse her X-rays. He admitted that his opinion was formed after reading the second defendant's case notes on the plaintiff.[16]

With regard to the issue of failure to disclosure risk, the trial judge applied the principle in the Australian High Court decision in *Rogers v Whitaker*.[17] His Honour cited the reason that the *Bolam* formulation had not been strictly followed in Malaysia[18] and in Australia. The applicable principle was stated by his Honour as follows:

> 'It is clear... that the determination of whether a doctor is negligent or not is for the court to determine based entirely on the evidence of each case...'.[19]

In reliance on the principle of *Rogers*, Mohktar Sidin J examined two relevant facts. The first was the undisputed fact that the second defendant failed to disclose the risk of paralysis inherent in the first open surgery to the plaintiff. Secondly, his Honour found that the second defendant had misrepresented the surgery as a 'simple and minor operation'.[20] Based on these facts, the trial judge held that the second defendant was negligent in failing to warn the plaintiff of the material risk of paralysis in the first surgical operation.

---

16 Ibid 758.

17 (1992) 175 CLR 479 (*Rogers*). Mohktar Sidin J cited the High Court decision in *Tan Ah Kau v Government of Malaysia* [1997] 2 CLJ (Supplementary) 168, where Low Hop Bing J applied the principle of *Rogers* to the issue of disclosure of risks.

18 The trial judge referred to the Federal Court decision in *Kow Nam Seng v Nagamah* [1982] 1 MLJ 128, 130 (*Kow Nam Seng*). The facts and principle of *Kow Nam Seng* were elucidated in Section 6.3.2 of Chapter 6.

19 *Foo Fio Na* [1999] 6 MLJ 738, 765.

20 Ibid 754.

Mokhtar Sidin J departed from the *Bolam* test when deciding whether the second defendant had breached his duty of care in performing the first open neck surgical operation. His Honour relied on the Federal Court decision in *Kow Nam Seng*[21] and stated that the Court in this case adjudicated the required standard of care in issues of negligent medical treatment based on an evaluation of overall evidence instead of expert medical opinion alone.[22]

In evaluating the evidence, Mokhtar Sidin J first examined the credibility of medical testimony of both opposing parties' experts. In particular, the reliability and credibility of Dr Gibson's testimony were put into question. The trial judge was concerned that the British expert's testimony was given without analysing the plaintiff's X-rays.[23] The High Court further observed that Dr Gibson's opinion was formed only after reading the case notes that were prepared by the second defendant doctor's solicitors and there was evidence to suggest that the notes had been altered or tampered with.[24] Mokhtar Sidin J also noted that Dr Gibson was a council member of the Medical Protection Society[25] and the second defendant also belonged to the Society as a member. In view of this evidence, his Honour commented that Dr Gibson's opinion was self-serving 'on the society which has interest in the decision to favour' the second defendant.[26]

Mokhtar Sidin J proceeded to compare the testimonies of both opposing experts and concluded that the body of medical opinion as expressed by the plaintiff's expert was 'more reliable'.[27] The following reasoning was given in support of his Honour's preference for the testimony of the plaintiff's expert:

> '... It is clear from the evidence of Dr Arumugasamy and the textbooks that the conservative treatments must be administered properly and carried on for a considerable period to produce any result. This appeared to me to be the normal practice. Furthermore, it is clear from the evidence of Dr Arumugasamy that

---

21 [1982] 1 MLJ 128. This interpretation of *Kow Nam Seng* by Mohktar Sidin J is in contrast to the argument in Section 6.3.2 of Chapter 6 that *Kow Nam Seng* only modifies the *Bolam* test instead of rejecting the test outright.

22 *Foo Fio Na* [1999] 6 MLJ 738, 766.

23 Ibid 758.

24 Ibid.

25 Ibid. The Society was quoted by Mokhtar Sidin J as an organisation which aimed to protect 'any undoing or negligence of [its] member'.

26 *Foo Fio Na* [1999] 6 MLJ 738, 758.

27 Ibid.

> there was no danger from the pains and the injuries suffered by the plaintiff that paralysis would set in immediately. According to him only a headstand would cause paralysis. As such there is no necessity for the second defendant to do the open reduction (first operation) within such a short period. Dr Gibson himself confirmed the view that paralysis would not set in immediately. As such the conservative treatments should be continued for a considerable period which may be months and not within one or two days. It is clear to me that treatments conducted by the second defendant was [sic] not normal...'.[28]

Finally, his Honour analysed all the evidence before him and found the second defendant had failed to exercise due care and skill in performing the first open neck surgery. These facts included: the opinion of the plaintiff's expert that the surgery was performed prematurely, the evidence that the wire loop compressed the spinal cord of the plaintiff, the fact that the plaintiff was able to move her upper limbs once the wire loop was removed and finally, the plaintiff was not paralysed prior to undergoing the first open neck surgery.[29]

The High Court also relied on the Federal Court decision in *Kow Nam Seng* in deciding whether the second defendant was negligent for performing the remedial surgical operation more than two weeks after acknowledging the plaintiff's paralysis. Mokhtar Sidin J stated that *Kow Nam Seng* established the proposition that a doctor who has complied with standard medical practice may still liable for negligence if 'something went wrong with the follow-up treatments such as observation'.[30] Applying this principle, his Honour took the view that although the second defendant rightfully chose the second surgery to rectify the paralysis of the plaintiff, the period within which the second defendant took this remedial step was far too long. In conclusion, his Honour found the second defendant negligent as he had failed to take 'immediate' step to treat the paralysis of the plaintiff.[31]

To sum up, the High Court held the second defendant liable for negligence in omitting to disclose the risk of paralysis to the plaintiff, failing to exercise reasonable care and skill in conducting the first surgical operation and failing to immediately rectify the paralysis of the

---

28 Ibid 764-765.
29 Ibid 753.
30 Ibid 766.
31 Ibid 753.

plaintiff.[32] These findings, however, were grounded upon a mixture of the application of two different tests. They were the applications of the principle in *Rogers* to issues of disclosure of risk and a total departure of the *Bolam* test in relation to negligent medical treatments. As far as the first defendant hospital is concerned, the High Court held that it was vicariously liable for the negligence of the second defendant given the employer-employee relationship between the parties.

7.2.2 The Malaysian Court of Appeal[33]

Dr Soo and Hospital Assunta appealed the whole of the High Court decision to the Court of Appeal on three main grounds: the rejection of the *Bolam* test by the trial judge, the procedural defects in the litigation process and the failure of Miss Foo to establish the issue of causation. The Court of Appeal upheld the appeal and set aside the orders of the High Court. The significance of the Court of Appeal decision lies in its affirmation of the *Bolam* test which later became the major contentious issue in the Federal Court appeal. Three grounds can be identified in the judgment of the Court for allowing the appeal:

One of the main grounds for allowing the appeal was that the High Court should have applied the *Bolam* test for determining whether the appellant doctor, Dr Soo, had breached his duty of care in conducting the first surgery. During the course of argument, counsel for the first respondent, Miss Foo, urged the Court not to apply the *Bolam* test, relying on a series of Australian cases which have departed from the test.[34] In delivering the unanimous judgment of the Court, Gopal Sri Ram JCA rejected the submission, giving two reasons for favouring the *Bolam* test.[35] One was the long-standing application of the formulation by the highest courts in Malaysia.[36] His Honour stated that the Court of Appeal, as the intermediate appeal court, was bound by the legal precedents and could not 'alter the law'.[37] The other related to

---

32 In giving judgment for Miss Foo, the Malaysian High Court awarded a general and special damages totalling RM480,000 (approximately A$150,000).

33 *Dr Soo Fook Mun v Foo Fio Na* [2001] 2 MLJ 193 (Court of Appeal).

34 Ibid 206, namely *F v R* (1983) 33 SASR 189, *Rogers* (1992) 175 CLR 479 and *Naxakis v Western General Hospital* (1999) 197 CLR 269 (*Naxakis*).

35 With whom two other judges, Haidar Mohd Noor and Azmel Maamor JJCA concurred.

36 The Court of Appeal did not list down the authorities that had affirmed the application of the *Bolam* test in Malaysia. Presumably, the Court referred to the Privy Council decision in *Chin Keow v Government of Malaysia* [1967] 2 MLJ 45 and the Federal Court case of *Swamy v Matthews* [1968] 1 MLJ 138. See Section 6.2 of Chapter 6 for a discussion of these cases.

37 *Foo Fio Na* [2001] 2 MLJ 193, 207. Under Section 69(1) of the *Courts of Judicature Act 1964* (Malaysia), the Court of Appeal only has the power to, *inter alia*, rehear all the evidence adduced in the High Court. The provision of Section 69(1) is read as follows:

policy grounds. Gopal Sri Ram JCA justified the application of the *Bolam* test on the basis that it 'maintains a fair balance between law and medicine'.[38] In his Honour's opinion, a departure from the test would mean raising the judicial 'intervention threshold' in medical negligence cases.[39] The adverse consequence of such an approach was that doctors would practise 'defensive medicine' and the costs of medical care would be increased.[40] There was, in addition, no compelling reason to reject the *Bolam* test in Malaysia. Gopal Sri Ram JCA stated:

> '... 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.'[41]

In upholding the *Bolam* test, Gopal Sri Ram JCA accepted the opinion of the appellant's medical expert, Dr Gibson, that the timing of the first surgery was appropriate. His Honour disapproved the negative comments by the trial judge that the British surgeon lacked independence and his opinion was not reliable, stating that those observations were not 'warranted'.[42] The Court of Appeal acknowledged that Dr Gibson's opinion was largely based on a reading of the first respondent's evidence and that of her expert witness. However, the Court regarded it as 'acceptable' and 'a common occurrence' in medical negligence litigation.[43] On the contrary, the trial judge was criticised for being 'unfamiliar with the normal practice and procedure' when dealing with expert testimony.[44]

The second ground for granting the appeal related to the procedural defects in the trial process.[45] Gopal Sri Ram JCA identified three flaws in the litigation that had adversely affected the interests of the appellant doctor to a fair trial. One was that the High Court had

---

> 'Appeals to the Court of Appeal shall be by way of rehearing, and in relation to such appeals the Court of Appeal shall have all the powers and duties, as to amendment or otherwise, of the High Court, together with full discretionary power to receive further evidence by oral examination in court, by affidavit, or by deposition taken before an examiner or commissioner'.

38 *Foo Fio Na* [2001] 2 MLJ 193, 207.

39 Ibid.

40 Ibid.

41 Ibid.

42 Ibid 206.

43 Ibid. His Honour made this statement based on his years of experience at the Malaysian Bar before elevation to the Bench.

44 *Foo Fio Na* [2001] 2 MLJ 193, 206.

45 It is unclear as to whether these issues had been dealt with during the trial. The judgment of the High Court did not indicate whether Dr Soo's lawyer raised any objection to these procedural defects.

failed to hear and determine the appellant's application for further particulars. The omission to dispose of this interlocutory application was reproached as 'an extreme example of procedural unfairness and oppression' which deprived the appellant of his right of appeal against any decision thereof.[46] The other flaw was that the trial judge had allowed counsel for the first respondent to raise allegations of negligence over and above those in the pleadings.[47] The first respondent's claim for negligence in relation to the first surgical operation 'pointed to negligence on the part of Dr Soo in using surgical instruments during the surgical procedure'.[48] The notes of evidence, however, suggested that the trial judge had permitted the first respondent's solicitors to raise a 'wide-ranging attack' of negligence against the appellant beyond that of the pleaded particulars.[49] Finally, there had been inordinate delay in the delivery of the judgment after the trial. The trial judge took four years after the completion of the trial to finalise the judgment, but without giving any reasons for doing so. The long delay had the legal effect of diminishing the weight of witnesses' testimony which the trial judge was entitled to give.[50] The longer the delay in the delivery of the judgment after trial, the lesser the weight the trial judge in *Foo Fio Na* was entitled to give to the testimony of witnesses and any findings of the trial judge could be subject to review by the Court of Appeal.[51]

The third ground for upholding the appeal was the failure of the High Court to consider the issue of causation. In arriving at this decision, the Court of Appeal relied on the House of Lords decision in *Wilsher v Essex Area Health Authority*[52] where Lord Bridge held that the onus of establishing causation in medical negligence cases rests on the plaintiff.[53] In the present case, Gopal Sri Ram JCA accepted the evidence that the first respondent's onset paralysis only came twenty-four hours after the first surgical operation. This evidence, according to his Honour, raised the important question as to whether the paralysis was brought about by the first open neck surgery. For this reason, the trial judge should have

46 *Foo Fio Na* [2001] 2 MLJ 193, 200.
47 Ibid 205.
48 Ibid.
49 Ibid. His Honour did not provide further details on any of the 'unpleaded charges of negligence' pertaining to the first surgery.
50 *Foo Fio Na* [2001] 2 MLJ 193, 204.
51 Ibid 204-205. Gopal Sri Ram JCA relied on the Federal Court decision in *Wong Chong Chow v Pan-Malaysian Cement Works Berhad* [1980] 2 MLJ 75, 77 where Chang Min Tat FCJ enunciated this principle of law.
52 [1988] AC 1074.
53 Ibid 1090.

determined the causal link between the paralysis suffered by the first respondent and the first surgical operation.[54]

7.2.3 The Malaysian Federal Court: Application for leave[55]

The appeal of Miss Foo to the Federal Court was based mainly upon the issue of standard of care. In the Court of Appeal proceedings, Dr Soo was exonerated from negligence on the grounds, *inter alia*, that the High Court should have applied the *Bolam* test when deciding whether the doctor had breached his duty of care in performing the first surgery. In the Federal Court, however, Miss Foo pursued the issue in a broader perspective, urging the Court to consider whether the *Bolam* test should apply in 'all aspects of medical negligence', including cases of disclosure of risk and diagnosis. The legal question upon which Miss Foo sought leave to appeal was postulated as follows:

> 'Whether the *Bolam* test as enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, in the area of medical negligence should apply in relation to all aspects of medical negligence?'.[56]

The Federal Court[57] unanimously granted the leave to appeal on the grounds that a consideration of the legal question posed by Miss Foo and a decision of the Court on the matter would be of public importance.[58] The Court stated that it was timely to revisit the application of the *Bolam* test in Malaysia, given that jurisdictions such as Australia and 'other Commonwealth countries' had 'refined' the test in medical negligence cases.[59] However, the Court singled out one area of medical negligence that needed special attention at the hearing of the substantive appeal:

> ' ... It may be noted that in this case, the particular aspect of medical negligence relates more specifically to the duty and standard of care of a medical

---

54 *Foo Fio Na* [2001] 2 MLJ 193, 204.

55 *Foo Fio Na v Dr Soo Fook Mun* [2002] 1 MLJ 129 (Federal Court)(Application for leave).

56 Ibid 130.

57 The panel judges comprised of Steve Shim CJ (Sabah and Sarawak), Abdul Malek Ahmad FCJ and Mohtar Abdullah FCJ.

58 *Foo Fio Na* [2002] 2 MLJ 129, 130.

59 Ibid. The Court did not name the 'other Commonwealth countries' to which it referred.

practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment.'[60]

This part of the judgment shows that the Federal Court granted leave to appeal specifically for the analysis of the issue of the standard of care in disclosure of risks. However, as it is shown later in the discussion of the substantial appeal, the Federal Court did not confine its ruling on this aspect of the doctor's duty of care. Instead, it went on to consider the issue of negligent treatment, which arguably adds confusion to the decision of the Federal Court.

7.2.4 The Malaysian Federal Court: The substantive appeal[61]

The Federal Court allowed the appeal of Miss Foo and ruled that the *Bolam* test should not apply to 'all aspect of medical negligence' cases.[62] The unanimous judgment of the full bench of the Federal Court,[63] which was delivered by Siti Norma Yaakob FCJ, held that the doctor's duty of care comprises of three distinct areas, provision of advice, diagnosis and treatment.[64] On the issue of a doctor's duty to warn, the Court expressly endorsed the Australian High Court decision in *Rogers*. The Court stated that in Malaysia a doctor must inform a patient of sound mind and understanding of all the material risks that are inherent in a proposed medical treatment before obtaining the patient's consent to undergo the treatment.[65]

The joint judgment of the Federal Court proffered a number of policy reasons for substituting the *Bolam* test for the principle in *Rogers* in the area of duty to warn. The major disadvantage of the *Bolam* test was that it restricts the courts from 'scrutinizing and

---

60 *Foo Fio Na* [2002] 2 MLJ 129, 130.

61 *Foo Fio Na* [2007] 1 MLJ 593 (Federal Court) (Substantive Appeal).

62 Ibid 594.

63 The judges comprised of Mohamed Dzaiddin CJ, Ahmad Fairuz Sheikh Abd. Halim CJM and Siti Norma Yaakob FCJ.

64 *Foo Fio Na* [2007] 1 MLJ 593, 601.

65 Ibid 594. The Federal Court decision in *Foo Fio Na* is arguably incomplete with regard to the issue of disclosure of risk. There are a number of issues that need clarification. One is that the Court did not state whether the test of materiality extends to all patients, whether it also applies to patients who are incapable of giving consent due to age and their mental state and those who do not ask questions about risk in a medical procedure or treatment. The Court also did not provide a clear definition of material risk and inherent risk as well as the differences between the two. Furthermore, there is the question whether the right of doctors to withhold information under the exception of therapeutic privilege should always prevail over the patients' best interests to be informed of medical risk. These issues have been thoughtfully raised and addressed by a leading Malaysian medico-legal academic, Norchaya Talib. See Norchaya Talib, '*Foo Fio Na v Dr Soo Fook Mun & Anor* – Beneath (and Alongside) the Surface of Change', [2007] *The Law Review* 587, 600-603.

evaluating' the conduct of the medical profession.[66] Such constraint exists because the test determines the issue of negligence solely on the basis of expert medical opinion.[67] Another reason, the Court stated, was directed at the over-protective nature of the test.[68] Since the defendant doctors' action or omission merely has to conform to 'one of the bodies' of medical opinion, a finding of negligence would be a rarity.[69] The third justification was that the *Bolam* test, which relies solely on the opinion or customary practices of the medical profession, is incompatible with the standard of reasonably competent doctors.[70] According to the Federal Court, the standard of reasonably competent doctors could only have been achieved if the courts, not the medical profession, were given the authority to determine the final outcome of medical negligence cases after drawing upon all the available evidence.[71] Lastly, the principle in *Rogers* would provide a critical analysis of the evidence in medical disputes for the benefits of litigants and the courts.[72] In line with this final reason, the Court called upon members of the medical profession to 'stand up to the wrong doings, if any, as is the case of professionals in other professions'.[73]

In applying the principle in *Rogers* to the present case, the Federal Court held that the first respondent doctor, Dr Soo, had breached his duty of care by failing to disclose to the appellant, Miss Foo, the material risk of paralysis in the open neck surgery and this failure had caused the injury.[74] In arriving at this decision, the Court also distinguished the facts in the present case with that in *Bolam v Friern Hospital Management Committee*[75] on three grounds. The first distinction related to the appellant's mental state. It was stated that the appellant was 'a bright' lady who was able to fully comprehend the nature of the risks, as compared with the plaintiff in the case of *Bolam* who was a mental patient.[76] The other differing fact was the degree of probability at which the injury would eventuate in *Foo Fio Na*. The risk of fracture in *Bolam* was estimated at 1 in 10,000 but the risk of paralysis to the appellant was described as 'present and real'.[77] Finally, unlike the case of *Bolam*, the failure

66 Ibid 601.
67 Ibid.
68 Ibid.
69 Ibid.
70 Ibid 611, quoting Michael Jones, *Medical Negligence* (Sweet & Maxwell, 2nd ed, 1996) 95.
71 *Foo Fio Na* [2007] 1 MLJ 593, 611.
72 Ibid.
73 Ibid 612.
74 Ibid 602.
75 [1957] 2 All ER 118 (*Bolam*).
76 *Foo Fio Na* [2007] 1 MLJ 593, 603.
77 Ibid.

of the first respondent doctor in *Foo Fio Na* to inform the appellant of the risk of paralysis in the first open neck surgery was an undisputed fact.[78]

As already noted earlier, the Federal Court limited the consideration of the legal question to the doctor's duty to warn the patient of medical risks. However, its ruling went beyond this scope of analysis. In affirming the findings of the High Court, the Federal Court held that the first respondent was also negligent in performing the first surgical operation and in failing to administer immediate post-operative treatment to rectify the paralysis of the appellant.

The Federal Court gave two justifications for preferring the findings of the High Court over those of the Court of Appeal. One was that that the Federal Court was bound by a series of cases which deterred it from interfering with the findings of facts of the court of first instance.[79] More importantly, the Court stated that the trial judge had 'sufficient evidence' to justify his conclusions.[80] One material fact was that the second corrective surgery successfully rectified the paralysis of the appellant, though not fully:

> 'It must also be remembered that the appellant suffered total paralysis after the first operation and it was to correct this situation that the second operation was performed. In this respect, the trial judge made the following observations:
>
> > "As to the first operation, it is clear to me that the second defendant had done something which caused the paralysis. I am satisfied that the paralysis was caused by the wire loop compressing the spinal cord and when the wire loop was removed during the second operation the plaintiff was able to move her upper limbs..."'.[81]

The Federal Court made further reference to the following judgment of the High Court which contains the trial judge's reasoning for the findings of negligence on post-operative treatment:

---

78 Ibid.

79 Ibid. Siti Norma Yaakob FCJ cited the cases of *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (*Maynard*), *Renal Link (KL) Sdn Bhd v Dr Harnam Singh* [1997] 2 MLJ 373 and *China Airlines Ltd v Maltran Air Corp Sdn Bhd* [1996] 2 MLJ 517. Of these three cases, only the English case of *Maynard* was related to medical negligence.

80 *Foo Fio Na* [2007] 1 MLJ 593, 603.

81 Ibid 602.

> '... The second defendant was again negligent when he did not take any step to remedy the paralysis immediately. Instead he waited for two weeks to do the remedial operation and all that time he kept on assuring the plaintiff that she would recover from the paralysis which was only temporary in nature. In my view the above shows that the second defendant failed to exercise the care and skill of an ordinary competent practitioner in that profession as stated by the Federal Court in the case of *Kow Nam Seng v Nagamah* [1982] 1 MLJ 128.'[82]

In summary, the Federal Court approved three findings of the High Court, two of which concerned the issue of negligent treatment and one relating to causation. In relation to the issue of negligent surgical operation, the Federal Court made an important observation that the trial judge did not apply the *Bolam* test when evaluating the expert opinion pertaining to the first open neck surgery, 'preferring instead to question, analyse... the evidence before him'.[83] On the contrary, the Federal Court did not make any observation in respect of the second findings of the trial judge that the first respondent doctor failed to take prompt step to remedy the paralysis of the appellant.

On the findings of causation, the Federal Court did not address the conflicting findings by the High Court and that of the Court of Appeal with regard to this matter. The High Court concluded that the appellant's paralysis was 'caused by the wire loop compressing the spinal cord'.[84] The Court of Appeal, on the other hand, found that the paralysis of the appellant might not have been caused by the first surgery since the injury occurred more than 24 hours after the appellant underwent the operation. The omission of the Federal Court to deal with the disparity in both findings further undermines the significance of its decision concerning negligent treatment.

The Federal Court allowed the appeal of the first respondent and restored the orders of the High Court on the grounds that the doctor was negligent on three counts: failing to warn the appellant of the risk of paralysis; performing the first open neck surgery without

---

82 Ibid. This passage was cited in *Foo Fio Na* [1999] 6 MLJ 738, 753.

83 *Foo Fio Na* [2007] 1 MLJ 593, 601.

84 Ibid 602 (As quoted by Siti Norma Yaakob FCJ). These findings were cited in *Foo Fio Na* [1999] 6 MLJ 738, 753.

exercising due care and skill; and failing to take immediate remedial step to rectify the appellant's paralysis.[85]

7.3 ASSESSMENT OF *FOO FIO NA*: THE STANDARD OF CARE IN DIAGNOSIS AND TREATMENT

This section assesses the Federal Court decision in *Foo Fio Na* relating to the standard of care in diagnosis and treatment in medical negligence cases. It argues that this decision is ambiguous on the principle that should be applied in deciding the standard of care in both branches of the doctor's duty of care. Not only that the Federal Court created confusion in its endorsement of the High Court's findings on negligent medical treatment, it also failed to make a definite pronouncement on the applicable principle for diagnosis and treatment in Malaysia. The view that *Foo Fio Na* is unclear on the legal position on the standard of care in diagnosis and treatment is also demonstrated by inconsistent interpretations of this decision by academic scholars and judges in subsequent lower court cases.

7.3.1 The ruling of the Court on the issue of the alleged negligent treatment

The Federal Court's endorsement of the findings of the trial judge on the issues of negligent medical treatment was ambiguous and internally inconsistent. The main concern was that the Court did not question the legal basis of the trial judge's findings on negligent medical treatments. It has been shown in the analysis of the decision of the High Court that the trial judge relied on the Federal Court decision in *Kow Nam Seng* for notably not applying the *Bolam* test. Paradoxically, the Federal Court in its legal analysis of previous appellate court cases in Malaysia stated that *Kow Nam Seng* was a case which affirmed the *Bolam* test.[86] Given this latter statement, it may be argued that the trial judge's interpretation of *Kow Nam Seng* was wrong and accordingly the legal basis upon which the findings of negligence on issues of medical treatment were made was also flawed. This internal inconsistency added confusion as to the actual legal position that the Federal Court took with regard to the interpretation of *Kow Nam Seng*. In addition, the lack of clarification by the Federal Court on

---

85 These decisions were reviewed by a five-man panel of the subsequent Federal Court on 4 October 2007. In a unanimous decision, the Federal Court affirmed its ruling in *Foo Fio Na* (Substantive Appeal). The grounds for approving *Foo Fio Na* were not reported in any of the law journals. The only statement of the Court was that of Alauddin Sherrif FCJ where his Honour stated, through the press, that 'We find this is not a fit and proper case to exercise our inherent powers to set aside the judgment of the Federal Court'. See 'Duty of Doctors to Inform Patients about Risks of Surgery', *New Straits Times* (Online), 5 October 2007 <http://malaysianmedicine.blogspot.com/2007/10/duty-of-doctors-to-inform-patients.html>.

86 *Foo Fio Na* [2007] 1 MLJ 593, 608.

the findings of the trial judge also obscured the pronouncement of the Court with regard to the applicable test for deciding the standard of care in negligent treatment cases. More importantly, all these problems raise the question as to whether the Federal Court did intend to endorse the *Rogers* principle 'in all aspects of medical negligence' cases.

7.3.2 The Court's legal analysis

The Federal Court in *Foo Fio Na* painstakingly examined authorities from Australia and the United Kingdom which had departed from the *Bolam* test in diagnosis and treatment,[87] but fell short of making any conclusion on the preferred test for Malaysia. In analysing the common law position in Australia, Siti Norma Yaakob FCJ dealt extensively with the case of *Naxakis*, particularly the judgments of Gaudron and McHugh JJ.[88] The quoted passages of both the High Court Justices, as summarised by Siti Norma Yaakob FCJ, essentially stated that the issue of medical negligence under Australian common law was not solely to be determined by what other medical experts would or would not have done in the circumstances.[89] Instead, it was a question which ultimately rested with the courts having regard to all the circumstances of a given case.[90]

With regard to the English precedents, Siti Norma Yaakob FCJ commenced examination of the authorities by the Court of Appeal decision in *Hucks v Cole*,[91] a case concerning negligent treatment. Her Honour noted that the case of *Hucks* had heralded a 'shift in attitude when determining a doctor's liability' by its ruling that the final authority to decide the medical standard of care in the area of treatment lay with the courts.[92] Her Honour further stated that although most English cases had previously applied the *Bolam* test, the legal position 'has somewhat changed',[93] notably by the more recent House of Lords decision in *Bolitho*. The Federal Court then referred to the ruling of Lord Browne-Wilkinson in *Bolitho* that the courts would be entitled to reject a medical opinion if it did not have a 'logical

---

87 Ibid 611. The Federal Court only briefly examined an Irish case of *Best v Wellcome Foundation Ltd* (1994) 5 Med LR 81.

88 The judgments of Gaudron and McHugh JJ in *Naxakis* were examined in Section 3.2.6 of Chapter 3.

89 *Foo Fio Na* [2007] 1 MLJ 593, 608. See *Naxakis* (1999) 197 CLR 269, 274-275 (Gaudron J) and 285-286 (McHugh J).

90 Ibid.

91 (1993) 4 Med LR 393 (*Hucks*).

92 *Foo Fio Na* [2007] 1 MLJ 593, 604. The Federal Court also cited two other English Court of Appeal cases which had applied the principle in *Hucks*, namely *Gascoine v Ian Sheridan* (1994) 5 Med LR 437 and *Joyce v Wandworth Health Authority* (1995) 6 Med LR 60.

93 *Foo Fio Na* [2007] 1 MLJ 593, 604.

basis'.[94] Siti Norma Yaakob FCJ also cited other remarks of Lord Browne-Wilkinson that the court would largely defer to expert medical opinion, and that it is only in 'rare' cases that this opinion might be overruled for want of 'logical basis'.[95]

Finally, the Federal Court took the analysis back to the Malaysian precedents. The Court noted that in Malaysia, the *Bolam* test had been 'extensively' applied by the appellate courts in *Chin Keow v Government of Malaysia*,[96] *Swamy v Matthews*,[97] and *Kow Nam Seng* in medical negligence cases.[98] The Court also observed that there were two High Court decisions which had applied the '*Rogers v Whitaker* test' in cases concerning disclosure of risks and medical treatment respectively.[99] They were *Tan Ah Kau v Government of Malaysia*[100] and *Kamalam a/p Raman v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore*.[101] The case of *Tan Ah Kau* dealt with the issue of breach of duty of care in disclosure of risks whilst *Kamalan* involved the issue of negligent treatment, where the doctors in both cases were held liable for negligence. In particular, Siti Norma Yaakob FCJ quoted with approval the judgment of Richard Talalla J in *Kamalam* that although 'due regard will be had to the evidence of medical experts', the courts would decide the issue of negligence based on 'overall evidence' rather than relying on established medical practices alone.[102] Having reviewed the legal precedents from Australia, the United Kingdom and Malaysia, the Federal Court concluded that the *Bolam* test had not been applied in these jurisdictions, and in the case of Malaysia, its lower courts.[103]

The Federal Court in *Foo Fio Na* arguably could have identified a number of material differences between the common principles in Australia and the United Kingdom in its legal analysis. One was the reference point upon which judges may overrule medical expert opinion. Under the English *Bolitho* principle, the court must be satisfied that expert medical opinion consists of a risk and benefit analysis and that this assessment reaches a defensible

---

94 Ibid 605. The 'logical basis' test, which is part of the English *Bolitho* principle, was examined in Section 2.6 of Chapter 2.

95 *Foo Fio Na* [2007] 1 MLJ 593, 604.

96 [1967] 2 MLJ 45.

97 [1968] 1 MLJ 138.

98 The first two cases were examined in Section 6.2 of Chapter 6, whilst the last case was analysed in Section 6.3 of Chapter 6.

99 *Foo Fio Na* [2007] 1 MLJ 593, 609.

100 [1997] 2 AMR 1382.

101 [1996] 4 MLJ 674 (*Kamalan*). See Section 6.4.1 of Chapter 6 for an analysis of the decision in *Kamalam*.

102 *Foo Fio Na* [2007] 1 MLJ 593, 610.

103 Ibid 605.

conclusion. In comparison, the decision in *Naxakis*, which extended the principle of *Rogers* to the spheres of diagnosis and treatment, held that judges may evaluate expert opinion on the basis of whether any precautionary measures should have been reasonably taken in the circumstances.[104]

The other difference between the common law principles in Australia and the United Kingdom is the manner in which the courts in both jurisdictions adjudicate expert medical opinion. Under the English qualified *Bolam* test, the courts cannot choose between conflicting opinions. Once an opinion fulfils the test of logic, English courts cannot prefer another opinion that is considered more 'logical'. Conversely, the *Rogers* principle, in the context of cases of diagnosis and treatment, does not impose such restriction and judges may prefer one body of medical opinion over another.[105] However, one difficulty with the Australian common law is the extent to which judges are capable of exercising this wide discretion given their limited expertise in medical science. Furthermore, the absence of any constraint on preference of opinion would mean that the courts may end up selecting a body of opinion that is not practiced by the mainstream medical profession. This arguably adds uncertainty to the outcome of medical disputes.

A final distinction that separates the Australian and English common law is the extent to which the courts give weight to expert opinion in medical disputes concerning diagnosis and treatment. The English courts are largely bound by expert medical opinion. The decision in *Naxakis*, on the other hand, allows the courts to be less deferential to the medical profession.[106] The Australian High Court in this case had made it clear that expert medical opinion or accepted practice in the medical profession is not conclusive of the outcome of medical disputes. Rather, the determination of the required standard of care is based on an overall evaluation of available evidence.[107] Furthermore, in situations where there is no direct medical opinion to support a plaintiff case, a judge may draw a reasonable inference of liability from the factual circumstances.[108]

---

104 (1999) 197 CLR 269, 277 (Gaudron J), 295 (Kirby J) and 311 (Calinan J).

105 Kathy Sant, 'A New *Bolam* Test?', (2004) 64 *Precedent* 20, 22.

106 *Naxakis* (1999) 197 CLR 269, 277 (Gaudron J), 286 (McHugh J), 295 (Kirby J) and 311 (Callinan J).

107 See Section 3.2.6 of Chapter 3 for an analysis of how the Court in *Naxakis* took the approach to evaluate all the available evidence.

108 Ibid 277 (Gaudron J), 295 (Kirby J) and 311 (Callinan J).

An analysis of the differences between the common law principles in Australia and the United Kingdom should have led the Federal Court in *Foo Fio Na* to recognise the need to make a clear statement as to whether Malaysia should follow either the Australian or English position. Instead, the Court treated the principles in both jurisdictions as of no difference, hence missing an opportunity to make an informed conclusion of the appropriate test in respect of diagnosis and treatment for Malaysia.

7.3.3 Inconsistent interpretations of Foo Fio Na by academic scholars

The argument that the justices of the Federal Court in *Foo Fio Na* did not definitively state the law for determining the standard of care in diagnosis and treatment can also be supported by the inconsistency in the interpretations of the decision by academic scholars. Overall, these scholarly commentaries suggested three different tests for diagnosis and treatment following *Foo Fio Na*. Academics such as Cusack and Veeriah argue that the *Bolam* test is still applicable, despite the ruling of the Federal Court that the *Bolam* test should not apply in 'all aspects of medical negligence' cases. In justifying her contention, Veeriah refers to the specific holding of the Federal Court that the *Bolam* test is not relevant in the doctor's duty to advise the patient of medical risks.[109] Cusack, on the other hand, justifies his argument by stating that the Federal Court had confined the question of law to medical negligence cases of disclosure of risk.[110] With regard to the Federal Court's reference to the Australian High Court case of *Naxakis*, Cusack argues that the discussion of this decision merely served as an illustration that the *Bolam* test had not been applied in the areas of diagnosis and treatment in Australia. Nonetheless, he concedes that the reference to *Naxakis* in the judgment of the Federal Court in *Foo Fio Na* 'has unfortunately introduced a degree of uncertainty' in the areas of diagnosis and treatment in Malaysia.[111]

The other explanation of *Foo Fio Na* was given by Sidhu who suggests that the English *Bolitho* principle should apply in cases of negligent diagnosis and treatment. Unlike

---

109 Sivameenambigai a/p Veeriah, 'Critical Analysis and Acceptability of *Foo Fio Na v Dr Foo Sook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229: Valid Concerns?', [2010] 1 *Malayan Law Journal* xlv, lx-lxi.

110 Denis A Cusack, 'The Standard of Care in Medical Practice: Has the Pendulum Swing in Favour of the Patients' (Paper presented at the public lecture jointly organised by Asean Law Association of Malaysia and the Malaysia Inner Temple Alumni Association, Kuala Lumpur, 16 September 2007). Cusack is a leading academic in forensic and legal medicine at the University College Dublin, Ireland. He is also a visiting academic at one of the medical colleges in Malaysia.

111 Ibid.

Cusack and Veeriah, Sidhu takes the view that the Federal Court in *Foo Fio Na* had rejected the *Bolam* test in medical disputes concerning diagnosis and treatment.[112] He is of the opinion that the Federal Court endorsed the English *Bolitho* principle in the areas of medical diagnosis and treatment in Malaysia because it expressly cited with approval the English House of Lords decision in *Bolitho*.[113]

An Australian academic, Mathew Thomas, offers another interpretation of the ruling of *Foo Fio Na* on the standard of care in diagnosis and treatment. Thomas argues that the Federal Court in *Foo Fio Na* might have extended the *Rogers* principle to cases of diagnosis and treatment.[114] He refers to the concluding statement of the Federal Court that 'the *Rogers* test would be a more appropriate and viable test of this millennium than the *Bolam* test'. This quotation shows the Court's preference for the *Rogers* principle over the *Bolam* test in 'all aspects of medical negligence'. Nonetheless, Thomas states that the extension of the principle of *Rogers* to the areas of diagnosis and treatment should, at its highest, be considered as *obiter*. The *ratio* in *Foo Fio Na*, Thomas states, is limited to the duty to warn of medical risks because the necessity to examine this issue was the basis upon which the Federal Court granted leave to appeal.[115]

7.3.4 Conflicting lower court decisions

Just as academic scholars have not been able to reach a consensus on the exact test in diagnosis and treatment that was pronounced by the Federal Court in *Foo Fio Na*, judges in the lower courts equally have not demonstrated a uniform approach in construing the decision. There are essentially three distinct groups of lower court cases that applied *Foo Fio Na* to issues concerning negligent treatment and diagnosis. One group ruled that the Federal Court in *Foo Fio Na* had endorsed the principle of *Rogers*. The other group of cases took the view that the *Bolam* test is still relevant. The third group applied the *Bolitho* principle. These discrepancies are arguably the result of a lack of clarity in *Foo Fio Na* with regard to the legal position on the standard of care in medical diagnosis and treatment. The following section elucidates the conflicting judicial interpretations of *Foo Fio Na* in subsequent Malaysian lower court cases.

---

112 Sarjeet Singh Sidhu, '*Bolam*, *Foo Fio Na* and Doctors', [2008] 6 *Malayan Law Journal* l, lvii.

113 Ibid.

114 Mathew Thomas, '*Rogers v Whitaker* Lands on Malaysian Shores – Is There Now a Patient's Right to Know in Malaysia?', [2009] *Singapore Journal of Legal Studies* 182, 197.

115 Ibid.

There are two Court of Appeal cases and a number of High Court decisions[116] in Malaysia which interpreted *Foo Fio Na* as extending the principle in *Rogers* to medical negligence cases of diagnosis and treatment. The following analysis confines itself to two Court of Appeal authorities as they are thus far the only available appellate court decisions after the Federal Court decision in *Foo Fio Na*. One of the Court of Appeal cases which applied the principle in *Rogers* to the issue of negligent medical treatment was *Hasan bin Datolah v Government of Malaysia*.[117] The appellant in *Hasan* suffered from paralysis after undergoing two surgical operations. In his claim for medical negligence, the appellant alleged that the doctor, who was employed by the respondent, had negligently performed the surgeries and had failed to inform him of the risk of paralysis in the procedures. The trial judge found the doctor not liable for both the claims. The major issue in the Court of Appeal was whether the trial judge had misdirected herself by solely relying on expert medical opinion of the doctor rather than evaluating all the available evidence before her, as required by the Federal Court in *Foo Fio Na*.

As similarly interpreted by academic commentators such as Thomas, the Court of Appeal[118] unanimously held that the Federal Court in *Foo Fio Na* 'had without doubt' rejected the *Bolam* test in favour of the principle in *Rogers* in all medical negligence cases.[119] In arriving at this ruling, the Court referred to the statement of the Federal Court in *Foo Fio Na* that:

> '... the *Rogers v Whitaker* test would be more appropriate and a viable test of this millennium than the *Bolam* test'.[120]

The Court of Appeal in *Hasan* also stated that in applying the principle in *Rogers* to issues of negligent medical treatment, expert medical opinion or the standard practice of the medical

---

116 *Sanmarkan a/l Ganapathy v Dr V Thuraisingham* [2012] 3 MLJ 817, 838 (Judicial Commissioner Chew Soo Ho) (failure to diagnose colon cancer); *Ang Yew Meng v Dr Sashikannan a/l Arunasalam* [2011] 9 MLJ 153, 173 (Judicial Commissioner Supang Lian) (prescription of inappropriate drugs) and *Chien Tham Kong v Excellent Strategy Sdn Bhd* [2009] 7 MLJ 261, 262 (Low Hop Bing J) (failure to take precautions to prevent injury to the plaintiff's spinal cord and omission to adopt an alternative diagnosis).

117 [2010] 2 MLJ 646 (*Hasan*).

118 The panel judges of the Court of Appeal consisted of Hasan Lah JCA, Sulaiman Daud JCA and Abdul Hamid Embong FCJ.

119 *Hasan* [2010] 2 MLJ 646, 647 and 654.

120 Ibid 654. This passage was cited in *Foo Fio Na* [2007] 1 MLJ 593, 594.

profession will be of paramount importance.[121] Having made the legal position clear, the Court reviewed the judgment of the trial judge and came to the conclusion that the findings of the trial judge were not based on the application of the *Bolam* test. Rather, the findings of the trial judge were grounded upon an assessment of all evidence, including the opinion of the appellant's medical expert.

Another Court of Appeal decision which concluded that the Federal Court in *Foo Fio Na* had endorsed the principle of *Rogers* in the areas of diagnosis and treatment was *Dominic Puthucheary v Dr Goon Siew Fong*.[122] The case concerned issues of negligent diagnosis and treatment. The appellants were personal representatives of the estate of the deceased. They sued the first respondent doctor for negligence, alleging that the doctor had failed to diagnose the deceased's spinal injury and to administer appropriate medical treatment, both of which caused the latter's death. The Court of Appeal unanimously dismissed the claims for medical negligence on the grounds that the causal link between the alleged failure and the deceased's death could not be established. On the issue of the standard of care in medical negligence cases, Gopal Sri Ram JCA,[123] who delivered the judgment of the Court, opined that the *ratio* in *Foo Fio Na* extended to all types of medical malpractice disputes in Malaysia:

> '... In *Foo Fio Na v Dr Soo Fook Mun* ... the Federal Court held 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. While I must reserve my comments on the correctness of the decision on the actual facts of that case, it is one that is plainly binding on this Court...'.[124]

---

121 Ibid. In support of this statement, the Court of Appeal in *Hasan* cited the statement of Gleeson CJ in the Australian High Court decision in *Rosenberg v Percival* (2001) 205 CLR 434, 439 where his Honour reportedly clarified the application of the principle of *Rogers* in medical negligence cases generally as follows:

> '... *Rogers v Whitaker*, makes clear, the relevance of professional practice and opinion was not denied; what was denied was its conclusiveness. 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...'.

122 [2007] 5 MLJ 552 (*Dominic*).

123 With whom two other judges of the Court of Appeal, Suriyadi JCA and Hasan Lah JCA concurred.

124 *Dominic* [2007] 5 MLJ 552, 559.

His Honour, however, did not refer to any of the parts of the judgment of the Federal Court in *Foo Fio Na* to support the above interpretation.[125]

There are at least two Malaysian High Court decisions which have shared the interpretation as given by Cusack and Veeriah that the *Bolam* test has survived the ruling of the Federal Court in *Foo Fio Na*. One is *Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk*.[126] The plaintiff in this case suffered from lung infection after undergoing an operation to remove a fish bone from his throat. Shortly after the surgery, the plaintiff was given two tablets to be consumed orally with a glass of soft drink. The plaintiff developed esophageal perforation in the upper part of his esophagus. His right lung became infected due to the perforation and the infection almost led to collapse of the lung. In his claim for negligence, the plaintiff alleged, *inter alia*, that the lung infection was a result of the defendant doctor's failure to administer appropriate post-operative treatment. The plaintiff also claimed that the defendant doctor had failed to advise him of the risk of lung infection from the surgery.

One of the issues before the High Court was whether the giving of oral drugs to the plaintiff shortly after the surgery was an appropriate treatment. The trial judge, Rohana Yusuf J, did not refer to the Federal Court case of *Foo Fio Na* in deciding this issue. Instead, her Honour relied on the decision in *Dr Chin Yoon Hiap v Ng Eu Khoon*[127] where the Malaysian Court of Appeal affirmed the application of the *Bolam* test in the late 1990s. Rohana Yusuf J quoted the decision in *Chin Yoon Hiap* where it was held that:

> '... the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proven to be guilty [sic] of such failure as no doctor of ordinary skill acting with ordinary care would be guilty [sic] of'.[128]

Relying on this passage, Rohana Yusuf J held that the defendant doctor was not negligent for the lung infection suffered by the plaintiff. Her Honour stated that the defendant doctor had 'treaded [sic] on the well-worn path' in giving the oral drugs to the plaintiff a few hours after

---

125 Gopal Sri Ram JCA was also one of the three judges in the Court of Appeal proceedings in *Foo Fio Na*. See Section 7.2.2 of this chapter.

126 [2008] 1 MLJ 115 (*Thomas Yau*).

127 [1998] 1 MLJ 57 (*Chin Yoon Hiap*). See Section 6.2.3 for an analysis of the Court of Appeal decision in *Chin Yoon Hiap*.

128 *Thomas Yau* [2008] 1 MLJ 115, 125. This passage was cited in *Chin Yoon Hiap* [1998] 1 MLJ 57, 58.

the throat operation and 'there is no evidence to suggest that he deviated from the accepted practice'.[129]

The other High Court case that had applied the *Bolam* test to the issue of negligent medical treatment was *James Kenneth Eng Siew Goh* (*suing as administrator of the estate of Melissa Jane Goh Mei Feng, deceased*) *v Lee King Ong*.[130] The plaintiff in this case, the administrator of the deceased, sued the defendant doctor for negligently prescribing a drug, Blocadren,[131] to treat the deceased's fast pulse rate and hand tremors. The plaintiff claimed that a few hours after the deceased took this drug, the latter suffered from breathing difficulties, collapsed and died some months later. The defendant doctor had not asked the deceased whether she had asthma or had been treated for asthma before prescribing this drug.

One of the issues for consideration was whether the defendant doctor had breached his duty of care by prescribing Blocadren to the deceased. On the legal principle for determining this issue, the trial judge, Abdul Wahab Patail J,[132] held that the Federal Court in *Foo Fio Na* did not reject the *Bolam* test in medical negligence cases but merely distinguished the facts of *Bolam*:

> '... the Federal Court delivered its decision in *Foo Fio Na v Dr Soo Fok Mun* [2007] 1 MLJ 593 ... where the *Bolam* test, appeared to be rejected. At the same time the Federal Court relied upon *Bolitho (administratrix of the estate of Bolitho, deceased*) *v City and Hackney Health Authority* [1997] 4 All ER 771 ... The more correct view is that *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 ... ('the *Bolam* test') was distinguished by the Federal Court...'.[133]

In applying the *Bolam* test, Abdul Wahab Patail J relied on the undisputed medical opinion that Blocadren is a type of drug that could block the effects of asthma medications. Based on this medical evidence, his Honour held that the defendant doctor had failed to exercise due care in prescribing Blocadren by failing to inquire about the deceased's medical history of

---

129 *Thomas Yau* [2008] 1 MLJ 115, 133.

130 [2009] 4 MLJ 396 (*James Kenneth Eng*).

131 Blocadren is used to treat high blood pressure, to prevent heart attacks and migraine headaches.

132 Justice Abdul Wahab Patail was recently elevated as the Court of Appeal judge.

133 *James Kenneth Eng* [2009] 4 MLJ 396, 401-402.

asthma. Nonetheless, the trial judge dismissed the plaintiff's case as there was not medical evidence to suggest that Blocadren caused or triggered the deceased's asthma attack.

The interpretation by Sidhu that the English *Bolitho* principle should apply to issues of negligent diagnosis and treatment following the Federal Court decision in *Foo Fio Na* was evident in at least one Malaysian High Court decision, *Wu Siew Yong v Pulau Pinang Clinic Sdn Bhd*.[134] In *Wu Siew Yong* the plaintiff, with a history of endometriosis[135] dating back to 1999, was suffering from pain in her abdomen before menstruation. In 2001 the plaintiff consulted the second defendant who was an obstetrician and gynaecologist practising at a hospital owned by the first defendant. The second defendant conducted an initial ultra sound scan on the plaintiff which indicated the presence of endometricotic cysts in her ovary. The second defendant then performed a second diagnostic test, called laparoscopy, with a view of confirming the presence of the cysts and then to remove them.

The second diagnostic test, however, failed to detect any cysts. The second defendant instead administered a drug named Zoladex[136] by way of injections with a view to eliminating the plaintiff's abdominal pain. A year later, the plaintiff consulted another medical specialist in Singapore. The Singaporean doctor detected two endometriotic cysts in the plaintiff's ovary. The plaintiff did not suffer from the same complaint after the cysts were removed. The plaintiff sued the second defendant for medical negligence. She alleged, *inter alia*, that the doctor was negligent in failing to detect endometriotic cysts. She also claimed that the doctor had wrongfully injected her with two doses of Zoladex.

In relation to the alleged failure to detect the endometriotic cysts, the plaintiff did not adduce any medical evidence to prove the negligence of the second defendant in conducting the laparoscopy. The High Court proceeded to consider whether the second defendant should have performed open surgery which would have confirmed the existence of the endometriotic cysts. In examining this issue, Judicial Commissioner Chew Soo Ho cited the Federal Court decision in *Foo Fio Na* but did not expressly state the applicable principle. Nonetheless, a

134 [2011] 3 MLJ 506 (*Wu Siew Yong*).

135 Endometriosis is a gynaecological condition where cells similar to the lining of the uterus appear outside the ovaries.

136 Zoladex is a drug that is used to suppress production of sex hormones (testosterone and oestrogen), particularly in the treatment of breast and prostate cancer.

detailed scrutiny of the following trial judge's decision revealed an application of the English *Bolitho* principle:

> '... I also do not find the second defendant to have breached his duty of care when he declined to carry out open surgery as he had balanced the risk and benefit of such open surgery to the plaintiff. Dr Alex also endorsed the fact that there are major blood tissues linked to major organs at the pelvis which is dangerous to operate...'.[137]

This finding was mainly based on the opinion of one defence expert witness, a prominent obstetrician and gynaecologist, Dr Alex,[138] who made an analysis of the risk and benefit of performing the open surgery.

Turning to the issue of prescription of Zoladex by the second defendant, Judicial Commissioner Chew also found the doctor not liable for negligence. This ruling was partly based on the overwhelming expert opinion of the defence's experts and the medical evidence of one expert witness of the plaintiff, that Zoladex injection was the 'recognised and accepted medication' for the treatment of endometriosis. More importantly, the High Court took into account the benefit of the drug in eliminating the risk of recurrence of endometriotic cysts on the plaintiff's ovary, as suggested by expert medical opinion of both opposing parties. Judicial Commissioner Chew made the following findings:

> 'From the evidence of all the obstetricians and gynaecologists ... there is no doubt that Zoladex injections are the recognised and accepted medication for the treatment of endometriosis. The plaintiff has had a history of endometriosis and her complaints indicated the recurrence of endometriosis ... I find that what the second defendant had administered on the plaintiff of Zoladex was the recognised beneficial medication for the plaintiff who suffered from the similar symptoms of endometriosis...'.[139]

---

137 *Wu Siew Yong* [2011] 3 MLJ 506, 519 (Judicial Commissioner Chew Soo Ho).

138 Dr Alex was stated to be Vice President of the College of Obstetrician and Gynaecologists, Academy of Medicine, Malaysia and had been practising obstetrics and gynaecology for the past 31 years.

139 *Wu Siew Yong* [2011] 3 MLJ 506, 520 (Judicial Commissioner Chew Soo Ho). The application of the English *Bolitho* principle in *Wu Siew Yong* appears to be in stark contrast with the interpretation of *Foo Fio Na* by Judicial Commissioner Chew in his Honour's subsequent decision in *Sanmarkan a/l Ganapathy v Dr V Thuraisingham* [2012] 3 MLJ 817, 838. In this latter case, Judicial Commissioner

In arriving at this decision, Judicial Commissioner Chew did not cite the case of *Bolitho*. However, the approach taken by his Honour in addressing the above issue suggested an application of the English *Bolitho* principle, which focuses on a comparative analysis of risk and benefit in a medical treatment.

7.3.5 Conclusion

The Federal Court case of *Foo Fio Na* is a significant decision in the law of medical negligence in Malaysia. The importance of this decision, however, has been overshadowed by the ambiguity in the pronouncement with regard to the standard of care in diagnosis and treatment, and the uncertainty in its interpretations in subsequent lower court cases. This raises the question of where Malaysia stands on issues concerning the standard of care in diagnosis and treatment. Clearly, the law is unsatisfactory and reform is called for.

7.4 THE LAW ON THE STANDARD OF CARE IN DIAGNOSIS AND TREATMENT – WHITHER MALAYSIA?

There are two major aspects on assessing the future direction of the law on the standard of care in medical diagnosis and treatment in Malaysia that need to be addressed. One relates to substantive principle. As shown in the foregoing analysis, case law development after the Federal Court case of *Foo Fio Na* leans towards an application of the principle in *Rogers*, although there is no certainty that this legal trend will continue at the Malaysian lower courts. Assuming that this development was to continue, the *Rogers* jurisprudence is nonetheless not shared by most jurisdictions. Even in Australia, six of its states replaced the common law principle with a legislated modified *Bolam* test to be applied in the areas of diagnosis and treatment. Only Northern Territory adopted *Naxakis* without any changes. The Australian Capital Territory qualified this decision statutorily.[140] The *Rogers* principle also has not found favour in the United Kingdom and Singapore. As the previous chapters of this thesis revealed, both these jurisdictions took a clear preference for the *Bolitho*-type *Bolam* test, albeit in different forms. The Australian modified *Bolam* test is similar to the *Bolitho* principle but

---

Chew takes the view that the Federal Court in *Foo Fio Na* endorses the *Rogers* principle in all aspects of medical negligence case.

[140] The distinctions between the application of the common law in the Australian Capital Territory and Northern Territory were discussed in Section 5.9 of Chapter 5.

with certain modifications.[141] The *Bolitho* principle that was interpreted by the Singaporean Court of Appeal decision in *Dr Khoo James v Gunapathy d/o Muniandy*[142] was more restrictive than that in the case of *Bolitho* itself.[143]

The application of the principle in *Rogers* to the spheres of diagnosis and treatment is arguably inappropriate. In the context of doctor-patient relationship, the role of a patient is limited to narration of medical symptoms. Based on this information, a doctor would use his or her skills to diagnose the patient's illness and make decision on the appropriate medical treatment to be administered.[144] Whilst judges may be allowed to ultimately decide on the required standard of care, their decision should be primarily based on the accepted practice or opinion of the medical profession[145] rather than an overall evaluation of all available evidence as required under the *Rogers* principle. In other words, the role of judges in adjudicating the standard of care in the areas of diagnosis and treatment should be limited to evaluation of expert opinion to ensure that this opinion is internally consistent and supported by cogent medical evidence.[146] This judicial role suits the limited expertise of most judges in medical science.[147]

There is also the concern that an overly interventionist approach in the areas of diagnosis and treatment, such as under the *Rogers* principle, might raise the spectre of defensive medicine in Malaysia. This issue has been raised by a number of appellate court judges in Malaysia,[148] Singapore,[149] and the United Kingdom.[150] Defensive medicine may be explained in two perspectives. One is that there might be an increase in the number of medical negligence litigation against doctors, the resulting consequence of which is the inevitable rise in medical indemnity premiums. The other aspect of defensive medicine, as suggested by a respected Malaysian medico-legal scholar, Norchaya Talib, is that doctors

---

141 Panel of Eminent Persons, *Review of the Law of Negligence: Final Report* (Commonwealth of Australia, 2002) 3.18[41]. See Section 5.7 of Chapter 5 for an analysis of the bases for the modified *Bolam* test in Australia.

142 [2002] 2 SLR 414 (*Gunapathy*).

143 See Section 2.9 of Chapter 2 for a comparative analysis of the *Bolitho* principles in the United Kingdom and Singapore.

144 *Rogers* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

145 See also Norchaya Talib, above n 65, 603.

146 *Gunapathy* [2002] 2 SLR 414, 433-434 (Yong CJ).

147 Ibid 454 (Yong CJ, during argument).

148 *Dr Soo Fook Mun v Foo Fio Na* [2001] 2 MLJ 193, 207 (Gopal Sri Ram JCA, during argument);

149 *Gunapathy* [2002] 2 CLR 414, 454 (Yong CJ, during argument).

150 *Roe v Ministry of Health* [1954] 2 QB 66, 86-87 (Denning LJ, during argument).

would do much less than they ought to.[151] In other words, doctors would most likely adopt medical treatment or procedures that are safe and satisfy the minimum requirement imposed to the medical profession to avoid unnecessary litigation.[152] If these concerns are real, the interests of patients would be compromised as they may incur additional medical costs and be deprived of an appropriate standard of medical care. No doubt there is a lack of empirical studies establishing the correlation between the practice of defensive medicine and the application of the *Rogers* principle in the areas of diagnosis and treatment in Australia[153] and Malaysia.[154] Nonetheless, the development in most Australian jurisdictions implementing the modified *Bolam* test should not be totally ignored in Malaysia.

On the basis of the above arguments, it is therefore proposed that the future direction of the standard of care in diagnosis and treatment in Malaysia should head towards the *Bolitho*-type *Bolam* test, not the principle in *Rogers*. This proposal would also place the medical jurisprudence in diagnosis and treatment in Malaysia in line with a majority of common law jurisdictions such as Australia, Singapore and the United Kingdom.

The other aspect on the assessment of the future direction of the law on the standard of care in medical diagnosis and treatment in Malaysia concerns the proper mode of legal reform. There are essentially two options to be considered for legal reform in Malaysia. One is for a future Federal Court to revisit *Foo Fio Na* in light of the analysis in this chapter. The other option is to state the law in legislation. It is argued that codification of the *Bolitho*-type *Bolam* test in legislation is the most appropriate reform choice for Malaysia. The analysis of the advantages and disadvantages of reform by legislation appears below.

7.4.1 The benefits of legislative changes

Legislation is arguably a more flexible way than litigation to address the shortcomings in *Foo Fio Na*. Case law development is dependent upon accidents of litigation. Given that the Malaysian Federal Court has not long ago examined the law of medical negligence in *Foo Fio Na*, the chance of a review in the near future is slender. Even assuming that the Federal Court is willing to explore the law on diagnosis and treatment, there is no assurance that any

151 Norchaya Talib, above n 65, 598.
152 Ibid.
153 Similar argument has been made in Section 4.4 of Chapter 4.
154 This scepticism has also been raised by Norchaya Talib, above n 65, 597-598.

established legal principle would fulfil the requirements of clarity, certainty and protecting the interests of doctors and patients in medical disputes. By contrast, legislative changes can be made at anytime, and the legislature can take advantage of the longer time period than that available to judges to produce a comprehensive and systematic legal framework for Malaysia.[155]

The proposed reform by legislation is also an effective way to resolve the long-standing problems of uncertainty and lack of clarity in the law. There is no doubt that the conditions in Australia and Malaysia are different. Malaysia has experienced neither a remarkable increase in medical insurance premiums nor the collapse of any medical indemnity providers such as the United Medical Protection in Australia. As compared with Australia, the medical profession in Malaysia has also not been subjected by the courts to substantial payouts in negligence claims.[156] Nonetheless, Malaysia can certainly adopt legislative reform as a means to providing a clear and predictable legal framework. This area of the law, as the analysis of cases prior to the Federal Court decision in *Foo Fio Na* shows, had gone through a prolonged period of uncertainty.[157] In *Foo Fio Na* the Federal Court also did not take the opportunity to state, clarify and define the scope of the law for the benefit of future litigants. Cases subsequent to the Federal Court decision in *Foo Fio Na* are also not consistent in their interpretations of the applicable test for diagnosis and treatment in Malaysia and this situation is clearly unsatisfactory.

7.4.2 Disadvantages of reform by legislation

Codifying the *Bolitho*-type *Bolam* test in legislation in Malaysia is not without shortcomings. There are concerns that the implementation of this proposal would undermine the nature and development of this common law principle. The English *Bolam* test, the English and Singaporean *Bolitho* principles had been gradually developed by the courts in the United

---

155 Roscoe Pound, 'Common Law and Legislation', (1908) 21 *Harvard Law Review* 383, 404-407.

156 In *Foo Fio Na*, the award of general and special damages totalling RM480,000 (approximately A$150,000) was considered as a substantial amount in the record of medical negligence litigation in Malaysia. See also Mathew Thomas, above n 118, 193. Comparatively, Australia had a much higher amount of damages awarded in medical negligence cases. In the New South Wales Court of Appeal case of *Diamond v Simpson (No 1)* [2003] NSWCA 67 (7 April 2003), for instance, a record compensation amounting to A$10,998,692 was awarded by the Court.

157 This problem was elaborated with a discussion of a series of cases in Sections 6.2, 6.3 and 6.4 of Chapter 6.

Kingdom over a long period of time.[158] Crystallisation of either of this common law principle into legislation would curtail the due development of the law, preventing judges from 'moulding' the principle except for changing the interpretative method of the statutory provisions.[159] There is also fear that the Malaysian legislatures, motivated by political considerations, may also set 'arbitrary and dogmatic' boundaries on this common law principle.[160] In Australia, for instance, the effort to replace the common law with a legislated modified *Bolam* test was criticised in a previous chapter as a political mechanism to provide a short term solution to the medical indemnity crisis.[161] For reasons only known to the Australian legislatures, the requirement of 'logical basis' under the *Bolitho* principle has been replaced with 'irrational' and 'unreasonable' provisos, both of which are to be judged against the broad and vague notion of 'community expectations'.[162]

Legislating the qualified *Bolam* test in Malaysia may also minimise the coherency which its application under the common law could otherwise provide. Although medical science advances and ethical values change over time, judges may still have to discharge their responsibility of expressing and refining the existing law in line with past legal principles from case law.[163] The legislatures, on the other hand, may be tempted to modify the common law principle to promote partisan causes at the expense of consistency and coherency.[164]

Finally, the proposal to enact the *Bolitho*-type *Bolam* test may cause uncertainty in the common law in Malaysia. If this suggestion is implemented, there may be calls to also codify the standard of care of other professionals. There may also be demands within the Malaysian public to emulate the Australian model by placing all principles of general negligence in a single statute in the name of providing certainty and predictability. The issue of floodgates in legislating the common law may be a concern. More questions may also be raised as to which

---

158 The development of the *Bolam* test and the *Bolitho* principle in the United Kingdom was examined in Sections 2.2 and 2.6 of Chapter 2 respectively.

159 Barbara McDonald, 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia', (2005) 27 *Sydney Law Review* 443, 461.

160 See also *Cattanach v Melchior* (2003) 215 CLR 1, 53 (Kirby J, during argument). This case dealt with the issue of birth of an unintended child resulted from the appellant doctor's negligent advice and failure to warn.

161 This criticism was analysed in Section 4.6.3 of Chapter 4.

162 This parliamentary intention of the Australian modified *Bolam* test was examined in Sections 5.5 and 5.7.1 of Chapter 5.

163 *Cattanach* (2003) 215 CLR 1, 53 (Kirby J, during argument).

164 Peter Cane, 'Taking Disagreement Seriously: Courts, Legislatures and the Reform of Tort Law', [2005] 3 *Oxford Journal of Legal Studies* 393, 416. Cane was one of the panel members of the Ipp Review Committee which proposed codification of the modified *Bolam* test in legislation in Australia.

aspects of the common law in Malaysia would be more appropriately governed by the legislatures rather than the courts.

It may be concluded that the proposed changes to the standard of care in diagnosis and treatment in Malaysia either by a future Federal Court or the Malaysian legislatures have both strengths and weaknesses. The balance of advantages lies with legislative changes as case law development is inflexible, dependent upon unplanned litigation and less comprehensive in its analysis than a review by the legislatures. The standard of care in diagnosis and treatment is an important aspect of the law of medical negligence that deserves a priority for legislative reform. As the experience in Australia shows, the issue of medical standard of care is inter-related with other matters such as stability of medical indemnity premiums and continual delivery of health care service by doctors.[165] A well considered and carefully structured legal framework will ensure that all these elements gain positive impacts. One feasible way to strike a balance between statute-based principle and case law development is to enact clear but flexible statutory provisions that aim to balance the interests of injured patients and defendant doctors in medical disputes.

7.5 CONCLUSION

This chapter analysed the significance and shortcomings of the Federal Court decision in *Foo Fio Na* with a view to providing a solution to the problems underlying the standard of care in medical diagnosis and treatment under the common law in Malaysia. As the current highest court precedent, *Foo Fio Na* is a pivotal point in the development of the law of medical negligence in Malaysia. However, the importance of this landmark decision was compromised by the Federal Court's failure to definitively pronounce the legal position on the standard of care in diagnosis and treatment in Malaysia. It may be argued, on the other hand, that the Federal Court in *Foo Fio Na* was not given a full opportunity to lay down a comprehensive legal principle for diagnosis and treatment, given that the issue concerning negligent diagnosis was not raised in the case itself.

This chapter argued that the law on the standard of care in medical negligence in diagnosis and treatment in Malaysia requires reform. The ambiguity and unpredictability in the law does not encourage litigants to resolve their medical disputes out of courts.

[165] See Section 4.2 of Chapter 4 for an analysis of these issues in the Australian context.

Conversely, it causes more cases to be filed in the courts to test the application of *Foo Fio Na*. As part of the proposed law reform, this chapter advocates implementation of the *Bolitho*-type *Bolam* test in Malaysia. The current development, as demonstrated by a majority of Court of Appeal and High Court cases, leans towards the application of the *Rogers* principle. It was argued that this legal trend requires correction as the extension of the *Rogers* principle in the areas of diagnosis and treatment is only evident in the Australian Territories, more particularly in Northern Territory. Major jurisdictions such as the United Kingdom, the Australian states and Singapore prefer the *Bolitho*-type *Bolam* test.

This chapter also argued that the law pertaining to the standard of care in diagnosis and treatment should be given full attention by the Malaysian legislature due to its potential implication for the medical indemnity industry and the spectre of defensive medicine in Malaysia. It concludes that codification of the applicable principle under legislation is also a more flexible and effective way than awaiting a future Federal Court to resolve the uncertainty that has riddled this aspect of medical negligence law for a long time. In light of the recent review of the legal standard of care in medical negligence cases in *Foo Fio Na*, there is no certainty that the Federal Court will reassess this area of the law in the near future.

One major concern in allowing the legislatures to set the law is that they are inclined to promote political values rather than coherency, consistency, fairness and reasonableness. One way to safeguard against this danger is to leave certain important requirements in the proposed test for interpretation by the courts. The substance of the proposed *Bolitho*-type *Bolam* test for Malaysia will be elucidated in the next chapter. What can be said at this stage is that the recommendations aim to protect the interests of doctors and injured patients who are involved in medical negligence disputes concerning diagnosis and treatment.

CHAPTER 8
LEGISLATIVE REFORM IN MALAYSIA: THE WAY FORWARD

8.1 INTRODUCTION

In the previous chapters of this thesis, it has been argued that the law for determining the standard of care in medical negligence cases of diagnosis and treatment is unsatisfactory. In Chapter 7 it was contended that the Malaysian Federal Court in *Foo Fio Na v Dr Soo Fook Mun*[1] missed an opportunity to clearly state the principle for determining the standard of care in medical negligence cases concerning diagnosis and treatment.[2] As a result, there is ambiguity and uncertainty in the current state of the law. Chapter 6 of this thesis also highlighted the uncertainty with regard to the application of the *Bolam* test in Malaysia between the 1960s and late 2006.[3] This chapter focuses on providing recommendations for reform to the law and to the procedural aspect of its application in Malaysian courts with a view to providing a long-term solution to the legal problems.

The suggested law reforms in this chapter consist of two aspects. One is codification of the *Bolitho*-type *Bolam* test in legislation as the Malaysian reform model. This would bring the Malaysian medical jurisprudence into line with the legal developments in the United Kingdom, Singapore and most jurisdictions in Australia. It is proposed that the Malaysian reform model should draw strong reliance on the Singaporean version of the *Bolitho* principle as it contains a clear and systematic mechanism to facilitate judicial evaluation of expert medical opinion and caters to judges' limited expertise in medical science. The proposed Malaysian reform model aims to protect the competing interests of doctors and patients in medical negligence disputes.

The other aspect relates to procedural changes to the use of expert witnesses in medical negligence litigation concerning issues of diagnosis and treatment. This chapter argues that the current rules of the courts in Malaysia may bring about the problems of biased expert medical opinions and delays in the resolution of medical disputes. Accordingly, recommendations are made to implement under legislation requiring the appointment of a

---

1 [2007] 1 MLJ 593 (*Foo Fio Na*).
2 This argument was elaborated in Section 7.3 of Chapter 7.
3 See the analysis of the relevant cases in Sections 6.2, 6.3 and 6.4 of Chapter 6.

single agreed or a single court-appointed expert before the commencement of medical negligence litigation. The proposals also allow the appointment of an additional agreed or court-appointed expert or experts after the commencement of legal proceedings, and in limited circumstance, to permit litigants to engage their own experts.

8.2 THE PROPOSED MALAYSIAN REFORM MODEL

This thesis has examined three different versions of the *Bolitho*-type *Bolam* test: the principle in the English House of Lords in *Bolitho v City and Hackney Health Authority*;[4] the more restrictive interpretation of the *Bolitho* principle by the Singaporean Court of Appeal in *Dr Khoo James v Gunapathy d/o Muniandy*[5] and the Australian modified *Bolam* test. The principles in each of these versions vary in form. The English and Singaporean version of the *Bolitho* principles authorise the courts to reject expert medical opinions on the basis that these opinions lack 'logical basis'. The Australian modified *Bolam* test places emphasis on the notion of 'widely accepted' expert medical opinion, whilst authorising the courts to dismiss the opinions if they are found to be 'irrational' or 'unreasonable'.[6] All three versions of the *Bolitho*-type *Bolam* test retain the courts' right to ultimately decide the required standard of care in the areas of medical diagnosis and treatment. The proposed Malaysian reform model is underpinned by this principle.

The proposed Malaysian reform model would allow the courts to assess 'a responsible body of medical opinion' based on the quality of the opinions, rather than on the number of opinions that are sought.[7] In this regard, the proposal draws strong reliance on the Singaporean version of the *Bolitho* principle, as it provides a systematic mechanism by which judges may scrutinise expert medical opinions. It is proposed that Malaysia should not adopt the Australian modified *Bolam* test as it is meant to limit liability of doctors for medical negligence and to prevent the recurrence of the medical indemnity crisis in Australia. The requirement for 'widely accepted' under the Australian model focuses on the quantity of expert medical opinions. The 'irrational' and 'unreasonable' provisos under the Australian modified *Bolam* test allow the courts to reject expert medical opinion when it is contrary to

4 [1998] AC 232 (*Bolitho*). See Section 2.6 of Chapter 2 for an analysis of the English *Bolitho* principle.

5 [2002] 2 SLR 414 (*Gunapathy*). The Singaporean version of the *Bolitho* principle was examined in Section 2.8 of Chapter 2.

6 The important wording of the Australian modified *Bolam* test was examined in light of the States' *Hansards* in Section 5.7 of Chapter 5.

7 See also *De Freitas v O'Brien and Connolly* (1995) 6 Med LR 108, 115 (Otton LJ) (English Court of Appeal).

'community expectation' – a vague notion that does not specifically invite a thorough examination of the medical bases of expert opinions.[8]

8.2.1 The proposed test

It is recommended that the proposed Malaysian reform model should take the following statutory wording:

> 'A doctor is not negligent if his or her acts or omissions in the areas of diagnosis and treatment are supported by a responsible body of medical opinion'.[9]

This formulation would provide a defence for a defendant doctor who has complied with accepted practice or opinion of the medical profession. The defence, however, would be subject to the requirement that the expert medical opinion in support of the acts or omissions in question must be representative of 'a responsible body of medical opinion'. In addition, the issue of liability would be determined by reference to body of medical opinion established at the date of the alleged negligence, not a later date.[10] This requirement would ensure that the action or omission of the defendant would not be judged according to a higher standard of care should it develop at a subsequent date.

8.2.2 The criteria for 'a responsible body of medical opinion'

Analysis of the *Bolitho*-type *Bolam* test in the United Kingdom, Singapore and the Australian states shows that these jurisdictions have chosen the terms 'logical basis', 'irrational' and 'unreasonable' as a yardstick for deciding whether expert medical opinions can be considered as 'a responsible body medical opinion'.[11] Analysis in the previous chapters reveals that these terms do not provide much assistance to enable the courts to adjudicate expert medical opinion unless clear guidance is provided. It is therefore suggested that the Malaysian

---

8 Section 5.8.3 of Chapter 5 elucidated this criticism.

9 This proposed formulation is an adaptation of the second part of the *Bolam* test which was discussed in Section 2.2.5 of Chapter 2.

10 *Roe v Ministry of Health* [1954] 2 QB 66, 84 (Denning LJ).

11 The 'irrational' proviso was implemented in *Civil Liability Act 2002* (NSW) Section 5O(2); *Civil Liability Act 1936* (SA) Section 41(2); *Civil Liability Act 2002* (Tas) Section 22(2); *Civil Liability Act 2003* (Qld) Section 22(2). The States of Victoria and Western Australia adopted the 'unreasonable' proviso in the *Wrongs Act 1958* (Vic) Section 59(2) and *Civil Liability Act 2002* (WA) Section 5PB(4) respectively. See Section 5.7 of Chapter 5 for an analysis of these provisos.

Bolitho-type *Bolam* test should adopt neither term, for the simple reason that it will only lead to unnecessary debates over their dictionary meanings.

It is recommended that the two-stage inquiry as articulated by the Singaporean Court of Appeal in *Gunapathy* be adopted as the mechanism for determining the criteria of 'a responsible body of medical opinion' under the proposed Malaysian reform model. The first stage of the inquiry would involve an examination of whether expert medical opinion has undertaken a comparative risk and benefit analysis.[12] It is proposed that the analysis should be entirely left to medical experts due to the intricacies and complexity associated with the analysis. In this regard, the courts should be concerned about the process of the assessment, not the result of the expert's reasoning.[13] In the second stage of the inquiry, judges would consider whether the risk and benefit analysis reaches a defensible conclusion: to probe the internal consistency of the expert opinions; and to assess whether these opinions are supported by proven extrinsic medical facts or advances in medical science.[14]

The proposal recognises that judicial functions under the Singaporean version of the *Bolitho* principle are more restrictive than its English original version in the evaluation of the 'logical basis' of expert medical opinion. Comparatively, the Singaporean version of the *Bolitho* principle is preferable as it contains an unambiguous and systematic methodology by which judges may evaluate expert medical opinion. The limited judicial function under the two-stage inquiry under the Singaporean version of the *Bolitho* principle also caters to judges' lack of medical expertise and knowledge in the adjudication of technical issues concerning diagnosis and treatment.

8.3 CLARIFICATIONS OF THE PROPOSED TWO-STAGE INQUIRY

Two clarifications must be made regarding the two-stage inquiry under the proposed Malaysian reform model. One relates to the reference point of the risk and benefit analysis, namely whether the analysis should be confined to a particular patient who is involved in a medical dispute, or to include a general body of patients. The other concerns the extent to which expert medical opinion may be adduced in litigation, namely whether it should be

12 *Bolitho* [1998] AC 232.
13 *Gunapathy* [2002] 2 SLR 414, 433.
14 Ibid 433-434.

limited to the country in which medical disputes arise or should be extended beyond the jurisdiction.

8.3.1 Reference point for risk and benefit analysis

It is proposed that the risk and benefit analysis specifically refers to a particular patient who is involved in a medical negligence litigation, and not the general body of patients. In considering the risk and benefit of receiving a diagnostic procedure or medical treatment by a particular patient, it is further proposed that expert medical opinion must give due consideration to a number of criteria. They are: physical and psychological health, the necessity to under a diagnostic procedure or medical treatment, amenity, future quality of life of this particular patient. Although it is recognised that medical experts will have the final say on the weighing up of this risk and benefit analysis, a consideration of these criteria aims to ensure that the interests of the particular patient are addressed and protected.

8.3.2 The boundary of which expert medical opinion may be adduced

It is recommended that expert medical opinions from jurisdictions beyond Malaysia may be adduced in medical negligence litigation concerning issues of diagnosis and treatment. This approach has been adopted by the Singaporean Court of Appeal in *Gunapathy*. In this case, the Court admitted into evidence two protocols from America which supported the opinion of the defence experts.[15] Although these protocols had not yet been widely adopted in Singapore due to their novelty, the courts determined that they were relevant to the case at hand. In comparison, the statutory provisions in four Australian State jurisdictions, New South Wales, Tasmania, South Australia and Queensland explicitly limit the locality of 'widely accepted' opinions under the modified *Bolam* test to 'Australia'.[16] In other words, it suffices for defendant doctors in these jurisdictions to adduce a 'widely accepted' medical practice within Australia as a defence to their medical negligence claims, subject to the 'irrational' or 'unreasonable' provisos.

The main advantage of allowing the admissibility of the opinion of medical experts from jurisdictions beyond Malaysia is that it may shed light on any advancement in medical

---

15 Section 2.8.1 of Chapter 2 outlined the facts of *Gunapathy*.

16 *Civil Liability Act 2002* (NSW) Section 5O(1); *Civil Liability Act 2002* (Tas) Section 22(1); *Wrongs Act 1958* (Vic) Section 59(1); *Civil Liability Act 1936* (SA) Section 41(1). The Queensland and Western Australia models do not expressly restrict the locality requirement.

science yet to be widely adopted in this country. Through this approach, medical practitioners would be encouraged to venture into cutting-edge medical practices which may lead to a more effective cure than conventional medicine or clinical procedures. This proposal would also suit local conditions in Malaysia as a large majority of doctors practising in this jurisdiction are trained in various recognised medical colleges and universities in over thirty countries.[17] These foreign trained graduates bring back diverse skills and expertise and are most likely to implement the knowledge they have learnt in their medical practice.

The proposal, however, recognises that the extension of the admissibility of the opinion of foreign medical experts may pose a financial burden on litigants. This may particularly raise concerns for injured patients who may not have the means to appoint medical experts from foreign countries. Furthermore, these foreign experts may not have in-depth knowledge of the context in which medical practices operate in Malaysia. Issues such as constraints facing medical practitioners as well as the interests and wellbeing of local patients can be more appropriately addressed by experts who have practiced medicine in Malaysia than by foreign experts.[18]

In view of these problems, it is suggested that two conditions should be satisfied before foreign experts may be called to give testimony in medical negligence litigation of diagnosis and treatment. One is that the foreign medical practices sought to be adduced in courts be well-established but not yet widely adopted in Malaysia. This approach aims to ensure that foreign experts are appointed only where their testimonies may assist judges to comprehend advances in medical science. The other condition is that the appointment of

---

17 These countries include Australia, Bangladesh, Belgium, Burma, Canada, Egypt, Hong Kong, India, Indonesia, Iran, Iraq, Ireland, Japan, Jordan, Malta, New Zealand, Pakistan, Russia, Saudi Arabia, Singapore, South Africa, Sri Lanka, Sudan, Taiwan, Turkey, Uganda, Ukraine, United Kingdom, United States of America and West Indies: *Medical Act 1971* (Malaysia) Second Schedule of Section 12(1)(a)(i). Medical graduates from recognised universities in these jurisdictions can obtain full registration as medical practitioners in Malaysia after completing one year housemanship in public hospitals: *Medical Act 1971* Section 13(1)(2). Medical graduates from unrecognised universities must pass a qualifying examination before they can commence housemanship: *Medical Act 1971* Section 12(1)(aa). Upon obtaining full registration, it is compulsory for all doctors to serve in public hospitals for a period of three years: *Medical Act 1971* Section 41.

18 Similar observation can be drawn from the findings of Lau Bee Lan J in the Malaysian High Court case of *Dennis Lee Thian Poh v Dr Michael Samy* [2012] 4 MLJ 673, 707 which concerned the issue of disclosure of risk and liability against the second defendant private hospital for failure to ensure a safe obstetric system. With regard to this latter issue, Her Honour rejected the testimony of the plaintiff's two foreign experts, of the United Kingdom and New Zealand respectively, on the grounds that both of them only addressed the required standard of medical care of private hospitals in their own jurisdictions, rather than that 'in Malaysia'.

foreign experts must not involve significant costs. In this regard, each litigant should be subject to a means test to assess their financial capability. This latter proposal is particularly important because the subsequent recommendation on the use of expert witnesses will be based on a single agreed or a single court-appointed expert.

8.4 REFORM OF THE SYSTEM OF EXPERT EVIDENCE IN MALAYSIA

The following section of this chapter provides an effective procedural framework to facilitate a fair evaluation of expert medical opinion and ensure the speedy resolution of medical negligence litigation concerning issues of diagnosis and treatment. It argues that the current rules of the court on the use of expert evidence are ineffective in ensuring impartial expert medical opinion in the litigation process. It also contends that the procedural framework is one of the main factors contributing to the problem of inordinate delay in the resolution of medical negligence cases of diagnosis and treatment by Malaysian courts. It is proposed that Malaysia should adopt a system of a single agreed or a single court-appointed expert prior to the commencement of medical negligence litigation.

8.4.1 The problems

One of the problems with the system of expert evidence in Malaysia is that it does not provide sufficient safeguard to ensure independence of expert opinion in medical negligence litigation. The present procedural rules governing the use of expert evidence in all civil proceedings in Malaysian courts are provided for under the *High Court Rules 1980* and *Subordinate Rules 1980* respectively. As far as the Malaysian High Court is concerned, Order 38 Rule 22 of the *High Court Rules 1980* enables litigants in all legal proceedings to appoint expert witnesses at their own expense.[19] There is, in addition, provision under Order 40 Rule 1 of the *Rules of the High Court 1980* to confer upon judges the discretion to appoint court experts at any stage of legal proceedings to 'inquire and report upon any question of fact or opinion not involving questions of law or of construction'.[20] The exercise of this power, however, may only arise where there is an application by one or more litigants in a dispute. There are no statutory provisions under the rules which authorise the courts to appoint medical experts on their own initiative. The overall procedural framework enables litigants to

[19] See also *Subordinate Courts Rules 1980* (Malaysia) Order 25 Rule 20.

[20] There is no corresponding provisions under the *Subordinate Courts Rules 1980* (Malaysia) for the appointment of court-appointed experts.

appoint their own medical experts to advance their case. This raises the strong likelihood that the testimonies of medical experts may be biased in favour of the parties who engage them.

There have been judicial observations in Malaysia that expert witnesses who have direct or indirect pecuniary interests in medical disputes are more likely to be biased. One example is in the High Court proceedings of *Foo Fio Na*. As noted in a previous chapter, the respondent doctor engaged a British expert to give expert opinion on his behalf. This British expert was a council member of the Medical Protection Society, of which the respondent doctor was also a member. One of the objectives of this organisation was to protect the interests of its members against medical negligence claims. The trial judge, Mokhtar Sidin J, rejected the opinion of this British expert on the grounds, among others, that his testimony was 'self-serving', aiming to favour the respondent doctor.[21] Recently, the trial judge in the Malaysian High Court case of *Sanmarkan a/l Ganapathy v Dr V Thuraisingham* also commented that so long as the opinion of medical experts is 'tainted with the probability of non-independence, it would be unsafe for the courts to rely on such evidence to ensure a fair trial'.[22] This 'probability of non-independence', to use the words of the trial judge, arguably exists in all medical negligence litigation where litigants are allowed to engage their own medical experts.

In Australia and the United Kingdom, the issue of biased expert testimonies is a perennial problem and has been the subject of continual commentary by judges in these jurisdictions. In a study conducted in 1999, it was found that 65 per cent of the 244 judges and magistrates who responded to the survey stated they encountered biased testimony 'occasionally', whilst 26 per cent rated it 'often'.[23] Forty per cent of the respondents stated that partisanship in expert testimony 'was a significant problem for the quality of fact finding in court'.[24] Judges were also invited to make comments in the study. Sperling J, the New South Wales Supreme Court judge, gave the following critique:

---

21 The High Court proceedings in *Foo Fio Na* were examined in Section 7.2.1 of Chapter 7.

22 [2012] 3 MLJ 817, 836-837 (Judicial Commissioner Chew Soo Ho, during argument).

23 Ian Freckelton, Prasuna Reddy and Hugh Selby, 'Australian Judicial Perspectives on Expert Evidence: An Empirical Study' (Australian Institute of Judicial Administration Incorporated, 1999) 25 and Appendix B.

24 Ibid.

> 'In the ordinary run of personal injury work and to a lesser extent in other work, the expert witnesses are so partisan that their evidence is useless. Cases then have to be decided upon probabilities as best one can'.[25]

Judicial observation of a similar nature can be found in reported judgments in the United Kingdom.[26]

The other problem that may have been generated by the current system of expert evidence is the acute delay in the resolution of medical negligence litigation dealing with issues of diagnosis and treatment. An illustration of this problem is the Federal Court decision in *Foo Fio Na*, a case resolved 19 years after litigation commenced. Legal action in this case was filed in the High Court in 1987. The first instance court only handed down its judgment in 1999. It took a further 7 years for the Federal Court to finally decide on the case in 2006. The severity of the problem is also evident in the Court of Appeal case of *Chin Yoon Hiap* which took a period of 16 years to complete. Litigation was initiated in the High Court in 1981, but the trial judge only delivered her judgment in 1995. By the time the case was concluded in the Court of Appeal in 1997, 16 years had passed.

There are various reasons why medical negligence litigation concerning issues of diagnosis and treatment has taken a prolonged period of time to complete. Some of these reasons are identifiable at different stages of the litigation process and may be beyond the control of the courts and the litigants: where litigants are waiting for documents and information from hospitals; during exchange and investigation of documents; and adjournments due to circumstances such as the illness of key witnesses.[27]

One of the main reasons for the delays in the resolution of medical negligence litigation in Malaysia may lie in the system of expert evidence. At present, Order 38 Rule 4 of the *High Court Rules 1980* (Malaysia) authorises the courts to limit the number of 'medical or

---

25 Justice Hal Sperling, 'Expert Evidence: The Problem of Bias and Other Things', (2000) 4 *Judicial Review* 429, 430. Similar comments have also been made in Australia by Justice of Appeal Geoffrey Davies, 'The Reality of Civil Justice Reform: Why We Must Abandon the Essential Elements of Our System' (Paper presented at the 20th AIJA Annual Conference, Brisbane, 12-14 July 2002).

26 See Section 2.7.3 of Chapter 2 for an observation of the problem of biased expert testimony in the United Kingdom by Sir Thomas Bingham MR in the English Court of Appeal decision in *Abbey National Mortgages v Key Surveyors Nationwide* [1996] 3 All ER 184, 191.

27 Puteri Nemie Binti Jahn Kassim, 'Mediating Medical Negligence Claims in Malaysia: An Option for Reform', [2008] 4 *Malayan Law Journal* cix, cxi-cxii.

other expert witnesses' who may be called to testify.[28] However, this provision is silent on its maximum threshold. More often than not, each litigant in medical negligence cases may call more than one medical expert witness, as evident in cases that were analysed in Chapter 6. The existence of a number of experts in litigation means that there is bound to be conflict of opinion. Inevitably, issues concerning medical diagnosis and treatment are often complex and technical. All of these make the task of resolving medical issues onerous for judges. Hence, judges may take more time to resolve medical negligence litigation concerning diagnosis and treatment.

In Malaysia, reforms to the use of expert witnesses in civil proceedings, or specifically medical negligence litigation, have yet to be introduced. Recently, the Malaysian judiciary adopted a series of measures to clear the backlog of civil litigation. Among the measures that have been implemented are: increasing the number of sittings in the Federal Court and Court of Appeal; setting a timeline for the disposal of civil cases: 6 months for the Magistrate's Court and 9 months for Sessions Court; introducing a system of e-filing;[29] introducing mediation as an alternative dispute resolution mechanism; setting up specialised courts dealing with admiralty and corruption cases; and providing continuing legal education for judges.[30] These measures, however, do not address the substantive procedural rules relating to the use of expert witnesses in civil proceedings, particularly medical negligence cases concerning diagnosis and treatment.

In contrast, in the United Kingdom, the Australian Capital Territory, New South Wales and Queensland, legislators in these jurisdictions have acknowledged the problems of biased expert medical opinion and delay in the resolution of civil proceedings that may be generated by the existence of multiple experts in litigation. Hence, procedural rules have been implemented in these jurisdictions for the appointment of a single agreed[31] or a single court-appointed expert whilst conferring upon the courts the authority to appoint additional experts should the need arise. This development is discussed in the following section of this chapter.

---

28 See also *Subordinate Courts Rules 1980* (Malaysia) Order 25 Rule 4.

29 E-filing is a facility which enables litigants to file cause papers online without the need to file hard copies. It means that a case may be filed anywhere in Malaysia without the need to be physically present in the courts in the state jurisdictions where the cause of actions arise.

30 See Chief Justice of Malaysia Tan Sri Arifin bin Zakaria, 'Speech by The Honourable Justice Arifin bin Zakaria, Chief Justice of Malaysia, at the Opening of the Legal Year 2012', [2012] 1 *Malayan Law Journal* cxxiv.

31 The term 'a single agreed expert' refers to an expert who is appointed by litigants in a medical dispute under mutual agreement.

8.5 THE SYSTEM OF A SINGLE AGREED OR A SINGLE COURT-APPOINTED EXPERT IN THE UNITED KINGDOM, THE AUSTRALIAN CAPITAL TERRITORY, NEW SOUTH WALES AND QUEENSLAND

The implementation of a single agreed or a single court-appointed expert in civil actions in the United Kingdom, New South Wales, Queensland and the Australian Capital Territory can be divided into two categories: the appointment of this expert before legal actions are filed in courts; and the more usual procedure for such appointment after litigation commences. The former was implemented in Queensland in 2004 by virtue of the amended *Uniform Civil Procedure Rules 1999* (Qld).[32] The latter was introduced in the United Kingdom under Part 35 of the *Civil Procedure Rules 1998* (England and Wales); New South Wales by virtue of Part 31 Division 2 of the *Uniform Civil Procedure Rules 2005* (NSW); and the Australian Capital Territory under Sections 85 and 86 of the *Civil Law (Wrongs) Act 2002* (ACT) read together with Division 2.12 of the *Civil Procedures Rules 2004* (ACT).[33]

There are a number of important common features in the implementation of a single agreed or a single court-appointed expert in civil proceedings in the United Kingdom, the Australian Capital Territory, New South Wales and Queensland. One is that the reforms impose an overriding duty on the single agreed or the single court-appointed expert to assist the court to adjudicate technical issues and to provide impartial testimony.[34] The other is that the court in these jurisdictions may allow the appointment of more than one agreed or court-appointed expert if it is in the interests of justice to do so.[35] The procedural reforms in all these jurisdictions, however, do not expressly exclude the retention of litigants' own experts. This means the court may exercise the discretion to allow litigants to retain their own experts if circumstances warrant it.[36] Despite the rules in each of these jurisdictions allowing more

---

32 The reform was introduced by the *Uniform Civil Procedure Amendment Rule (No 1) 2004* (Qld) and took effect from July 2004. The procedural rules of the Queensland model can be retrieved at <www.legislation.qld.gov.au/LEGISLTN/SLS/2004/04SL115.pdf>.

33 Division 2.12 of the *Civil Procedures Rules 2006* (ACT) governs the giving of expert evidence in court.

34 *Civil Procedure Rules 1998* (England and Wales) Rule 35.3; *Uniform Civil Procedure Rules 1999* (Qld) Rule 426; *Civil Law (Wrongs) Act 2002* (ACT) Section 87(1)-(3); *Uniform Civil Procedure Rules 2005* (NSW) Schedule 7 Clauses (2)-(3) of Rule 31.23.

35 *Civil Procedure Rules 1998* (England and Wales) Rule 35.1 and 35.4(1); *Uniform Civil Procedure Rules 1999* (Qld) Rule 423(d); *Civil Law (Wrongs) Act 2002* (ACT) Section 86(2)(b); *Uniform Civil Procedure Rules 2005* (NSW) Rule 31.17(e).

36 One good example in which the court exercised this discretion is the English High Court decision in *Simms v Birmingham Health Authority* [2001] Lloyd's Rep Med 382 (*Simms*). *Simms* concerned liability for negligent management of the plaintiff's delivery during a Caesarean operation and his consequent cerebral palsy. The district court judge ordered the appointment of a single agreed medical expert or experts to give opinion on issues of breach of duty of care and causation. On appeal to the

than one expert to be appointed, the court retains the authority to limit the number of experts who may be called in a trial.[37]

The implementation of a single agreed or a single court-appointed expert in Queensland is novel[38] and it is worth noting the relevant procedures. The *Uniform Civil Procedure Rules 1999* (Qld) established a presumption in favour of appointing a single agreed or a single court-appointed expert prior to and after the commencement of legal proceedings in all civil proceedings in the Supreme Court of Queensland. If parties to a medical dispute cannot reach an agreement on who should be appointed prior to legal actions, either party may make an application for a court-appointed expert.[39] This application must include the names of at least 3 experts who are qualified to give expert evidence and consent to being appointed.[40] The court may, however, appoint an expert other than an expert named in the application.[41] The costs of the application and the appointment of this court-appointed expert will be borne by the party who makes the application, unless the court orders otherwise.[42] Should either a single agreed or a single court-appointed expert be engaged, this expert will be the only expert witness when litigation process commences.[43]

The Queensland model also allows the appointment of an additional agreed or court-appointed expert or experts after the commencement of legal proceedings.[44] If no agreement can be reached, either litigant may apply for a court-appointed expert by naming three potential experts,[45] although the court may appoint an expert other than those who are named in the application.[46] In considering this application, the court would consider a number of factors, namely the complexity of the issue; the impact of the appointment on the costs of the proceedings; the likelihood of the appointment would expedite or delay the trial; the interests

---

English High Court, Curtis J overturned this order and allowed litigants to engage their own medical experts on the basis that the issues involved were highly complex.

37 *Civil Procedure Rules 1998* (England and Wales) Rule 35.4; *Uniform Civil Procedure Rules 1999* (Qld) Rule 423; *Civil Law (Wrongs) Act 2002* (ACT) Section 81; *Uniform Civil Procedure Rules 2005* (NSW) 31.20(e).

38 New South Wales Law Reform Commission, *Expert Witnesses*, Report No 109 (2005) 54[4.45].

39 *Uniform Civil Procedure Rules 1999* (Qld) Rule 429S(1).

40 Ibid Rule 429S(4)(d).

41 Ibid Rules 429S(6).

42 Ibid Rule 429S(12).

43 Ibid Rules 429R(6) and 429S(11).

44 Ibid Rule 429G(1).

45 Ibid Rule 429(I)(2).

46 Ibid Rule 429(I)(4).

of justice; and any other relevant consideration.[47] The trial judge may, at any stage of the proceedings, also appoint an expert on its own initiative if it thinks that this expert may help in resolving the substantive medical issue.[48] In situations where more than one expert is appointed, the trial judge may at any stage of a proceeding direct the experts to identity the matters on which they agree and to resolve any disagreement.[49]

8.6 A CRITIQUE OF A SINGLE AGREED OR A SINGLE COURT-APPOINTED EXPERT IN MEDICAL NEGLIGENCE LITIGATION CONCERNING ISSUES OF DIAGNOSIS AND TREATMENT

The implementation of a single agreed or a single court-appointed expert in the United Kingdom and some jurisdictions in Australia raises the question of whether this system is useful and appropriate in medical negligence litigation concerning issues of diagnosis and treatment. This section analyses the advantages and disadvantages of a single agreed or a single court-appointed expert as it applies to these cases.

8.6.1 The advantages

The appointment of a single agreed or a single court-appointed expert would solve the problem of adversarial bias in medical negligence litigation concerning issues of diagnosis and treatment.[50] An expert appointed by the parties jointly or by the court is more likely to be impartial than a party's own expert. In April 2002, a study assessing the impact of the implementation of a single agreed or a single court-appointed expert in the United Kingdom found that medical experts were less partisan in clinical negligence cases as a result of the reform.[51] A further empirical study released in August 2002 revealed that the system of a single agreed or a single court-appointed expert 'has contributed to a less adversarial culture and helped achieve earlier settlements'.[52] Early settlement of disputes may be encouraged by the system of a single agreed or a single court-appointed expert as the parties to a medical

---

47 Ibid Rule 429(K)(1). Similar requirements apply to an application for a court-appointed expert prior to legal proceedings: See Ibid Rule 429S(7).

48 Ibid Rule 429G(3).

49 Ibid Rule 429B(1).

50 Lord Woolf, 'Access to Justice' (Final Report to the Lord Chancellor on the Civil Justice System in England and Wales, Her Majesty's Stationery Office, London, 1996) Chapter 13[21].

51 Tamara Goriely, Richard Moorhead and Pamela Abrams, 'More Civil Justice?: The Impact of the Woolf Reform in Pre-Action Behaviour' (Law Society and Civil Justice Council, 2002) xxi.

52 United Kingdom Department for Constitutional Affairs, *Further Findings: A Continuing Evaluation of the Civil Justice Reforms* (August 2002) <http://www.dca.gov.uk/civil/reform/ffreform.htm>.

dispute could assess the success of their case against the opinion of this expert before the conclusion of court proceedings.[53]

The appointment of a single agreed or a single court-appointed expert would also save costs for litigants as they would not have to engage a number of medical experts. Litigants would also contribute to the costs of engaging this single expert on an equal basis or as directed by the court. This creates a level playing field between the parties of unequal resources particularly in favour of injured patients who, in most instances, have less financial means that defendant doctors to engage medical experts.[54]

The appointment of a single agreed or a single court-appointed expert could also reduce the time taken to conduct medical negligence litigation in a number of aspects. One is that the opposing parties in a medical dispute may narrow down disputed facts and issues with this expert at an early stage. The other is that it could resolve the issue of multiple experts in litigation, the existence of whom may complicate the dispute with conflicting medical opinions. Furthermore, since the appointment of additional agreed or court-appointed experts during legal proceedings is subject to the needs and discretion of the courts, judges could control the number of medical experts who may be called to testify.

8.6.2 The disadvantages

The system of a single agreed or a single court-appointed expert may not be suitable for all medical negligence cases concerning issues of diagnosis and treatment. It has been argued that reliance on the testimony of one medical expert is flawed in that it only recognises one answer to complex medical diagnosis and treatment issues.[55] This criticism may be supported by judicial recognition that there are genuine differences of opinion in the areas of medical diagnosis and treatment.[56] In the *Access to Justice (Final Report)*, Lord Woolf also acknowledged that the appointment of a single expert, either jointly or by the court, may only be appropriate in cases where there is an established area of medical science:

---

53 Lord Woolf, above n 50, Chapter 13[21].

54 Ibid.

55 See Justice Garry Downes, 'Expert Evidence: The Value of Single or Court-Appointed Experts' (Paper presented at the Australian Institute of Judicial Administration Expert Evidence Seminar, Melbourne, 11 November 2005).

56 *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, 639 (Lord Scarman); *Hunter v Hanley* [1955] SC 200, 204 (Clyde LP).

> '... There are in all areas some large, complex and strongly contested cases where the full adversarial system, including oral cross-examination of opposing experts on particular issues, is the best way of producing a just result. That will apply particularly to issues on which there are several tenable schools of thought, or where the boundaries of knowledge are being extended. It does not, however, apply to all cases. As a general principle, I believe that single experts should be used wherever the case (or the issue) is concerned with a substantially established area of knowledge and where it is not necessary for the court directly to sample a range of opinions...'.[57]

This observation has also been accepted in Australia, particularly in New South Wales.[58] It is this recognition of the limitation of a single agreed or a single court-appointed expert that arguably explains why the procedural rules in the United Kingdom and the jurisdictions in Australia do not expressly exclude the right of litigants to engage their own experts.

There is also a concern that a single agreed or a single court-appointed expert might usurp the role of a trial judge if the conclusion or opinion of this expert is unquestioningly adopted.[59] As the decision of the court would be mainly based on the testimony of the single agreed or a single court-appointed expert, there is a fear that this expert might become an 'almost quasi-commissioner or a judge'.[60] If these concerns are real, the emphasis on judges as the final arbiters of the standard of care in medical diagnosis and treatment under the proposed Malaysian reform model[61] may not achieve this desirable effect in practice.

8.6.3 Conclusion

The foregoing analysis showed that although the use of a single agreed or a single court-appointed could ensure a more independent expert testimony as well as save time and costs in the resolution of disputes, it may not be suitable for all medical negligence cases of diagnosis and treatment. The system is particularly inappropriate in situations where there are highly complex medical issues, the areas of medical science are developing and where there are

---

57 Lord Woolf, above n 50, Chapter 13[19].

58 New South Wales Law Reform Commission, *Expert Witnesses*, Report No 109 (2005) 115[7.29].

59 Justice Garry Downes, 'The Use of Expert Evidence in Court and International Arbitration Processes' (Paper presented at the 16th Inter-Pacific Bar Association Conference, Sydney, 3 May 2006).

60 Julie Lewis, 'Breaking the Mould', (2006) 44(9) October *Law Society Journal* 22, 23.

61 See Section 8.2 of this chapter.

major genuine differences of opinion. On the basis of the analysis, it is proposed that the system of a single agreed or a single court-appointed expert should not be adopted as the only solution to the problems of delay and biased expert testimony in medical negligence litigation in Malaysia.

What Malaysia should adopt is a flexible procedural framework that caters to medical issues of different complexities. It may be argued that the procedural reforms in the United Kingdom, the Australian Capital Territory, New South Wales and Queensland satisfy this important criterion. In a situation where there is an established area of medical science, courts in these jurisdictions may rely on the testimony of a single agreed or a single court-appointed expert. A more complex medical issue may be resolved by allowing the appointment of an additional agreed or court-appointed expert or experts during the commencement of legal proceedings. More importantly, judges in these jurisdictions may exercise discretion to allow litigants to engage their own experts should circumstances warrant it. The remaining questions for consideration are which model Malaysia should adopt and what measures should be taken to improve the chosen procedural framework.

8.7 THE PROPOSED PROCEDURAL REFORM ON EXPERT EVIDENCE FOR MALAYSIA

It is proposed that Malaysia should adopt the Queensland model on the use of expert witnesses in medical negligence litigation of diagnosis and treatment. The benefits of the Queensland model in saving time and costs may provide one of the long term solutions to the issue of inordinate delay in the resolution of medical negligence litigation concerning issues of diagnosis and treatment in Malaysia. Unlike the procedural reforms in the United Kingdom and in the other Australian jurisdictions, the Queensland model can encourage parties to a dispute to narrow down disputed facts and issues, or negotiate settlements, even before litigation commences. More significantly, the Queensland model takes a better approach to save costs. In practice, parties to a medical dispute often have already engaged their own respective expert or experts for advice before legal actions are filed in the courts. The statutory provisions requiring the appointment of medical experts after the commencement of legal proceedings would mean wastage of additional costs.[62]

---

[62] Justice of Appeal Geoffrey Davies, 'Court-Appointed Expert', (2004) 23 *Civil Justice Quarterly* 367, 375. See also the analysis of the Queensland model from the perspective of a former English Court of

There are two aspects in the implementation of the Queensland model in Malaysia that need to be clarified. One relates to when the court may allow litigants to engage their own experts and what requirements the courts should consider in exercising this discretion. It is proposed that the exercise of this judicial discretion should be limited to exceptional circumstances or the problems associated with litigants' appointed experts would arise. It is also proposed that this issue be decided at an early stage in the legal proceedings. In determining whether to allow litigants to engage their medical experts, a trial judge should take into account a number of factors: the complexity of the medical issues; the novelty of the area of medical science; the existence of different schools of thought; the impact on costs and delays should multiple experts be called in a trial; the interests of justice; and other relevant considerations.[63]

The other aspect relates to the selection of medical experts. It is proposed that these experts may be selected from a list of medical specialists approved by the Academy of Medicine of Malaysia. The Academy of Medicine of Malaysia, whose members consist of local and foreign doctors, is similar to the Royal Colleges in the United Kingdom and Australia except that it embraces all medical specialities.[64] The Academy has a high standard of professional and ethical practice. Entry into the Academy is based on merit and application is subject to a stringent vetting process. Applicants must possess a recognised higher professional qualification and must be certified to be specialists by the appropriate medical authorities. The appointment of medical specialists approved by the Academy would ensure that the court may be assisted with credible and reliable expert testimony in the adjudication of the standard of care in medical diagnosis and treatment.

8.8 LEGISLATIVE OPTIONS FOR ENACTING THE REFORM PROPOSALS

The statutory provisions relating to the reforms proposals in this thesis must be placed in an appropriate legislation to facilitate easy reference and centralisation of regulation. There are

---

Appeal judge, Sir Robin Jacob, 'Court-appointed Experts v Party Experts: Which is Better?', (2004) 23 *Civil Justice Quarterly* 400, 406-407.

63 See also Paul Freeburn, 'Single Experts' (2012) 56(June) *Hearsay* <http://www.hearsay.org.au/index.php?option=com_content&task=view&id=164&Itemid=48>. These requirements are in fact an adaptation of the factors for considering the appointment of a court-appointed expert after the commencement of legal proceedings under Rule 429K(1) of the *Uniform Civil Procedure Rules 1999* (Qld).

64 The Academy of Medicine of Malaysia has established its own Specialist Register since 2000. This Specialist Register is available in the Academy's website at <www.acadmed.org.my.index.cfm> for inspection and reference.

two options available in this legislation reform. An appropriate form would be to incorporate the proposed Malaysian reform model and the procedural changes on the use of expert witnesses into a single legislation, to be named the *Medical Liability Act* (Malaysia). This specific legislation would be the sole reference point by which doctors, patients, judges and legal practitioners assess liability for medical negligence as well as ascertain its relevant procedural rules in Malaysian courts. Any future reform pertaining to the duty and liability of doctors in Malaysia could be introduced in this proposed single Act.

The alternative would be to codify the reform proposals in existing legislation. The Malaysian reform model may be implemented under the *Medical Act 1971* (Malaysia). This Act governs registration, practice of medical practitioners in Malaysia, as well as disciplinary proceedings against them. In this respect, an amendment bill may be introduced to implement the Malaysian reform model under the *Medical Act 1971*. The procedural reform on the use of a single agreed or court-appointed expert prior to legal proceedings, which is based on the Queensland model, may be implemented under the Malaysian *High Court Rules 1980* and the *Subordinate Courts Rules 1980*. The major shortcoming of this alternative option is that the proposed legislative reform would be implemented on a piecemeal basis and may lead to confusion.

8.9 CONCLUSION

The objective of this chapter has been to make recommendations for legislative reforms in Malaysia to facilitate the determination of the issue of standard of care in medical negligence litigation concerning diagnosis and treatment. One of the main proposals proffered in this chapter is the codification of the Malaysian version of the *Bolitho*-type *Bolam* test under legislation. This proposed Malaysian reform model adopts a two-stage inquiry under the Singaporean version of the *Bolitho* principle for deciding whether an expert opinion can be considered as part of 'a responsible body of medical opinion'. The hallmark of this two-stage inquiry is the assessment of risk and benefit. The risk and benefit analysis will be made by the medical profession subject to the requirement that the analysis must give due weight to the interest of a particular injured patient. Judges would play the ultimate role of deciding whether the assessment is defensible, by ensuring that the opinion is supported by proven medical facts and is internally consistent. All expert medical opinions would be subject to the same process of evaluation and judges must not decide the requirement for 'responsible body

of medical opinion' on the basis of the seniority and standing of medical experts. The main rationale for all these proposals is to enable the rights of all litigants, either defendant doctors or injured patients, to be determined by the courts on the same footing whilst retaining the right of the courts to be the final arbiter on the issue.

The proposed Malaysian reform model is complemented by the recommendation for procedural changes on the use of expert witnesses in medical negligence litigation. This chapter identified the potential loopholes in the present procedural rules on expert witnesses which may be abused by litigants. The current rules of the courts in Malaysia allow litigants to call multiple medical experts at their own expense. This may create a number of problems for judges: confusion as a result of various conflicting opinions; lack of independence in expert medical opinions; wastage of time on cross-examination of a multiple expert witnesses; and delays in the resolution of medical issues. The proposed procedural reform on the use of expert witnesses in medical negligence litigation concerning issues of diagnosis and treatment is based on the Queensland model under the *Uniform Civil Procedure Rules 1999* (Qld). There are also clarifications on the situations in which the court may exercise discretion to allow litigants to appoint their own experts and the conditions which need to be satisfied. The benefits of the proposal in saving time and costs, as well as encouraging litigants to negotiate early settlements, mean that the backlog of medical negligence cases in Malaysian courts may be eased in the long run. Ideally, all the recommendations in this chapter should be implemented in a single statute to enable easy reference and to promote centralised regulation.

CHAPTER 9
DISCUSSION AND CONCLUSIONS

9.1 INTRODUCTION

This thesis has considered whether the law for determining the standard of care in medical diagnosis and treatment in Malaysia is satisfactory. It has been argued that this area of the law is uncertain and ambiguous, and reforms are needed. The most effective way to address these problems, this thesis proposes, is legislative reform rather than case law development.

In addressing the central question of this thesis, analysis of the law on the standard of care in medical diagnosis and treatment in Malaysia, both past and present, was pursued. The Malaysian medical jurisprudence on the standard of care in diagnosis and treatment was founded on English common law principle, the *Bolam* test. This required an analysis of the evolution and development of this principle in its place of origin, the United Kingdom. The subsequent development of the *Bolam* test in the United Kingdom was also considered, together with the corresponding legal changes in other Commonwealth jurisdictions such as Singapore and the Australian states. The seminal Federal Court decision in *Foo Fio Na v Dr Soo Fook Mun*[1] were analysed with a view to highlighting the shortcomings in the current state of the law. Recommendations for reform in Malaysia were proffered in light of the developments in the United Kingdom, Singapore and the Australian states. It is hoped that the legal analysis and recommendations in this thesis may spearhead legislative reform in Malaysia. In its theoretical perspective, the study in this thesis will serve to contribute to the debates on this important aspect of the law of medical negligence in Malaysia.

9.2 SUMMARY OF CONCLUSIONS OF EACH CHAPTER

The analysis in the foregoing chapters of this thesis has prompted a number of conclusions. Chapter 2 reviewed the historical development of the *Bolam* test in the United Kingdom leading up to the English House of Lords decision in *Bolitho v City and Hackney Health Authority*.[2] It was concluded that *Bolitho* did not significantly alter judicial deference to the medical profession in the United Kingdom on two grounds. One of them is the statement of Lord Browne-Wilkinson in *Bolitho* that the opinion of medical experts of high standing and

[1] [2007] 1 MLJ 593 (*Foo Fio Na*).
[2] [1998] AC 232 (*Bolitho*).

seniority is presupposed to satisfy the 'logical basis' test. The other limitation is the restrictive authority of the courts to reject expert medical opinion for want of 'logical basis' in 'rare cases'. Chapter 2 also compared the English and Singaporean versions of the *Bolitho* principles. The analysis identified two major distinctions between the two versions. One was that judicial evaluation of the defensibility of expert medical opinion in Singapore is restricted by a two-stage inquiry. In the first stage of the inquiry, judges must ensure that the opinion of medical experts relating to the risk and benefit analysis is internally consistent. The second stage of the inquiry requires judges to be satisfied that this opinion is supported by extrinsic proven facts or advancement in medical science. In comparison, English judges are not restricted by this process of inquiry. Another distinction is that unlike its original English version, the Singaporean *Bolitho* principle does not impose undue judicial deference to the opinion of medical experts of high standing. Singaporean judges may reject any opinion which does not satisfy the 'logical basis' test. On the basis of these two distinctions, Chapter 2 concluded that the Singaporean version of the *Bolitho* principle is preferable to its English original version as the former allows a more systematic and fairer evaluation of expert medical opinion.

Chapters 3, 4 and 5 examined the legal developments on the standard of care in medical diagnosis and treatment in Australia. Chapter 3 examined the common law position as established by the Australian High Court decision in *Naxakis v Western General Hospital*.[3] The Court in *Naxakis* extended the principle in the Australian High Court decision in *Rogers v Whitaker*[4] to the areas of medical diagnosis and treatment, and held that the required standard of care in both branches of the doctors' duty of care is determined by all available evidence, not just expert medical opinion. Chapter 3 concluded that the decision in *Naxakis* lacks a definitive testing mechanism to assist judges to evaluate expert medical opinion. More significantly, the High Court in *Naxakis* has gone too far in allowing the courts to determine the issue of standard of care when there is no direct medical evidence to support an injured patient's case. It was argued in Chapter 2 that the decision in *Naxakis* may enable injured patients to more easily establish liability for negligence against defendant doctors and hence, expose Australian doctors to high risk of medical negligence claims.

[3] (1999) 197 CLR 269 (*Naxakis*).
[4] (1992) 175 CLR 479.

Chapter 4 gave a detailed analysis of the medical indemnity crisis that led to legislative changes in Australia. The analysis found a lack of cogent empirical study in Australia establishing a causal link between the decision in *Naxakis* and the occurrence of the crisis. It was argued that the Australian Commonwealth Government had failed to adopt a wide-ranging analysis into the real causes behind the crisis, such as conducting an in-depth investigation into the financial management of medical defence organisations in Australia. Although it had been argued in Chapter 3 that the common law position on the standard of care in medical diagnosis and treatment in Australia is flawed, Chapter 4 concluded that the establishment of the Ipp Review Committee to review, among others, the common law of medical negligence, did not in actual fact address the possible causes of the crisis.

In Chapter 5 the substantive legislative changes in Australia following the recommendations by the Ipp Review Committee were examined. Materials extrinsic to the legislative reform reveal that the Australian modified *Bolam* test is based on the principle in the House of Lords decision in *Bolitho*, albeit with some modifications. Chapter 5 found that the implementation of the Australian modified *Bolam* test lacks uniformity as the test carries different language in most of the state jurisdictions. The more significant shortcoming in the Australian modified *Bolam* test, Chapter 5 concluded, was the lack of practical guidance with regard to interpreting some of the important wording of its statutory provisions.

Chapter 5 also analysed the application of the Australian modified *Bolam* test. Examination of a number important Australian Court of Appeal and Supreme Court decisions found that judges in these cases configured the modified *Bolam* test as a defence rather than a complete revamp of the decision in *Naxakis*. The principle in *Naxakis*, as these cases held, is still relevant in determining whether a plaintiff has discharged his or her burden of proving negligence. The modified *Bolam* test is only applicable in deciding whether a defendant doctor has disproved negligence. Although the modified *Bolam* test ultimately decides the standard of care in a medical dispute, it was argued in Chapter 5 that the reintroduction of the common law principle is inconsistent with the legislative intent of the modified *Bolam* test. The more appropriate approach, Chapter 5 suggested, is to state that a plaintiff discharges his or her burden of proof by solely relying on expert medical opinion. Accordingly, the role of the court is to determine whether expert medical opinion adduced by the plaintiff or the defendant satisfies the requirements of the modified *Bolam* test.

The law on the standard of care in medical diagnosis and treatment in Malaysia, both past and present, was examined in Chapters 6 and 7 respectively. Chapter 6 analysed the transplantation of the English common law principle, the *Bolam* test, into Malaysian courts between the 1960s and 2006. It concluded that the application of the *Bolam* test during this period was uncertain. There were three discernible ways in which the *Bolam* test was applied in Malaysian courts. In the majority of appellate court decisions, Malaysian judges adopted the interpretation of the test by the House of Lords in the 1980s. A small number of appellate and lower courts cases modified the test, enabling judges to make findings of medical negligence where the issues involved were straightforward. A minority of lower court decisions that emerged in the 1990s simply did not apply the *Bolam* test; judges in these cases determined the required standard of care based on an evaluation of all available evidence, not on expert medical opinion alone.

Chapter 7 analysed the current legal position on the standard of care in medical diagnosis and treatment in Malaysia following the Federal Court decision in *Foo Fio Na*. A main argument was that the Court in *Foo Fio Na* did not provide a clear legal principle for determining the standard of care in medical diagnosis and treatment. This ambiguity is evident in the ruling of the Court with regard to the issue of medical treatment and conflicting interpretations by academic scholars and judges in subsequent Malaysian lower court cases. Chapter 7 found that this state of the law in Malaysia is unsatisfactory and legislative reform is called for. It further examined the advantages and disadvantages of reforming the law by way of legislation. Codification of the applicable principle in legislation would curtail the due development of the common law, introduce the elements of political interests in law reform and minimise the coherency which its application under the common law could otherwise provide. Chapter 7, however, concluded that the balance of advantages lies with legislative changes as case law development is inflexible, dependent upon unplanned litigation and less comprehensive in its analysis than a review by the legislatures. There is also the likelihood that the Malaysian judiciary could not provide a satisfactory solution to the problems in the law. Chapter 7 also recommended that Malaysia should adopt the *Bolitho*-type *Bolam* test so as to bring the law in this jurisdiction into line with the developments in the United Kingdom, the Australian states and Singapore.

Finally, Chapter 8 provided substantive reform recommendations with respect to the law on the standard of care in medical diagnosis and treatment and its application in

Malaysian courts, to be preferably codified in a new Act of Parliament. These recommendations consist of two aspects: the substantive principle for the *Bolitho*-type *Bolam* test as the proposed Malaysian reform model; and procedural rules on the use of expert witnesses in medical negligence litigation. The proposed Malaysian reform model is based on the *Bolitho* principle that was interpreted by the Singaporean Court of Appeal decision in *Dr Khoo James v Gunapathy d/o Muniandy*.[5] The justifications for this proposal are that the Singaporean *Bolitho* principle is clear, allows a systematic evaluation of expert medical opinion and does not impose undue judicial deference to the medical profession. Chapter 8 also proposed the appointment of a single agreed or a single court-appointed expert prior to the commencement of medical negligence litigation. Under the proposed procedural framework, litigants may also appoint an additional agreed or court-appointed expert or experts at any stage of legal proceedings should the need arise. The court may also exercise discretion to allow litigants to instruct their own experts in exceptional circumstances and this issue would be decided by the court at the early stage of legal proceedings. These proposals, which are based on the modification of the Queensland model under the *Uniform Civil Procedure Rules 1999* (Qld), aims to promote a more independent expert medical opinion in the adjudication of the standard of care in diagnosis and treatment, provide a flexible way of resolving medical disputes, save costs and time of litigants; and resolve the issue of inordinate delay in the resolution of medical disputes concerning issues of diagnosis and treatment in Malaysian courts.

9.3 CONCLUDING REMARKS

This thesis has found that the law on the standard of care of doctors in the areas of diagnosis and treatment in Malaysia is unsatisfactory and is in need of reform. There are two options available for reform: awaiting another Malaysian Federal Court decision or changing the law by way of legislation. This thesis argues for legislative reform. A clear, predictable, simplified legal framework has been proposed for legislative enactment in Malaysia. The benefits of implementing these reform proposals are that they would balance the interests of injured patients and defendant doctors in medical disputes, reduce the time and costs of conducting medical negligence litigation, and ensure a properly regulated standard of medical care in Malaysia. In the long run, these benefits would translate into boosting public confidence in the judicial system and the delivery of health service in Malaysia. The next step

[5] [2002] 2 SLR 414.

would be for the Malaysian Attorney-General Chambers to obtain feedback from interested parties such as the Malaysian Medical Association, the judiciary, the Bar Council, the medical indemnity industry and the general public before drafting the relevant statutory provisions.

BIBLIOGRAPHY

LEGISLATION

AUSTRALIA

Civil Law (Wrongs) Act 2002 (ACT)

Civil Liability Act 1936 (SA)

Civil Liability Act 2002 (NSW)

Civil Liability Act 2002 (Tas)

Civil Liability Act 2002 (WA)

Civil Liability Act 2003 (Qld)

Civil Liability Amendment Act 2003 (Tas)

Civil Liability Amendment Act 2004 (WA)

Judiciary Act 1903 (Cth)

Law Reform (Ipp Recommendations) Act 2004 (SA)

Medical Indemnity (IBNR Indemnity) Contribution Act 2002 (Cth)

Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003 (Cth)

Medical Indemnity (Prudential Supervision and Product Standards (Consequential Amendments Act 2003 (Cth)

Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth)

Medical Indemnity Amendment Act 2003 (Cth)

Uniform Civil Procedure Amendment Rule (No 1) 2004 (Qld)

Uniform Civil Procedure Rules 1999 (Qld)

Uniform Civil Procedure Rules 2005 (NSW)

Wrongs Act 1958 (Vic)

Wrongs and Other Acts (Law of Negligence) Act 2003 (Vic)

MALAYSIA

Civil Law Act 1956

Federal Constitution

Courts of Judicature Act 1964

High Court Rules 1980

Medical Act 1971

Subordinate Courts Rules 1980

UNITED KINGDOM

Civil Procedure Rules 1998 (England and Wales)

Constitutional Reform Act 2005 (United Kingdom)

Senior Courts Act 1981 (England and Wales)

HANSARDS

AUSTRALIA

Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 September 2002

Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 24 June 2003

Australian Capital Territory, *Parliamentary Debates*, House of Assembly, 21 August 2003

New South Wales, *Parliamentary Debates*, Legislative Assembly, 23 October 2002

Northern Territory, *Parliamentary Debates*, House of Assembly, 27 November 2002, Parliamentary Record No. 9
<http://notes.nt.gov.au/lant/hansard/hansard9.nsf/WebFullTextTranscript/270727FE049F987D69256C990006076F?opendocument>

Queensland, *Parliamentary Debates*, Legislative Assembly, 11 March 2003

South Australia, *Parliamentary Debates*, House of Assembly, 16 February 2004

South Australia, *Parliamentary Debates*, House of Assembly, 23 February 2004

Victoria, *Parliamentary Debates*, Legislative Council, 26 November 2003

Victoria, *Parliamentary Debates*, Legislative Council, 30 October 2003

Western Australia, *Parliamentary Debates*, Legislative Council, 19 August 2004

CASES

AUSTRALIA

Albrighton v Royal Prince Alfred Hospital [1980] 2 NSWLR 542

Anchor Products Ltd v Hedges (1966) 115 CLR 493

Australian Capital Health Authority v Moorby [1997] NSWCA 32 (25 June 1997)

Battersby v Tottman (1985) 37 SASR 524

Braikoulias v Karunaharan [2012] VSC 272 (12 June 2012)

Cattanach v Melchior (2003) 215 CLR 1

Diamond v Simpson (No 1) [2003] NSWCA 67 (7 April 2003)

Dobler v Halverson (2007) 70 NSWLR 151

E v Australian Red Cross (1991) 27 FCR 310

F v R (1984) 33 SASR 189

Florida Hotels Pty Ltd v Mayo (1965) 113 CLR 588

Goode v Nash (1979) 21 SASR 419

Howarth v Adey [1996] 2 VR 535

King v Western Sydney Local Health Network [2011] NSWSC 1025 (7 Septermber 2011)

Lowns v Woods (1996) Aust Torts Report 81-37

Naxakis v Western General Hospital (1999) 197 CLR 269

Rogers v Whitaker (1992) 175 CLR 479

Rosenberg v Percival (2001) 205 CLR 434

Sarian v Elton [2011] NSWCA 123 (19 May 2011)

Schellenberg v Tunnel Holdings Pty Ltd (2000) 200 CLR 121

Wingecarribee Shire Council v Lehman Brothers Australia Ltd (in liq) [2012] FCA 1028 (21 September 2012)

CANADA

Anderson v Chasney [1950] 4 DLR 223

Reibl v Hughes (1981) 114 DLR (3d) 1

IRELAND

Best v Wellcome Foundation Ltd (1994) 5 Med LR 81

MALAYSIA

Abdul Rahman Bin Abdul Karim v Abdul Wahab Bin Abdul Hamid [1996] 4 MLJ 623

Ang Yew Meng v Dr Sashikannan a/l Arunasalam [2011] 9 MLJ 153

Asiah Bte Kamsah v Dr Rajinder Singh [2002] 1 MLJ 484

Chien Tham Kong v Excellent Strategy Sdn Bhd [2009] 7 MLJ 261

Chin Keow v Government of Malaysia [1967] 2 MLJ 45

China Airlines Ltd v Maltran Air Corp Sdn Bhd [1996] 2 MLJ 517

Dennis Lee Thian Poh v Dr Michael Samy [2012] 4 MLJ 673

Dominic Puthucheary v Dr Goon Siew Fong [2007] 5 MLJ 552

Dr Chin Yoon Hiap v Ng Eu Khoon [1998] 1 MLJ 57

Dr K S Sivananthan v Government of Malaysia [2001] 1 MLJ 35

Dr Soo Fook Mun v Foo Fio Na [2001] 2 MLJ 193

Elizabeth Choo v Government of Malaysia [1970] 2 MLJ 171

Foo Fio Na v Dr Soo Fook Mun [2002] 1 MLJ 129

Foo Fio Na v Dr Soo Fook Mun [2007] 1 MLJ 593

Foo Fio Na v Hospital Assunta [1999] 6 MLJ 738

Government of Malaysia v Chin Keow [1965] 2 MLJ 91

Hasan bin Datolah v Government of Malaysia [2010] 2 MLJ 646

Hong Chuan Lay v Dr Eddie Soo Fook Mun [1998] 7 MLJ 481

Hong Chuan Lay v Dr Eddie Soo Fook Mun [2006] 2 MLJ 218

Inderjeet Singh a/l Piara Singh v Mazlan Bin Jasman [1995] 2 MLJ 646

James Kenneth Eng Siew Goh (*suing as administrator of the estate of Melissa Jane Goh Mei Feng, deceased*) *v Lee King Ong* [2009] 4 MLJ 396

Kamalam a/p Raman v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore [1996] 4 MLJ 674

Kow Nam Seng v Nagamah [1982] 1 MLJ 128

Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk [2008] 1 MLJ 115

Mariah Bte Mohamad (Administratrix of the Estate of Wan Salleh Bin Wan Ibrahim, Deceased) v Abdullah Bin Daud (Dr Lim Kok Eng, Third Parties) [1990] 1 MLJ 240

Renal Link (KL) Sdn Bhd v Dr Harnam Singh [1997] 2 MLJ 373

Sanmarkan a/l Ganapathy v Dr V Thuraisingham [2012] 3 MLJ 817

Swamy v Matthews [1968] 1 MLJ 138

Tan Ah Kau v Government of Malaysia [1997] 2 CLJ (Supplementary) 168

Udaya Kumar A/L Karuppusamy v Penguasa Hospital Daerah Pontian [2004] 2 MLJ 661

Wong Chong Chow v Pan-Malaysian Cement Works Berhad [1980] 2 MLJ 75

Wu Siew Yong v Pulau Pinang Clinic Sdn Bhd [2011] 3 MLJ 506

NEW ZEALAND

MacDonald v Pottinger [1953] NZLR 196

SINGAPORE

Dr Khoo James v Gunapathy d/o Muniandy [2002] 2 SLR 414

UNITED KINGDOM

Abbey National Mortgages v Key Surveyors Nationwide [1996] 3 All ER 184

Associated Provincial Picture Houses Ltd v Wednesbury Corporation [1948] 1 KB 223

Blyth v Birmingham Waterworks Co (1856) 11 Exch 781

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118

Bolitho v City and Hackney Health Authority (1993) 4 Med LR 381

Bolitho v City and Hackney Health Authority [1998] AC 232

Cassidy v Ministry of Health [1951] 2 KB 343

Cavanagh v Bristol and Weston Health Authority (1992) 3 Med LR 49

Council of Civil Service Unions v Minister for the Civil Service [1985] AC 374

De Freitas v O'Brien and Connolly (1995) 6 Med LR 108

Gascoine v Ian Sheridan (1994) 5 Med LR 437

Hatcher v Black [1954] CLY 2289

Hucks v Cole (1993) 4 Med LR 393

Hunter v Hanley [1955] SC 200

Invercargill City Council v Hamlin [1996] 1 All ER 756

Joyce v Merton, Sutton and Wandsworth Health Authority (1996) 7 Med LR 1

Joyce v Wandworth Health Authority (1995) 6 Med LR 60

Lanphier v Phipos (1838) 173 ER 581; (1838) 8 Car & P 475

Mahon v Osborne [1939] 2 KB 14

Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635

Nyali Ltd v Attorney-General [1956] 1 QB 1

Penney v East Kent Health Authority [2000] Lloyd's Rep Med 41

R v Bateman [1925] All ER (Reprint) 45

Rich v Pierpoint (1862) 176 ER 16; [1862] 3 F & F 35

Roe v Ministry of Health [1954] 2 QB 66

Sidaway v Bethlem Royal Hospital [1985] AC 871

Simms v Birmingham Health Authority [2001] Lloyd's Rep Med 382

Toomey v London, Brighton and South Coast Railway Co (1857)140 ER 694; (1857) 3 CB (NS) 146

Whitehouse v Jordan [1981] 1 All ER 267

Wilsher v Essex Area Health Authority [1988] AC 1074

BOOKS

Devereux, John A, *Australian Medical Law* (Routledge-Cavendish, 2007)

Giesen, Dieter, *International Medical Malpractice Law* (Martinus Nijhoff Publishers, 1988)

Glegg, Arthur Thomson, *The Law of Reparation in Scotland* (W Green & Son, 1939)

Grubb, Andrew and Ian Kennedy, 'Consent to Treatment: The Competent Patient' in Andrew Grubb and Ian Kennedy (eds), *Principles of Medical Law* (Oxford University Press, 1998) 109

Herring, Jonathan, *Medical Law and Ethics* (Oxford University Press, 2008)

Jahn Kassim, Puteri Nemie, *Medical Negligence Law in Malaysia* (International Law Book Services, 2008)

Jones, Michael, 'Breach of Duty' in Ian Kennedy and Andrew Grubb (ed), *Principles of Medical Law* (Oxford University Press, 1998) 335

Jones, Michael, *Medical Negligence* (Sweet & Maxwell, 1996)

Kennedy, Ian and Andrew Grubb, *Medical Law: Text With Materials* (Butterworths, 1994)

Luntz, Harold, David Hambly, Kylie Burns, Joachim Dietrich and Neil Foster, *Torts Cases and Commentary* (Lexis Nexis Butterworths Australia, 2009)

Mason, Ken and Graeme Laurie, *Mason and McCall Smith's Law and Medical Ethics* (Oxford University Press, 2011)

McLean, Sheila, 'Negligence – Dagger at the Doctor's Back?' in Peter Robson and Paul Watchman (ed), *Justice, Lord Denning and the Constitution* (Gower Publishing, 1981) 99

McPherson, Bruce, *The Reception of English Law Abroad* (Supreme Court of Queensland Library, 2007)

Rutter, Michael, *The Applicable Law in Singapore and Malaysia* (Malayan Law Journal, 1989)

Sappideen, Carolyn and Prue Vines, *Fleming's The Law of Torts* (Thomson Reuters (Professional) Australia, 2011)

Skene, Loane, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 2008)

Watson, Alan, *Legal Transplants* (University of Georgia Press, 1993)

REPORTS

AUSTRALIA

Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group (Chair: Marcia Neave), *Responding to the Medical Indemnity Crisis: An Integrated Reform Package* (2002)

Freckelton, Ian, Prasuna Reddy and Hugh Selby, 'Australian Judicial Perspectives on Expert Evidence: An Empirical Study' (Australian Institute of Judicial Administration Incorporated, 1999)

Goriely, Tamara, Richard Moorhead and Pamela Abrams, 'More Civil Justice?: The Impact of the Woolf Reform in Pre-Action Behaviour' (Law Society and Civil Justice Council, 2002)

Insurance Statistics Australia Ltd, 'Medical Indemnity Report: An Analysis of Premium and Claim Trends for Medical Indemnity Insurance in Australia from 1995 to 2005' (Medical Indemnity Industry Association of Australia, 21 August 2006)

New South Wales Law Reform Commission, *Expert Witnesses*, Report No 109 (2005) Panel of Eminent Persons, *Review of the Law of Negligence: Final Report* (2002)

Parliament of Victoria Law Reform Committee, *Legal Liability of Health Service Providers: Final Report* (1997)

Senate Community Affairs References Committee, Parliament of Australia, *Rocking the Cradle: A Report into Childbirth Procedures* (1999)

Treasury, Commonwealth of Australia, *Available and Affordable: Improvements in Liability Insurance Following Tort Law Reform in Australia* (Attorney-General's Department, 2006)

Trowbridge Consulting, 'Public Liability Insurance: Practical Proposals for Reform' (May 2002)

Wright, Ted, 'National Trends in Personal Injury Litigation: Before and After "Ipp"' (Law Council of Australia, 26 May 2006)

UNITED KINGDOM

Association of Anaesthetists of Great Britain and Ireland, 'Recommendations for the Transfer of Patients with Acute Head Injuries to Neurosurgical Units' (May 2006)

United Kingdom Department for Constitutional Affairs, *Further Findings: A Continuing Evaluation of the Civil Justice Reforms* (August 2002) <http://www.dca.gov.uk/civil/reform/ffreform.htm>

Woolf (Lord), 'Access to Justice' (Final Report to the Lord Chancellor on the Civil Justice System in England and Wales, Her Majesty's Stationery Office, London, 1996)

WRITTEN SUBMISSIONS

AUSTRALIA

Written Submissions to the Ipp Review Committee (2002)

<http://www.revofneg.treasury.gov.au/submissions.asp>

ARTICLES

Adeney, Elizabeth, 'The Challenge of Medical Uncertainty: Factual Causation in Anglo-Australian Toxic Tort Litigation', (1993) 19 *Monash University Law Review* 23

Amirthalingam, Kumaralingam, 'Anglo-Australian Law of Medical Negligence – Towards Convergence?', (2003) 11 *Torts Law Journal* 117

Amirthalingam, Kumaralingam, 'Judging Doctors and Diagnosis the Law: *Bolam* Rules in Singapore and Malaysia', [2003] *Singapore Journal of Legal Studies* 125

Brazier, Margaret and Jose Miola, 'Bye-bye *Bolam*: A Medical Litigation Revolution?', (2000) 8 *Medical Law Review* 85

Cane, Peter, 'Reforming Tort Law in Australia: A Personal Perspective', (2003) 27 *Melbourne University Law Review* 649

Cane, Peter, 'Taking Disagreement Seriously: Courts, Legislatures and the Reform of Tort Law', [2005] 3 *Oxford Journal of Legal Studies* 393

Cashman, Peter, 'Tort Reform and the Medical Indemnity Crisis', (2002) 25(3) *University of New South Wales Law Journal* 888

Chalmers, Donald and Robert Schwartz, '*Rogers v Whitaker* and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure', (1993) 1 *Medical Law Review* 139

Chambers, Kerrie, 'Medical Indemnity – Is There a Crisis? Is There a Solution', (2002) 11(2) *Australian Health Law Bulletin* 13

Corbett, Angus, 'Regulating Compensation for Injuries Associated with Medical Error', (2006) 28 S*ydney Law Review* 259

Davidson, Joanna, 'Reform of the Law of Negligence: Balancing Costs and Community Expectations', Foreword, (2002) 25(3) *University of New South Wales Law Journal* 808

Davies, Geoffrey (Justice of Appeal), 'Court-Appointed Expert', (2004) 23 *Civil Justice Quarterly* 367

Davis, Rob, 'The Tort Reform Crisis', (2002) 25(3) *University of New South Wales Law Journal* 865

Fordham, Margaret, 'The *Bolam* Test Lives On: *Bolitho v City and Hackney Health Authority*', [1998] *Singapore Journal of Legal Studies* 140

Freeburn, Paul, 'Single Expert' (2012) 56(June) *Hearsay* <http://www.hearsay.org.au/index.php?option=com_content&task=view&id=164&Itemid=48>

Goldrein, Iain, '*Bolam* – Problems Arising out of "Ancestor" Worship', (1994) 144 (July-December) *New Law Journal* 1237

Goldsmith (Lord), 'Expert Evidence: The Problem or the Solution? The Role of Expert Evidence and Its Regulation', [2007] 2 *Quarterly Law Review* 50

Gunson, John, 'Turbulent Causal Waters: The High Court, Causation and Medical Negligence', (2001) 9 *Torts Law Review* 53

Holyoak, Jon, 'Raising The Standard of Care', (1990) 10(2) *Legal Studies* 201

Howie, Robert B M, 'The Standard of Care in Medical Negligence', (1983) 21 *The Juridical Review* 193

Ipp, David (Justice of Appeal), 'The Politics, Purpose and Reform of the Law of Negligence', (2007) 81 *Australian Law Journal* 456

Irvine of Lairg (Lord), 'The Patient, the Doctor, Their Lawyers and the Judge: Rights and Duties', (1999) 7 *Medical Law Review* 225

Jacob, Sir Robin, 'Court-appointed Experts v Party Experts: Which is Better?', (2004) 23 *Civil Justice Quarterly* 400

Jahn Kassim, Puteri Nemie, 'Mediating Medical Negligence Claims in Malaysia: An Option for Reform', [2008] 4 *Malayan Law Journal* cix

JL Montrose, 'Is Negligence an Ethical or a Sociological Concept?', (1958) 21 *Modern Law Review* 259

Jones, Michael, 'The *Bolam* Test and the Responsible Expert', (1999) 7 *Torts Law Review* 226

Keown, John, 'Doctor Knows Best?: The Rise and Rise of "The *Bolam* Test"', [1995] *Singapore Journal of Legal Studies* 342

Khan, Malcolm, '*Bolitho* – Claimant's Friend or Enemy?', (2001) 20 *Journal of Medicine and Law* 483

Lavery, James, 'The Rise and Rise of *Res Ipsa Loquitor* in Medical Negligence Litigation', (1998) 7 *Australian Health Law Bulletin* 17

Lewis, Julie, 'Breaking the Mould', (2006) 44(9) October *Law Society Journal* 22

Low, Kelvin Fatt Kin and Lee Yuan Zhen, '*Bolam* in Singapore: Special Treatment for Doctors?', [2003] *Singapore Journal of Legal Studies* 610

Luntz, Harold, 'Medical Indemnity and Tort Law Reform', (2003) 10 *Journal of Law and Medicine* 385

Luntz, Harold, 'Reform of the Law of Negligence: Wrong Questions – Wrong Answers', (2002) 25(3) *University of New South Wales Law Journal* 836

Luntz, Harold, '*Rogers v Whitaker*: the Aftermath', (2003) 11(9) *Australian Health Law Bulletin* 102

Luntz, Harold, 'The Australian Picture', (2004) 35 *Victoria University of Wellington Law Review* 879

Maclean, Alasdair, 'Beyond *Bolam* and *Bolitho*', (2002) 5 *Medical Law International* 205

Madden, Bill, 'Three Dimension of the Standard of Care in Professional Negligence Cases', (2008) 4(8) *Australian Civil Liability* 89

Mason, Keith (Justice), 'Fault, Causation and Responsibility: Is Tort Law Just An Instrument of Corrective Justice', (2000) 19 *Australian Bar Review* 201

McDonald, Barbara, 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia', (2005) 27 *Sydney Law Review* 443

McDonald, Barbara, 'The Common Law of Negligence', (2003) 17(2) (June-August) *Commercial Law Quarterly* 12

McHugh, Michael (Justice), 'Introduction: Sydney Law Review Torts Special Issue', (2005) 27 *Sydney Law Review* 385

Montgomery, Jonathan, 'Medicine, Accountability and Professionalism' (1989) 16 *Journal of Law and Society* 319

Morris, Julian, 'Insuring Against Negligence: Medical Indemnity in Australia', (2002) 18(3) *Policy* 10

Pound, Roscoe, 'Common Law and Legislation', (1908) 21 *Harvard Law Review* 383

Powell, Raphael, 'The Unreasonableness of the Reasonable Man', (1957) 10 *Current Legal Problem* 104

Reid, Scarlett, '*Res Ipsa Loquitur*: A Chameleon in Medical Negligence Cases', (1999) 7 *Journal of Law and Medicine* 75

Sant, Kathy, 'A New *Bolam* Test?', (2004) 64 *Precedent* 20

Sidhu, Sarjeet Singh, '*Bolam*, *Foo Fio Na* and Doctors', [2008] 6 *Malayan Law Journal* l

Sim, Disa, '*Dr Khoo James & Anor v Gunapathy d/o Muniandy and Another Appeal*: Implications for the Evaluation of Expert Testimony', [2003] *Singapore Journal of Legal Studies* 601

Skene, Loane and Harold Luntz 'Effects of Tort Law Reform on Medical Liability', (2005) 79 *Australian Law Journal* 345

Skene, Loane, 'Withdrawing Cases from Juries After *Naxakis v Western General Hospital*', (2000) (November) *Law Institute Journal* 78

Sperling, Hal (Justice), 'Expert Evidence: The Problem of Bias and Other Things', (2000) 4 *Judicial Review* 429

Spigelman, James (Chief Justice), 'Negligence and Insurance Premiums: Recent Changes in Australian law', (2003) 11 *Torts Law Journal* 291

Spigelman, James (Chief Justice), 'Negligence: The Last Outpost of the Welfare State', (2002) 76 *Australian Law Journal* 432

Sri Ram, Gopal (Justice of Appeal), 'The Standard of Care: Is the *Bolam* Principle Still The Law?', [2000] 3 *Malayan Law Journal* lxxxi

Stapleton, Jane, 'Factual Causation', (2010) 38 *Federal Law Review* 467

Stewart, Angus, '"Best Interests": Towards A More Patient-Friendly Law?', (2007) 11 *Edinburgh Law Review* 62

Talib, Norchaya, '*Foo Fio Na v Dr Soo Fook Mun & Anor* – Beneath (and Alongside) the Surface of Change', [2007] *The Law Review* 587

Teff, Harvey, 'The Standard of Care in Medical Negligence—Moving on from *Bolam*', (1998) 18 *Oxford Journal of Legal Studies* 473

Thomas, Mathew, '*Rogers v Whitaker* Lands on Malaysian Shores – Is There Now a Patient's Right to Know in Malaysia?', [2009] *Singapore Journal of Legal Studies* 182

Underwood, Peter, 'Is Ms Donoghue's Snail in Mortal Peril?', (2004) 12 *Torts Law Journal* 39

Veeriah, Sivameenambigai, 'Critical Analysis and Acceptability of *Foo Fio Na v Dr Foo Sook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229: Valid Concerns?', [2010] 1 *Malayan Law Journal* xlv

Woolf (Lord), 'Are The Courts Excessively Deferential to the Medical Profession?' (2001) 9 *Medical Law Review* 1

Yeo, Stanley Meng Heong, 'The Standard of Care in Medical Negligence Cases', (1983) 25 *Malaya Law Review* 32

Zakaria, Arifin (Chief Justice of Malaysia), 'Speech by The Honourable Justice Arifin bin Zakaria, Chief Justice of Malaysia, at the Opening of the Legal Year 2012', [2012] 1 *Malayan Law Journal* cxxiv

CONFERENCE PAPERS

AUSTRALIA

Davies, Geoffrey (Justice of Appeal), 'The Reality of Civil Justice Reform: Why We Must Abandon the Essential Elements of Our System' (Paper presented at the 20th AIJA Annual Conference, Brisbane, 12-14 July 2002)

Downes, Garry (Justice), 'Expert Evidence: The Value of Single or Court-Appointed Experts' (Paper presented at the Australian Institute of Judicial Administration Expert Evidence Seminar, Melbourne, 11 November 2005)

Downes, Garry (Justice), 'The Use of Expert Evidence in Court and International Arbitration Processes' (Paper presented at the 16th Inter-Pacific Bar Association Conference, Sydney, 3 May 2006)

Harrex, Gillian, Keran Johnston and Estelle Pearson, 'Medical Indemnity in Australia' (A presentation to the Institute of Actuaries of Australia XIII General Insurance Seminar, Trowbridge Consulting, November 2001)

Phelps, Kerryn, 'Tort Law Reform' (Unpublished address to a seminar, Sydney, 12 February 2000)

MALAYSIA

Cusack, Denis A, 'The Standard of Care in Medical Practice: Has the Pendulum Swing in Favour of the Patients' (Paper presented at the public lecture jointly organised by Asean Law Association of Malaysia and the Malaysia Inner Temple Alumni Association, Kuala Lumpur, 16 September 2007)

Das, Cyrus, 'Recent Developments in the Common Law and their Reception in Malaysia' (Paper presented at the Conference on the Common Law in Asia, University of Hong Kong, 15-17 December 1986)

PRESS RELEASE

AUSTRALIA

Faulkner, Kingsley, 'Surgeons Set to Quit Over Cover', *The Australian* (Sydney), 8 May 2003

O'Brien, Susie, 'Doctors Lash Out at Delay', *Herald Sun* (Melbourne), 5 May 2003

Rofail, Nadine, 'Rural Doctors May Stop Delivering Babies', *Australian Current Law News* (Brisbane), 23 April 2001

Special Report, 'What Brought UMP Down', *Medical Observer* (Sydney), 31 May 2002

White, Andrew and John Kerin, 'Medical Insurer Faces Closure', *The Australian* (Sydney), 24 April 2002

MALAYSIA

Anbalagan V, 'Now Easier to Win Suits Against Specialists', *New Straits Times* (Online), 30 December 2006 <http://malaysianmedicine.wordpress.com/2006/12>

Malaysian Bar, *Demise of Bolam Principle: Foo Fio Na v Dr Soo Fook Mun & Assunta Hospital* (3 February 2007) <http://www.malaysianbar.org.my/content/view/8271/27>

Ng Chelsea, 'Court Punctures Docs' Defence', *The Star* (Online), 30 December 2006 <http://www.thestar.com.my/news/story.asp?file=/2006/12/30/nation/16445027&sec=nation >