HAS THE LAW FORCED DOCTORS TO PRACTISE DEFENSIVE MEDICINE?

The starting point on any discussion of the impact of the law on the medical profession is the classic statement by McNair J when directing a jury in **Bolam v Friern Hospital Management Committee [1957] 2 All ER 118**:

> "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 at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with

one of those proper standards then he is not negligent. Counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds."

In a later passage he said:

"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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. 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 takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century".

That clearly would be wrong."

The critical words in the direction are these: "failure to act in accordance with the standards of reasonably competent medical men at the time". Since medical science is constantly advancing through research and new techniques, whether at any given point in time and circumstances a doctor acted negligently depends on the peculiar facts of a case: it is also a question of degree.

The case of **Elizabeth Choo v Government of Malaysia [1970] 2 MLJ 171** provides a valuable illustration. The facts were these.

The plaintiff was suffering from a very advanced stage of haemorrhoids. She was admitted into hospital for surgery. A pre-operative sigmoidoscopic was carried out by an anaesthetist to whom the surgeon had delegated the task. The procedure was carried out under general anaesthesia. The sigmoidoscope which was about 16 cm. long is introduced into the rectum slowly using a certain amount of pressure. Great concentration is needed to see that the passage is not obstructed and that is done with the aid of the light in the instrument and by inflating the rectum with air. When the instrument reached the 13 cm. level the

anaesthetist saw some blood and he was doubtful of some abnormal pathology. He consulted the surgeon who carried out an immediate laparotomy when a small laceration was found and sutured and a temporary iliac sigmoid-colostomy carried out. The colostomy was closed and the sigmoid colon replaced.

The plaintiff brought suit for damages for negligence of the anaesthetist in performing the sigmoidoscopy. She called Mr. Alhady, whom the judge described as an eminent surgeon in this country and generally held in high esteem in the profession. He had successfully performed hundreds of sigmoidoscopic examinations under general anaesthesia. This technique was in vogue in his unit since 1956 and that technique had not earned the condemnation of medical opinion generally or of any medical man in particular except the plaintiff's personal physician, who had expressed the view that it is better to perform sigmoidoscopy without anaesthesia because the patient could forewarn the anaesthetist of any pain. He recalled his own experience in undergoing sigmoidoscopic examination in Australia without anaesthesia. The anaesthetist in question had done his surgical training under Mr. Alhady and it was during his housemanship that he had acquired this technique of using general anaesthesia during sigmoidoscopy. He had successfully performed hundreds

of sigmoidoscopic examination under general anaesthesia. No one had complained about this technique.

Applying the Bolam test Raja Azlan Shah J, who tried the action, dismissed the claim.

The **Bolam test** was applied throughout the Commonwealth with no complaint from either the legal or the medical profession. The only qualification to that test was imposed in the speech of Lord Browne-Wilkinson in **Bolitho v City and Hackney Health Authority [1997] 4 All ER 771**. The qualification is this. A doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible.

The most obvious case of gross carelessness is afforded by the facts of **R v Adomako [1994] 3 All ER 79**.

The defendant was the anaesthetist during an eye operation on a patient. In the course of the operation the tube from the ventilator supplying oxygen to the patient became disconnected. The defendant failed to notice the disconnection for some six minutes before the patient suffered a cardiac arrest, from which he subsequently died. The defendant was charged with manslaughter. At his trial it was conceded on behalf of the defendant that he had been negligent and medical evidence was called by the Crown that the defendant had shown a gross dereliction of care. The judge directed the jury that the test to be applied was whether the defendant had been guilty of gross negligence. The defendant was convicted. He appealed to the Court of Appeal on the ground that the judge had wrongly directed the jury by applying the test of gross negligence for manslaughter. The Court of Appeal, applying the test that the ingredients of involuntary manslaughter by breach of duty which needed to be proved by the Crown were (1) the existence of the duty, (2) a breach of the duty causing death and (3) gross negligence which the jury considered justified a criminal conviction, dismissed the

appeal on the ground that the jury had been directed according to the proper test and the evidence justified a verdict of guilty. The defendant appealed to the House of Lords which dismissed the appeal.

These decisions kept the lawyer away from the doctor's backyard. A place that is not meant as a lawyer's habitat. The cases where intervention took place were so plain and obvious that any reasonable body of professional opinion in the medical field would have condemned the doctor in question as negligent. Such an obvious case came before us in the Court of Appeal in 1996.

The victim was a young girl in her teens. One evening she complained of abdominal pain. Her parents took her to their family doctor who was a general practitioner and who had his clinic not far from their home. He examined the girl and found her abdomen distended. There was fluid in it. He referred her to the Penang General Hospital. He wrote a referral note in which he said this: "Rule out appendicitis. Peritonitis? Do not recommend surgery."

Two doctors at the Penang General Hospital attended to the girl.

They decided to ignore the GP's note. They were asked in court why they chose to do so. They said that the GP was a mere MBBS from India. And he was not a specialist. They, on the other hand had graduated from University Malaya and trained here.

These 2 doctors then proceeded to operate on the girl. They opened her abdomen and found it filled with fluid. They stitched her up and put her in the ward. The ordered an x-ray to be taken. They then lost it. Two days following the surgery the girl developed high temperature and died of septicaemia.

The parents brought suit against the Government. The sessions court dismissed the claim. They then appealed to the High Court which allowed the appeal, found the doctors negligent and awarded damages. The Government then appealed. Unfortunately for them, the appeal came before a panel over which I presided. The first question I asked was whether the doctors had inserted a tube in the abdomen to drain the fluid. I received a negative response. I then asked whether these 2 doctors were still in the Penang GH or whether they had been transferred to the appropriate department. Federal Counsel then

asked me: "What department is that, my lord". I said that it was the veterinary department that I had in mind. In my view those doctors were unfit to treat humans.

Save such obvious cases, courts kept lawyers well out of the way of doctors.

Plaintiffs do complain that the bar set by the courts is far too high; that doctors are unwilling to testify against their colleagues; and that it is nigh impossible to bring home a charge of negligence against a doctor. There is a policy answer to the first complaint. Medicine is not a perfect science. One human body is not necessarily physiologically the same as another. A doctor by his or her training sets out to either manage a condition or to save a life. I am yet to meet a doctor who begins on the footing that he intends to kill his or her patient. Second, there is a need to ensure that defensive medicine is discouraged. Defensive medicine leads to increased costs to the State or the insurance industry and needless exposure of the patient to tests that may really not be required. Third, regard must be had to the fact that not all doctors have the same sort of experience or skill. It is the same with lawyers. Hence the requirement of a preponderance

of opinion on the given case. Last, but not the least, a charge of negligence when proved against a doctor destroys his professional life. It is not the same in other professions. The complaint of unwilling medical witnesses no longer holds good. Senior members of the medical profession are as keen as anyone else to punish bad medical practice. As such it is no longer the case that doctors are unwilling to testify on issues of practice against their colleagues.

All was well for quite some time. Then in 1992, the High Court of Australia sought to move away from the well-trodden path of placing a high bar that plaintiffs have to overcome. It was in **Rogers v Whitaker [1992] 175 CLR 479**.

Ms Whitaker had for many years been almost totally blind in her right eye. She consulted Dr Rogers, an ophthalmic surgeon. He advised her to undergo surgery to the right eye to restore sight and improve cosmetic appearance. He did not warn her that as a result of the surgery she might develop a condition known as sympathetic ophthalmia in her left eye. After surgery, the left eye inflamed and lost sight. The doctor was found liable in negligence.

The special feature of the case appears in the following passage in the joint judgment of the High Court:

> "The appellant in this case was treating and advising a woman who was almost totally blind in one eye. As with all surgical procedures, the operation recommended by the appellant to the respondent involved various risks, such as retinal detachment and haemorrhage infection, both of which are more common than sympathetic ophthalmia, but sympathetic ophthalmia was the only danger whereby both eyes might be rendered sightless. Experts for both parties described it as a devastating disability, the appellant acknowledging that, except for death under anaesthetic, it was the worst possible outcome for the respondent. According to the findings of the trial judge, the respondent "incessantly" questioned the appellant as to, amongst other things, possible complications. She was, to the appellant's knowledge, keenly interested in the outcome of the suggested procedure, including the danger of unintended or accidental interference with her "good", left eye.

On the day before the operation, the respondent asked the appellant whether something could be put over her good eye to ensure that nothing happened to it; an entry was made in the hospital notes to the effect that she was apprehensive that the wrong eye would be operated on. She did not, however, ask a specific question as to whether the operation on her right eye could affect her left eye.

The evidence established that there was a body of opinion in the medical profession at the time which considered that an inquiry should only have elicited a reply dealing with sympathetic ophthalmia if specifically directed to the possibility of the left eye being affected by the operation on the right eye. While the opinion that the respondent should have been told of the dangers of sympathetic ophthalmia only if she had been sufficiently learned to ask the precise question seems curious, it is unnecessary for us to examine it further, save to say that it demonstrates vividly the dangers of applying the *Bolam* principle in the area of advice and information. The respondent may not have asked the right question, yet she made clear her great

concern that no injury should befall her one good eye. The trial judge was not satisfied that, if the respondent had expressed no desire for information, proper practice required that the respondent be warned of the relevant risk. But it could be argued, within the terms of the relevant principle as we have stated it, that the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective. However, the respondent did not challenge on appeal that particular finding."

The critical passage on the law is as follows:

"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. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life'."

Whatever the position in Australia may be (and it might be worth mentioning that they even play a different type of football altogether from the rest of the civilised world) the position in Malaysia continued unchanged, that is, until the controversial decision of the Federal Court in **Foo Fio Na v Dr Soo Fook Mun [2007] 1 MLJ 593**. It is a judgment of the Court comprising Dzaiddin CJ, Ahmad Fairuz CJ (Malaya) and Siti Norma FCJ.

In the Court of Appeal, I summed up the facts of the case as follows.

> "The plaintiff is a bright young lady. But she is confined to a wheelchair. This is how it happened.
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> At about 10pm on the night of 11 July 1982, the motor car in which she was traveling as a passenger crashed into a tree. It was near the Assunta Hospital ('the Hospital'). The plaintiff displayed much courage. She helped the other occupants of the car. Soon after, she admitted herself into the Hospital. The plaintiff was injured in the accident. The injuries she suffered included a closed dislocation of the C4 and C5 vertebrae. She complained of pain in her neck when she moved her head. X-rays were taken. The plaintiff was attended to by a Dr Pereira who fitted her with a surgical collar and advised her not to move her head. Dr Pereira then communicated with Dr Soo, the orthopaedic surgeon. Dr Soo advised that the collar was to be continued to be fitted and that the plaintiff was to be kept in bed with sandbags around her head to minimize movement. This was

to reduce the risk of paralysis.

At about 8.30am on the following morning, Dr Soo saw the plaintiff. After a brief physical examination, he placed the plaintiff on traction. There is a dispute about how long the traction lasted, but I do not regard this to be of any great importance. What is certain is that on 13 July 1982, the plaintiff gave her consent for a closed reduction procedure. On 14 July 1982, Dr Soo attempted closed reduction under general anaesthetic. Despite three attempts it produced no success.

Then on 15 July 1982, Dr Soo obtained the plaintiff's consent to perform an open reduction on her. That procedure was carried out on 19 July 1982. The nape of the plaintiff's neck was surgically opened. The dislocated vertebrae were moved to their original positions. A wire was then inserted to lend stability to the cervical spine. Dr Soo gave evidence that he inserted the wire under the laminar. According to Dato (Dr) Arumugasamy, the expert called by the plaintiff, the correct procedure was to insert the wire in this fashion. X-rays were taken after surgery. They were not however

produced at the trial, with a consequence I will refer to later in this judgment.

Unfortunately, the plaintiff became paralyzed the day after this surgical procedure was performed on her. Dr Soo obviously suspected that the paralysis was caused by vascular infarction because he prescribed a course of medication for it over four days. On the morning of 5 August 1982, a myelogram was done by the late Dr Mohandas. He found a block in the C4 to C5 vertebrae. On the afternoon of the same day, a second operation was performed on the plaintiff by Dr Soo. The wire that been placed below the laminar was removed. But the paralysis did not improve. The plaintiff did nothing for about five years. And it was only on 8 January 1987 that she caused a writ to be issued against Dr Soo and the Hospital, claiming damages for negligently injuring her."

Now, the negligence alleged against Dr Soo was primarily directed at his carry out the surgical procedure in a competent manner. The only particular raised in respect of advice said this: "wrongly advising the plaintiff to undergo the said operation and

the second operation, which no doctor of reasonable skill and competence would have advised to undergo the same."

You will see at once that there was no allegation against the doctor for failing to advise on the risks of the particular procedure. Therefore, the Rogers Case had as much relevance to Dr Soo's as cheese has to chalk. In Rogers, there was a specific allegation against Dr Rogers that he had failed to advise Ms Whitaker on the dangers to vision in the good eye by reason of surgery to the affected eye. Dr Soo faced no such charge of negligence.

Now, it is a settled principle of the law of negligence that a plaintiff must prove the charge of negligence as laid. A defendant cannot be found guilty upon an unpleaded case of negligence. Proof of the particular must be brought home. Also, a plaintiff cannot plead one type of negligence and lead evidence of another type. In the context of the case under discussion, Ms Foo had not pleaded that she had not been warned of the risks of surgery. She could not therefore succeed on that ground. Yet that is the very ground on which she succeeded in the Federal Court. We in the Court of Appeal confined ourselves to the pleaded case.

And we found the evidence to have fallen short of proof. Also, there were other factors. The record of proceedings showed that the doctor had not received a fair trial. Let me quote from my judgment to show the miscarriage of justice.

> "These are particulars of the most general nature. It therefore comes as no surprise that the solicitors for Dr Soo, after delivering a holding defence, took out an application for particulars. Their summons is dated 29 July 1987, and although made returnable on 24 September 1987, it was never actually heard and disposed of. Consequently, when the suit came up for trial in February 1995, Dr Soo's pleaded case was far from complete. In fact, it appears from the record of appeal that the suit was called up on 13 February, on which date the learned judge appears to have given directions for the plaintiff to deliver a single particular of her statement of claim. But Dr Soo's summons for particulars lay in the file without being disposed of, and an application by his counsel to amend the holding defence was vigorously opposed and dismissed. With respect, I find the way in which this case was handled by the learned trial judge to be an extreme example of

procedural unfairness and oppression.

Nothing is clearer in adjectival law than a litigant's right to have his interlocutory applications heard and dealt with. In the present case for instance, Dr Soo had a legitimate expectation to have his application for particulars heard and determined according to law. If he was unhappy with any decision made in respect of his application, he was entitled to appeal. The failure of the High Court to hear and determine Dr Soo's application for particulars therefore occasioned a most serious and fundamental miscarriage of justice. It not only deprived him of his basic right to have his application heard, but it also deprived him of the substantive and valuable right to appeal against any decision made against him. By refusing to determine his application, the High Court effectively precluded him from going further: no decision and so no appeal. To add insult to injury, a perfectly legitimate application by Dr Soo to amend his defence was dismissed with an unusual order that he pays the costs in any event. In these circumstances, who can blame his counsel for the

> complaint he so legitimately made to us at the outset of the hearing of this appeal about the way in which his client's case was treated by the trial court? The effort of the plaintiff's counsel to justify what happened in the High Court cannot wash away the harm occasioned in this case.

Let me say at once that the Federal Court never addressed the procedural injustice meted out to Dr Soo anywhere in its judgment. This is a serious injustice to any litigant. More so to a doctor who is fighting to preserve his professional integrity.

The net result in my view is that the judgment of the Federal Court in the case of **Foo Fio Na v Dr Soo Fook Mun** was a travesty of justice. It is one of consequences of having judges who were ill-equipped to see the essence of the complaint made by the doctor against the trial judge in the way in which his case was treated at first instance.

The upshot of the decision of the Federal Court in the **Foo Fio Na case** is this. No matter what the charge of negligence against a doctor, the **Bolam** test no longer applies. The test is this.

Although acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care. So, it is no longer relevant that experienced doctors testify to the propriety of what was done by the defendant doctor. It is the court that will say whether there was negligence. And that means that a layman is going to judge experts. With respect, this nothing more than a load of nonsense.

The effect of the decision in **Foo Fio Na** is that the medical profession had at once to go into extra care mode. Patients must not only be advised against risks. They must also be subjected to unwanted tests. The blame now again shifts to the doctors. The allegation is that the tests are ordered to enrich the hospital – particularly if it is a private hospital. Costs multiply with no benefit in real terms.

One can understand the chagrin felt by the doctors. General practitioners are particularly at risk. Because they will be found guilty unless they refer the patient to a specialist. And specialisation has reached excessive limits. There used to be a time when there was a family doctor who knew the ills of every member of the patient's family. And for those who were

superstitious – especially among the Indians – there were doctors with lucky hands who were believed to have a cure to matter what the illness. It is my belief that the difference between then and now is this. A patient then died **of** a heart attack. Now he dies **from** a heart attack. But it cannot be gainsaid that medical science has advanced and decreased the mortality rate. And when it comes to the question of research and experience one cannot help but recall to mind the words of Bramwell J in **Hart v Lancashire and Yorkshire Rly Co (1869) 21 LT 261 at 263** "People do not furnish evidence against themselves simply by adopting a new plan in order to prevent the recurrence of an accident. I think that a proposition to the contrary would be barbarous. It would be, as I have often had occasion to tell juries, to hold that because the world gets wiser as it gets older therefore it was foolish before".

Returning to the mainstream, the effects of Foo Fio Na have since been brought under control by reason of a fairly recent decision of the Federal Court in **Dr Hari Krishnan v Megat Noor Ishak [2018] 3 MLJ 281**.

The plaintiff had a giant retinal tear with detachment in his right

eye. He was operated on by the first defendant doctor with the second defendant doctor being the attendant anaesthetist. Two procedures were performed. According to the finding made by the High Court both were badly done. Before the second surgery the plaintiff had asked for Dr Manavalan – the well-known anaesthetist. He was not called in by the first defendant who instead got in the second defendant. The court also found that the plaintiff had not been advised of the risks of bucking and blindness. The bucking had happened during the second surgery. The High Court found both the ophthalmologist and the anaesthetist negligent. The Court of Appeal affirmed. A further appeal by leave to the Federal Court also failed.

In the course of its judgment the Apex Court held that **Rogers v Whitaker**, which was followed in **Foo Fio Na**, with regard to the standard of care in medical negligence, was restricted only to the duty to advise of risks associated with any proposed treatment. It does not extend to diagnosis and treatment. With regard to the standard of care for diagnosis and treatment, the **Bolam** test still applies subject to the qualifications as stated in **Bolitho**. The Bolam test is essentially a 'doctor knows best' test. As long as there are two conflicting views on the acceptable medical practice, and the defendant doctor acted based on one of the

conflicting views, he would be exonerated from liability. In short, the standard of care is decided by the medical profession. The **Bolitho** test is merely an extension of the **Bolam** test, which calls upon the court to analyse the logic and reasonableness of the conflicting medical opinion advanced by the defence before accepting the same.

Put simply it means this. When a doctor decides upon a course of treatment – surgical or through the administration of drugs – he or she is duty bound to advise on the specific risks of the course of treatment. If this is not done and the risk occurs there may be liability for negligence. But whether the particular course of action was or was not negligent will be decided by members of the profession. To recall the words of McNair J in **Bolam**: "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 medical act... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view."

So, I would answer the question posed in this way. At one time,

the law forced doctors to practise defensive medicine. This was because of the erroneous decision of the Apex Court in **Foo Fio Na**. Today that is no longer the case. Therefore, doctors please do not worry too much. The lawyer is no longer in your backyard.

But this does not entitle the medical profession to take a laid-back attitude to diagnosis and treatment. I am given to understand that there are some among you – especially from the local universities – who do not know how to perform even an appendectomy. They nevertheless carry licences to treat patients. It is my earnest plea to you not to allow them to become James Bonds with a licence to kill. If that happens the law will rise to meet that challenge. And you cannot then blame the court for looking over your shoulder.

Dated: 16 September 2018

Gopal Sri Ram