MEDICAL NEGLIGENCE LITIGATION IN MALAYSIA : WHITHER SHOULD WE TRAVEL?

by

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Abstract

The deficiencies of the tort system in handling medical negligence claims have been apparent for a number of years. Most of the criticisms are directed at whether the action of negligence is a suitable means to compensate victims of medical injury. For a medical negligence claim to succeed, the patient has to overcome the substantive law as well as the procedural law inherent in the tort system. Often, both the substantive and the procedural law tend to work against the interest of the patient. The inaccessibility of the litigation system and particular difficulties of proving medical negligence deter many potential litigants from pursuing their claim. This means that those cases that are pursued are unrepresentative of the number of medical mishaps that have occurred. Furthermore, the current fault-based system seems ill equipped to provide non-legal remedies such as explanation and investigation of events leading to the mishap. There is a cry for reform within the tort system itself and also for the implementation of alternatives to the fault-based system such as a no-fault compensation scheme and methods of alternative dispute resolution. Such methods can be seen to do away with the rigours of litigation and offer settlement through a fairer, cheaper and helpful approach. Developments in other countries such as New Zealand and Sweden shows how medical mishaps are tackled without resorting to the tort system. However, to have such radical change implemented in Malaysia would require consideration of many

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factors. At the moment, it is more realistic to suggest that the tort system should exists as the traditional and primary avenue available to medically injured victims seeking remedy. However, incremental changes such as adopting measures to complement the tort system should be introduced to promote efficiency, predictability and accountability.

Introduction

Litigation has never been a haven for neither the doctor nor the patient. Although at present, Malaysia is not experiencing the kind of 'malpractice crisis'[1] as in the United States and possibly, in the United Kingdom, there is certainly a rise in the number of negligence claims and the size of awards.[2] These factors are sufficient to cause alarm for future implications and generate serious thoughts for reform of the present system. Rising number of medical negligence claims is not considered healthy for a country as it leads to a reduction in the amount of money available for patient care. A single large award can distort the amount government or private hospitals can use to enhance healthcare.

Moving to a 'No-fault' System

A radical solution to the problem is to move away from the current fault-based system towards a 'no-fault' based system of liability for medical negligence. The arguments in support of a no-fault system are clearly attractive, but emotive.

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[1] A country is said to be experiencing 'malpractice crisis' if the number of malpractice cases has risen dramatically in the last 10 to 15 years in terms of medical malpractice suits by the patients. Other symptoms include dramatic rise in medical malpractice insurance premiums, rise in the amount of courts' awards and settlements whether for economic or non-economic damages and greater availability of punitive damages. See McQuade, J.S., 'The medical malpractice crisis – reflections on the alleged causes and the proposed cures' (1991) Journal of the Royal Society of Medicine, at pp 408-411.

[2] In the year 1998, the Attorney General Chambers Malaysia recorded a total number of 16 medical negligence cases and the amount of compensation paid for that year was RM23, 288. In the year 1999, the total number of cases recorded was 31 and the amount of compensation paid for that year was RM72, 000.

On the positive side, the system would enable victims of medical mishaps to be compensated quickly and at little administrative cost. Legal fees are eliminated and the adversarial features of the tort system are avoided. Claimants do not have to find a skilled lawyer to act on their behalf. As a consequence, it is possible to provide compensation to a larger number of people than under tort law. Thus, the bulk of the expenditure involved goes directly to the claimants.

There is no doubt that introducing a no-fault compensation scheme would overcome many of the shortcomings that have been identified in the present system such as the expense and time in pursuing a tort claim, the unpredictability and the tendency to award disproportionate compensation to similar situated plaintiffs. However, it is not easy to design a no-fault scheme for medical accidents which is simple to run, straight forward in operation and acceptable in costs. Many lessons can be learned from the New Zealand and Swedish schemes.[3] On the positive side, the scheme provides universal entitlement for victims of accidents who come within the scope of the scheme. Claims are settled quickly and at little administrative cost. The adversarial features of the tort system are avoided and those injured do not have to meet legal expenses.

However, can Malaysia adopt a no-fault compensation scheme? Although theoretically appealing, it seems unlikely that Malaysia is suited to the development of an extensive social safety net for its population. There are fundamental issues, which prevent the no-fault system from being the elixir to the medical malpractice problems in Malaysia.

Firstly, the size of the population in Malaysia is considerably larger, as compared to New Zealand or Sweden. New Zealand's 3.3 million[4] populations compared to Malaysia's own 23 million people.[5] Sweden's population of 8.5 million[6] is no where close to Malaysia. Nevertheless, the adoption of a no-fault compensation scheme as that, which exists in New Zealand or Sweden, designed

[3] For explanation on the New Zealand scheme, see Puteri Nemie, J.K. 'No-Fault Compensation for Medical Injuries: The New Zealand Experience' (2003) 11 *IIUM Law Journal* 83.
[4] http://www.statistics.gov.nz.
[5] http://www.statistics.gov.my.
[6] http://www.statistics.gov.se.

to deal with a substantially larger population of 23 million is financially not viable.

Secondly, the welfare scene in New Zealand and Sweden has enjoyed generous social security benefits. For instance, in the year 2001, New Zealand spends 6.45%[7] of her Gross Domestic Product (GDP) on health expenditure whereas Sweden's was 4.8%.[8] In these countries, hospital treatments are free whereas the fees of general practitioners are minimal as they are heavily subsidised. Malaysia on the other hand, spends only 2.59% of her Gross Domestic Product (GDP) on healthcare.[9]

Thirdly, New Zealanders have never been afraid of the state and have used the state to promote their aims. Pragmatism rather than political ideology has been the dominant influence. Average New Zealanders trust that government bureaucracies can and do the work and these bureaucracies have been efficient and free from political interference. Absence of a federal government makes the operation of the government much simpler than it would otherwise have been.[10] However, in Malaysia, the federal government appears to influence decision-making and control over public bodies. This makes it difficult to implement any policy without absolute co-operation from the federal government.

Fourthly, for a system not based on fault to be truly comprehensive and for it genuinely to meet needs, not only the political will but also the financial commitment has to be available. New Zealand is an egalitarian society[11], with a fairly narrow range of incomes, which has made it easier for Parliament to fix ceilings for earnings-related compensation under the new schemes. However, the disparity of income is wide in Malaysia and this causes difficulty for Parliament to offer a viable level of compensation that suits the need of the whole population.

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[7] http://www.treasury.govt.nz/forecasts/befu/2001.
[8] http://www.finans.regeringen.se/inenglish.
[9] Table 2.2, *Economic Report 2000/2001*, Ministry of Finance, Kuala Lumpur, at p. xi.
[10] Palmer, G., 'Compensation in New Zealand: A Requiem 'American Comparative law Journal, at pp. 3 - 4.
[11] Ibid.

Fifthly, the main hurdle a no-fault compensation scheme may encounter is funding difficulties. It is difficult to predict the number of cases eligible for compensation per year. Presumably, the number of people seeking no-fault compensation would be greater than the number who can sue for damages or accept settlements as there are less obstacles to encounter in such a scheme compared to recourse to the courts. The sources of funding are critical. For example, to fund its scheme, the New Zealand Accident Compensation Scheme established a social insurance scheme, which is funded through levies of the employers and self-employed persons, motor vehicles and drivers of motor vehicles and general revenues. Thus implementing a no-fault insurance scheme in Malaysia would not be welcomed if it means increasing taxes on a society, which already feels overburdened with taxes.

Sixthly, the New Zealand No-Fault compensation scheme as a whole contains few incentives to improve safety and encourage prevention of accidents. Although the Accident Compensation Corporation[12] has a role in accident prevention but it has no power to monitor standards of medical care. This rests principally with the medical profession who may not be the appropriate body to provide effective disciplinary steps against negligent doctors. Furthermore, the scheme does not overcome the difficulty experienced by victims of medical accidents in obtaining explanation of why an accident happened. Ways of strengthening medical accountability and responsibility by improving complaints procedures, reinforcing procedures used to discipline doctors and encouraging the use of medical audit are needed to complement a no-fault scheme. Thus, a no-fault scheme offers advantages but not without a price. The price for patients may have to be the limits on the level of compensation but the price for doctors is that they have to comply with effective inquisitorial complaints procedures. This means that for a no-fault scheme to be workable, co-operation from all sectors, be it the government, patients, medical profession, medical disciplinary board and lawyers are essential.

No-fault compensation may have a place in the current medico-legal scene but at present, such radical change may not be a realistic answer to current problems.

[12] This is a corporate body set up to administer the scheme.

Reforming the present fault-based system

The difficulties in implementing a no-fault compensation scheme suggests that policymakers should look to sustainable and incremental reform of the tort based system rather than pursuing the implementation of a full fledged no-fault scheme. The tort system, despite its demerits, has the unique feature of presenting the victim of negligence with a financial incentive to pursue a claim against the person believed to be responsible. The present system is useful in making large institutions more publicly accountable for their actions. Public interest is also served by issues of poor care being discussed in open court and court decisions can have positive effect on standard of care. The fear of litigation may encourage doctors and health authorities to take greater care and help reduce the number of accidents by raising quality of treatment. Thus, the tort system of civil liability has a role to play in signalling the social costs of resource allocation decisions to policy-makers in the health sector. If the tort system is not seen as purely compensatory but as a mechanism for creating an incentive to provide high quality service, the case for its abandonment is less clear-cut.

Nevertheless, if the present system is to be retained, some changes have clearly to be made. One of the major criticisms of the tort system concerns the difficulties facing patients and their relatives in bringing a claim against doctors. The tort system is criticised because the plaintiff bears the burden of proving all components of the medical negligence claim. To prove that the doctor had positively breached a standard of care owed in the circumstances to the patient is peculiarly onerous for the plaintiff due to the existence of the *Bolam* principle.[13]

[13] In *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, at pp. 586-587, McNair J. formulated a test, known as the *Bolam principle*, to determine whether the doctor's act fell below the required standard of care: '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.... 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.... I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. .... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that would take a contrary view.'

Thus, to alleviate this problem, it is crucial that the *Bolam* principle is restored to its proper limits and appropriate context as what was originally intended by McNair J.[14] This would be beneficial and not detrimental to medicine and to medical negligence litigation. The courts should no longer blindly accept assertions of good medical practice but evaluate that practice. Such developments in *Bolitho v City & Hackney Health Authority*[15] should not cause doctors and other health professionals to fear their professional integrity and independence. Doctors, like other professionals, cannot be judges in their own cause. The judge in a malpractice claim should be free to scrutinise the basis of opinion professed to him as representing responsible practice. Returning the *Bolam test* to its proper limits as has been done in cases like *Bolitho*[16], *Rogers v Whittaker*[17] *and Naxakis v Western General Hospital*[18] does not mean the

[14] In *Bolam*, McNair J. makes it clear that negligence is not proven merely because a doctor conforms to one school of thought and practice rather than another. He aptly said that: '...that does not mean a medical man can obstinately and pigheadedly carry on with some old technique if it has been proved contrary to what is really substantially the whole of informed medical opinion.' [1957] 1 WLR 582, at p. 587.

[15] [1997] 4 All ER 771. Lord Browne-Wilkinson delivering judgment in the House of Lords in Bolitho held that the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment and diagnosis accorded with sound medical practice. His Lordship held that the word 'responsible' used by McNair J. in *Bolam* 'show[s] 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.' [at p. 778] This means that merely by showing that the defendant's action was supported by expert medical opinion will not automatically exculpate him. The expert medical opinion in question has to have a sufficient logical basis. Lord Browne-Wilkinson then went on to explain that before a judge can accept a body of opinion as being 'responsible', the judge will have 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.' [at p. 778] Thus, a 'responsible' view presupposes that the experts in forming their opinions have weighed the relative risks and benefits. His Lordship further held that 'if it can be demonstrated that the expert medical opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not responsible.' [at p. 779]

[16] *Supra.*

[17] [1992] 109 ALR 625.

[18] [1999] 73 ALJR 782. In the High Court, Gaudron J. stated that the standard of care is not to be decided using the *Bolam principle* and therefore, it is not a matter of medical judgment. His Lordship reiterated the ratio in *Rogers v Whittaker* where it was held that '[the standard of care] 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. It has to be decided 'whether it was reasonable for one or more of the steps to be taken.... [and this] was not for expert medical witnesses to say whether those steps were or were not reasonable.' [(1992) 175 CLR 479, at p. 487]

threshold for a plaintiff to cross in an action for medical negligence is lowered. Instead, it may be higher as judges will now be the gatekeepers of medical expert evidence. In many instances, professional medical opinion will remain highly and rightly influential, as it will be evaluated on a par with professional opinion advanced by any other kind of professional.

Far more complicated is the proof of causation. The 'but for' test only award full compensation to plaintiffs who are successful in showing the causal link between damage and the negligent conduct. This all or nothing approach to compensation has rightly attracted much criticism for its lack of proportionality, its inefficiency and its inequity. It is high time that the Malaysian courts consider adopting the common sense approach development in Australia[19] and recently in England[20], where the law will allocate responsibility by answering questions of fact using ordinary common sense instead of asking whether the plaintiff would not have suffered injury but for the defendant's act. For medical negligence cases, which involve inexact science, such question clearly causes injustice.

As a compensatory mechanism, the tort system proves to be efficient to successful claimants. Clearly, for those fortunate enough to succeed in securing damages through the tort system, it represents very generous compensation. This is because the principle of restitution requires the courts to place the

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[19] See *Chappel v Hart* [1998] 156 ALR 517. [19] For discussion of this case, see Puteri Nemie, J.K. 'Medical Negligence: Causation and Disclosure of Risks in the light of the Decision in *Chappel v Hart*' [1999] 4 *Malayan Law Journal* ccii.

[20] See *Chester v Afshar* [2002] 3 All ER 552. The Court of Appeal in arriving at its decision applied the majority approach in the High Court case of *Chappel v Hart*. Sir Dennis Henry stated that: 'The purpose of the rule requiring doctors to give appropriate information to their patients is to enable the patient to exercise her right to choose whether or not to have the particular operation to which she is asked to give her consent…. The law is designed to require doctors properly to inform their patients of the risks attendant on their treatment and to answer questions put to them as to that treatment and its dangers, such answers to be judged in the context of good professional practice, which has tended to a greater degree of frankness over the years, with more respect being given to patient autonomy. The object is to enable the patient to decide whether or not to run the risks of having that operation at that time. If the doctor's failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he were not to be held responsible when the very risk about which he failed to warn her materialises and causes her an injury which she would not have suffered then and there.'[at p. 572]

successful plaintiff in a position he or she would have been, had the defendant had not injured him, so far as it is possible through monetary damages. This means that all economic loss resulting from past, present and future interruptions to work as a result of the injury are incorporated into the award as well as any expenses involved in the care of the plaintiff. Also, some attempt is made to take into account non-economics losses associated with pain and suffering and loss of amenity. In comparison with other compensatory mechanisms, this is generous to the successful claimant. Usually successful claimants will be satisfied with the generosity of the compensation they receive, should they get there. The problem lies with the fact that not many can get there. Essentially, the system is costly, lengthy as there exists considerable delay between the accident and its compensation and unfair because it is inequitable between injured patients. As a result, only a small proportion of patient suffering medically related injuries obtain compensation. Furthermore, the current fault-based system also seems ill equipped to provide non-legal remedies such as an explanation and investigation of what has occurred to claimants. The emphasis on establishing fault destroys the proper relationship of mutual trust between patient and doctor by introducing a confrontational element. This further encourages concealment and lack of frankness between the parties. Dissatisfaction among plaintiffs' centres on the difficulty to get information from hospitals, difficulty in getting their medical records released, a feeling that the outcome of legal action left them unable to put matter behind them or to come to terms with what had happened. In particular, plaintiffs felt that many of their questions remained unanswered. Improvements, which they want to see in the existing system, are greater openness and more frequent meetings. Remedies such as prevention of recurrence, apologies and opportunities to talk issues through with the other side were not readily forthcoming. Thus, there is a need to recognise the need for a vehicle through which patients and indeed staff can channel their unease and is relatively 'user friendly'. No one should be deterred from making a legitimate complaint and complainants have the right to expect their grievances be dealt with expeditiously, sympathetically and comprehensively. If investigations of a given complaint reveals a remedial defect or defects in systems of patient care, there is a valid expectation that these where identified will be rectified. Medical complaints can often be defused at an early stage by sympathetic communications with patients where things are thought to have gone wrong. Consultants must set ample time to allay

anxieties and doubts early, with candour. If a given complaint is likely to result in a legal action, steps which must be taken to provide a more conciliatory process, which does not result in winner or loser. As it is essential that complaints be investigated thoroughly and without bias, there is a need for a comprehensive and well-publicised procedure acceptable to the health care professions and public alike. It has to be a simple, rapid and easy access for patients to channel their complaints. Thus, there is clearly a pressing need to set up effective complaints machinery[21] suitable for both doctors and patients to channel their grievances.

Promoting mediation

If the present tort system is to be retained, there is a need for mediation, as a form of dispute resolution, to be an integral part of the litigation process. As pressures placed on the court system of this country continue to increase and the economics of effectively conducting litigation continue to be difficult, mediation be used more frequently. This particular method of dispute resolution will provide an opportunity for the parties to meet the other side face to face and hear what the other side has to say and to talk through all issues. This process seeks to maximise the parties' interests and take into account remedies not capable of being granted by the courts. The power to agree to a solution in mediation lies with the parties themselves rather than with the mediator, who cannot impose a decision upon them. In mediation, parties have a more substantial role than they would in court, including an opportunity to present their own argument. The outcome being that which all parties agrees upon. It is a win-win process rather than win-lose scenario. The adversarial and confrontational approach to conflict would be removed. However, not all kinds of cases are suitable for mediation. Cases that are suitable for referral to mediation are cases where non-legal remedies such as apologies and

[21] For instance, setting up a complaints machinery called Medical Review Bureau. The Bureau would be the starting point of entry to provide a forum outside the courtroom in which the problem may be solved without the expense, publicity and the difficulty of court proceedings. This Bureau should aim at providing a framework to resolve disputes by offering an independent, accessible and impartial alternative to the courts.

explanations are being sought. It is also suitable for cases where parties wanted greater involvement in case management[22], where speedier resolution is required and where parties have established a long-term relationship with the healthcare provider. Cases that are not suitable for mediation are cases that lacked settlement potential such as cases where there was a desire to set precedent, where the claim value is high and insufficient information on which to base settlement negotiations. Thus, mediation may not be suitable for all medical negligence cases but it certainly has the potential to encourage more appropriate and effective resolution of disputes. It clearly provides an opportunity to explore all aspects of the claim rather than just those elements on which the legal system focuses. It facilitates settlements, which involve more than financial compensation, including explanations. It provides a more conciliatory and less inhibiting environment for the parties and less likely to prompt defensive responses. It remains a private forum with no external check on the fairness of the process and outcome. Mediation is an extra toolkit of litigators and defendants.

However, there remains the risk that inappropriate use of mediation could increase the number of claims lodged against the health service. Also, the use of mediation may discourage the commissioning or use of appropriate expert advice, which is of course, the key to all professional actions. However, the increased use of methods of alternative dispute resolution offers much promise in making the litigation system fairer to all parties, more consistent and less costly.

Conclusion

Nevertheless, there is no easy answer to the problems faced in solving medical negligence cases. Opinions may differ on what is the best method to be used to resolve this conflict. But there is widespread consensus that continuing with the present system unaltered is clearly an unsatisfactory policy option. As Lord Justice Otton aptly said:

[22] See Order 34 and 35A of the Rules of High Court 1980.

'The question [that need to] be asked is [a]s a civilised society, are we content with a system where a person who has by ill-fortune suffered grievous injury as a result of medical treatment can be denied all form of compensation due to the failure to establish negligence? The present system requires...serious thought. It is time that society, government, doctors, judges and academics, and in particular members of this prestigious and influential [s]ociety considered the possibility of thoroughgoing change.'[23]

[23] Lord Justice Otton, 'Medical Negligence - Is there something wrong? [2001] 69 Medico-Legal Journal 72, at p. 75.