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The Doctrine of Informed Consent and Duty of Disclosure: A Comparative Essay between the US, UK, Australia, and Malaysia with Indonesia

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Abstract

The study aims to compare and contrast the position of four countries (The US, UK, Australia, and Malaysia) regarding informed consent, particularly on the subject of disclosure of information with Indonesia. Other than that, the legal issues to be studied were the implications brought upon the healthcare and judicial system in the respective countries as well as the advantages and disadvantages of each test propounded. It was found that previously the welfare of the patient in regards to their right to receive information (especially risks) regarding their medical treatment was only up to the discretion of the medical practitioner and other members of the medical profession, which eliminates liability against a negligent doctor if it was found that other members of the medical community would have done the same as him. It was not until the case of Rogers v Whitaker that the spectrum widened and allowed the courts to determine that whatever that should be disclosed to the patient must be something that the patient attaches significant risk to, this is then named the "Prudent Patient Test", used by most countries in this study. The study finds that as an implication, most countries have departed from the previous paternalistic approach by doctors and as an advantage, encouraged individualism and the reduction of the patients as passive recipients in their own health care. Since most of the comparative countries are similar in application, it was found that the medical law envisioned and enforced in the respective countries was quite different compared to the civil legal system in Indonesia. Other than that, as a country that is highly ingrained with Islamic values of life, the perspective of human rights and individualism in Indonesia is distinct with most of the other countries studied.

Keywords: *medical law, comparative law, informed consent*

1. Introduction

The maxim of *volenti non fit injuria* means that no wrong is done to those who consent. Making choices and having the freedom to do so is a basic human right and should be available to anyone in any circumstance. In the context of medical treatment, a doctor must obtain legally valid consent from patients of sound mind. According to the Cambridge Advanced Learner's Dictionary & Thesaurus, consent literally means permission to do something, acceptance, or approval. Provision 1 of the Consent Guidelines of the Malaysian Medical Council (MMC) 2013 provides consent to mean "voluntary acquiescence by a person to the proposal of another; the act or result of reaching an accord; a concurrence of minds; actual willingness that an act or an infringement of an interest shall occur". In addition, Provision 2 of the consent guidelines states that generally no procedure, surgery, treatment or examination may be undertaken on a patient without the patient's consent. This is due to the fact that in the perspective of common law, non-consensual touching of another person may amount to battery, which was the rule during the early onset development of the doctrine of

Informed consent. It was considered that if the patient was not properly informed of the nature, purpose, risks, and alternatives of the proposed medical treatment, it can be said that the consent was thus vitiated and the subsequent performance of the medical procedure became a battery. Similarly, under Indonesian law, the absence of informed consent may trigger either civil or criminal action against the doctor. Civil action can be based on Article 1365 of the Civil Code (governing tort), while criminal action can be based on Article 351 of the Penal Code (governing maltreatment). Therefore, this gives rise to the fact that the issue of informed consent is not just an ethical principle, but also a legal one.

For the patient to give consent, they need to be informed prior to medical treatment about the nature of their proceedings. This means that doctors are required to provide their patients with sufficient information so that the patients could assent to or withhold consent from a proffered medical treatment. This coincides with two human rights issues under the doctrine of informed consent, which is a patient's right to information, and a patient's right to self-determination which supports the logical reasoning to let the patient make the decision on whether or not to undergo the proposed treatment. Moreover, it also conforms with a patient's right to privacy because lack of consent makes medical intervention a violation of the patient's privacy.

The case of *Chatterton v Gerson*[1] where Bristow J held "once the parties are informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real…" highlights this. Some courts have also held that this knowledge of certain risks could be material to understanding of the basic nature and character of an operation and that failure to disclose them would vitiate consent and could amount to battery.[2]

The two early major landmark cases involved in the doctrine of informed consent are the American *Canterbury v Spence*[3] and the British *Sidaway v. Governors of Bethlem Royal Hospital*.[4] The two cases were on opposite ends of the doctor-patient spectrum, with *Canterbury* being patient-oriented and *Sidaway* leaning more towards the doctors. This is due to a paradigm shift in medical practice from medical paternalism, which is based on the idea that a doctor knows what is best for his patient, in contrast to the idea that the patient knows his own best interest and therefore must be involved in the decision-making process relating to medical treatment.[5] It was not until the Australian High Court case of *Rogers v Whitaker*[6] that effectively endorsed the patient-oriented "American" rule of liability in *Canterbury* that presented Australia with the strongest and most patient-oriented doctrine of informed consent among the common law jurisdictions.[7] However, the case still did not resolve a significant issue surrounding informed consent: who decides how much information must be provided to patients—the judge or the jury and what constitutes relevant evidence on the issue of what a physician should have disclosed to a patient.

2. Method

This is a descriptive and comparative study. The scope of study included related laws, case laws, and statutory provisions concerning informed consent and disclosure

[1] *Chatterton v Gerson* [1981] 1 All ER 257

[2] *Kelly v. Hazlett* (1976) 15 O.R. (2d) 290, 310 (C.A.).

[3] *Canterbury v. Spence* 464 F. 2d 772 (1972) (D.C. Cir.).

[4] *Sidaway v. Governors of Bethlem Royal Hospital* [1985] A.C. 871 (H.L.).

[5] Ibid.

[6] *Rogers v Whitaker* (1992) 175 CLR 479

[7] Chalmers, Don, and Robert Schwartz. 1993. "Rogers V Whitaker and Informed Consent In Australia: A Fair Dinkum Duty Of Disclosure". *Medical Law Review* 1 (2): 139-159.

in countries such as the United States of America, the United Kingdom, Australia, Malaysia, and Indonesia. Data was gathered from systematic internet research, and library resources.

3. Analysis and Results

3.1. United States

In the United States (henceforth referred to as the US), the doctrine of informed consent loosely started in 1914 with the case of *Schloendorff v. Society of New York Hospital*[8] where a patient named Mary Schloendorff had been subjected to surgery against her expressed wishes and protests. She successfully sued the surgeon and the hospital. Justice Benjamin Cardozo's quote in the case is said to be the root of the principle of autonomy: 'every human being of adult years and sound mind shall have the right to determine what shall be done with his own body ....' However, the term 'informed consent' was not used until much later in the case of *Salgo v Leland Stanford Jr University Board of Trustees*[9]. The plaintiff, Martin Salgo had undergone an aortography, a minimally invasive procedure of an x-ray examination of the body's main artery. After waking up paralysed, he realised he had never been informed that such a risk existed. It was held that the physician would be considered violating his duty and subjecting himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. The case however then backtracks by providing that even though a full disclosure of facts is necessary to obtain an informed consent, the issue of how much information to be given to the patients was up for debate by consulting fellow doctors.

However, the principle that can be derived from Salgo is then brought up and challenged in the landmark case of *Canterbury v Spence*[10]. In the case, the plaintiff Jerry Canterbury was partially paralyzed after thoracic spine surgery. His claim that he had not been informed that such a risk existed was confirmed in testimony by his surgeon. In the decision, the Court had held that it is an established rule that a treatment without authorization (i.e consent) from the patient would amount to a tort and that a consent is not complete unless the physician first explains the options and risks of the treatment for the patient's education. Furthermore, in regards to the notion that the issue of the extent of the information to be divulged to the patient is no more than what other reasonable practitioners would divulge, the court held that:

> *"Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."*

What this means is that previously the standard of duty that was judged by the medical profession is now ultimately to be decided by the courts. Moreover, it was also held that the doctor must disclose all "material" risks inherent in a proposed treatment. To determine what constitutes a material risk, the case introduced a "prudent patient" test. It was regarded that "[a] risk is material when a reasonable person, in what the physician

[8] *Schloendorff v. Society of New York Hospital* 105 N.E. 92, 211 N.Y. 125

[9] *Salgo v Leland Stanford Jr University Board of Trustees* 154 Cal. App. 2d 560 (Cal. Ct. App. 1957)

[10] *Canterbury v. Spence* 464 F.2d 772 (D.C. Cir. 1972)

knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in determining whether or not to forego the proposed therapy."[11]

Other than that, *Canterbury* also presents the defence of therapeutic privilege, which is an exception that allows the doctor to withhold information from his patient concerning risks of proposed treatment if it can be established by means of medical evidence that disclosure of this information would pose a serious threat of psychological harm to the patient. The reason for this is to alleviate more harm that could befall the patient.

In certain academic discussions, it was proposed that the implication of *Canterbury* is that in order for a patient successfully to argue that a physician is liable in negligence for failure to disclose information to the patient, the patient must also show that the breach of the duty by the physician actually (and proximately) caused some damage to the patient, which brings rise to the test of causation normally found as an element in negligence cases.

In *Canterbury* the court had faced the question of whether the causation test should be the subjective standard applied in all other negligence actions (would this patient have foregone this procedure if she were provided with the withheld information?) or an objective one (would a *reasonable* patient have foregone this procedure if she were provided with the withheld information?). Looking at the fact that in hindsight every person injured during a medical procedure would testify that she would have foregone the procedure if only she had access to whatever information was withheld, the court concluded that the objective rule would eliminate one of the most substantial barriers in medico-legal litigation, which is obtaining expert witness testimony and deciding between two conflicting ones.[12] Therefore the objective test had eliminated the possibility of informed consent actions arising out of most medical procedures.

An example of this is that no reasonable person with cataracts would choose to not undergo a cataract surgery if fully informed about the risks, benefits, and alternatives of the surgery because the choice to not undergo the treatment simply would not be a reasonable one. Thus, a cataract surgery cannot give rise to a negligence-based informed consent action (if the objective rule is applied), no matter what that person is (or is not) told about the procedure, because the patient will not be able to show that a reasonable person would have foregone the surgery under any circumstances, with all the information. Therefore, only truly elective procedures can give rise to a successful action. This means that although Canterbury is patient-oriented by being broad in defining its rule of duty, the success rate of the patient has been somewhat diminished with its rule of causation.

All in all, even though the *Canterbury* approach seems to be a satisfactory patient-oriented precedent, however only about half of the American jurisdictions have actually accepted it; the other half still apply the doctor-oriented test. With that being said, it can be seen how more

[11] Ibid.

[12] Jahn Kassim, Puteri Nemie. 2007. *Law And Ethics Relating To Medical Profession*. Petaling Jaya, Selangor Darul Ehsan: International Law Book Services.

advantageous the approach of *Canterbury* as compared to *Salgo* in terms of the success rate for the plaintiff/patient and in refining the doctor-patient relationship. Although there are many variations on this patient-oriented rule such as stated above, most apply the combination of the two subjective and objective tests which formed the basis of the test in *Canterbury* itself. Other than that, the existence of *Canterbury* also introduced the defence of therapeutic privilege in which the amount of disclosure of facts is not just a matter of medical judgment but also contingent upon the psychological state of the patient and whether the information will affect it.

3.2. United Kingdom

In England (henceforth referred to as the UK), the doctrine of informed consent used to have no place within English law.[13] It is believed that doctors need only to tell their patients what other doctors think, and the standard is to be based on medical judgment as well. However, in contrast to the US, what constitutes a "material risk" is not determined by the "prudent patient" test, but the "prudent doctor" test, which means that the material risk could only be assessed as material according to other doctors' opinions. This first materialised in the case of *Sidaway v Board Governors of Bethlem etc*[14]. The plaintiff had undergone an operation on her spine designed to relieve her neck, shoulder, and arm pain. The operation had carried an inherent and material risk of damage to the spinal column and nerve roots which was assessed at between 1 and 2%. The risk had materialised, leaving the plaintiff severely disabled. She had sued in negligence, claiming that the surgeon had failed to disclose or explain to her the risks involved in the operation. The majority of the court held that the question on whether an omission to warn a patient of inherent risks of proposed treatment constituted a breach of a doctor's duty of care was to be determined by applying the *Bolam* principle.

In spite of the differing opinions between the members of the majority regarding the extent of application of the *Bolam* principle, it was still held that the legal standard of disclosure was still principally judged and governed by what was a commonly accepted practice by the medical professionals. This was due to the notion that although a patient may make an unbalanced judgment if he is deprived of information, he may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training. Thus, the prudent doctor test was upheld.

In spite of that, many had called into question the appropriateness of the decision and the open-ended questions it had raised, especially in the legal fraternity.[15] However, in 2015, the principle in *Sidaway* was (to some, finally) overruled and the UK Law of Consent finally included the prudent patient test in the case of *Montgomery v Lanarkshire Health Board*[16]. In this case, the pregnant appellant had claimed that she should have been given advice about the risk of shoulder dystocia which would be involved in vaginal birth and also advice

[13] Ibid

[14] *Sidaway v Board Governors of Bethlem etc* [1985] AC 871

[15] Ian Kennedy, 'The Patient on the Clapham Omnibus' (1984) 47 Med L Rev 454

[16] *Montgomery v Lanarkshire Health Board* [2015] UKSC 1

pertaining to alternative means of delivery by caesarean section as she was diabetic. The risk was about 9-10%. During the vaginal birth, the risk materialized, and her son was born with severe disabilities. The appellant had claimed that had she been told of the risk, she would have opted for a caesarean section. Although the appellant had lost in the Court of Sessions, the outcome in the Supreme Court had represented one of the rare occasions in which a patient had succeeded in a negligence case at appellate court level.

The justification given by the physician in withholding the information from her was essentially the risks were very small and if mentioned, would merely serve to confuse the patient and open a floodgate of caesarean-only birth requests from mothers which do not overall serve the interests of the mother. This is also reminiscent of the paternalistic 'doctor knows best' culture that has been a dominant feature in English medical law. Heywood in his article[17] highlighted that the information regarding the risk in *Montgomery* was "so crucial to the mindset of the mother in determining the trajectory of her pregnancy that the failure to disclose it effectively meant that she was never afforded the opportunity to exercise her basic right of patient choice."

The presiding judges Lords Kerr and Reed had held that a doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. Much like in the cases of *Canterbury* and *Rogers*, the test of materiality declared by the judges was defined as whether, in the circumstances of a case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should be reasonably be aware that the particular patient would be likely to attach significance to it. However, it was also subjected to therapeutic privilege (which entitles a doctor to withhold information from a patient if it is reasonably considered that the disclosure would be seriously detrimental to the patient's health.). It was also established from this case that patients are no longer passive recipients in medical care.

The significance of *Montgomery* was not just in its overruling of *Sidaway* but also in its endorsement of the framing of the duty of disclosure in the Australian case of *Rogers v Whitaker* of which the facts will be discussed further in this study. By endorsing the *Rogers* approach, the Lords concurred that the test of materiality would no longer be restricted to what the reasonable person in the patient's position would consider significant but is now extended to include the notion that a risk would also be material if the doctor is or should be reasonably be aware that the *particular patient* would be likely to attach significance to it. The reason that this is significant is because it acknowledges the differing perspectives of each patient, not as just a reasonable man but a reasonable man in the *patient's position*. As per in *Montgomery*, the 'circumstances of each individual patient may affect their attitude towards a proposed form of treatment…'.

The implications of the principle laid out in *Montgomery* can be said to be disadvantageous to some. For instance, opponents of the particular patient standard might argue that under the same

[17] Heywood, Rob. 2015. "R.I.P Sidaway: Patient Oriented Disclosure - A Standard Worth Waiting For?". *Medical Law Review* 23 (3): 455-466.

limb, smaller risks that have very low percentages should then also be disclosed which means that the focus would then be moved away from the likeliness of occurrence to just the severity of the materialised risk.

In conclusion, the key difference between both *Sidaway* and *Montgomery* which has laid out the basis of the duty of disclosure is that in *Montgomery*, the duty of the doctor has been strengthened and substantiated and in doing so has increased the protection that the law offers to the patient's right to receive appropriate and adequate information prior to any medical treatment or procedures. This new test recognises that the relationship between doctor and patient has evolved such that they may have a dialogue over the patient's options, and the doctor should facilitate the patient's understanding. As mentioned by Lord Kerr and Lord Reid in *Montgomery*, 'the doctor's duty of care takes its precise content from the needs, concerns, and circumstances of the individual patients,' therefore the rights of a patient should not just be acknowledged, but also prioritised, as they are no longer passive recipients in the care of the medical profession.

3.3. Australia

In Australia, the landmark case to be discussed on the issue of informed consent and disclosure is the case of *Rogers v Whitaker*[18]. In this case, the patient, Ms Whitaker, decided to have elective surgery on her right eye, which was vision-impaired from an accident that occurred during her youth. Despite that, she had led a "substantially normal life", working, marrying and raising children. However, on having a check-up, surgery was recommended. After the surgery, certain complications had developed in the right eye, spreading to the left eye and resulting in almost total blindness. This is known as "sympathetic ophthalmia," and is a recognized risk of eye surgery. At no stage was Ms Whitaker warned of the probability of this occurring. Ms Whitaker sued in negligence on several grounds, including failure of the defendant, Dr Rogers to warn her of the risk of sympathetic ophthalmia, performing an ill-advised operation, failure to follow up missed appointments, and failure to enucleate the right eye following development of symptoms of sympathetic ophthalmia in the left eye.

Rogers had argued that the issue should be resolved by application of the Bolam Principle as applied in the UK and described in Sidaway. However, the majority High Court judges refused to apply the *Bolam* test. In their majority judgement Mason CJ, Brennan, Dawson, Toohey and McHugh JJ rejected this principle, noting that in relation to standard of care:

> *"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."*

The main reasons for the rejection of the *Bolam* principle was because firstly, the Law Lords were divided themselves about the way the *Bolam* test should be applied to evaluate the provision of medical advice. Secondly, the *Bolam* test "has

[18]*Rogers v Whitaker* [1992] HCA 58; 175 CLR 479; 23 NSWLR 600; 109 ALR 625; (1991) Aust Torts Reports 81–113

invariably been applied in English courts", but has not been so well accepted in Australia and lastly, it did not attach any significance to the patients' questions to their physicians, as under the British rule Mr Rogers would not have had to answer her questions honestly if other members of the ophthalmic surgeon brotherhood would not have done so.

Another point that could be made is that their Lordships had also felt that the decision in *Sidaway* was confusing and discordant, therefore they concluded that the *Bolam* test cannot be used to determine the scope of the doctor's duty of disclosure because there was a difference between diagnosis and treatment and the provision of advice and information. This is because in diagnosis and treatment, the patient's role is insignificant as they would only be required to narrate symptoms and relevant history of their illness to the doctor. However, in the provision of information, it merely involves communication skills, and they are not exclusive to only medical practitioners. Therefore, the High Court concluded that the scope of a doctor's duty of disclosure is "…to warn a patient of material risks inherent in the proposed treatment; a risk is material if, in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it…". Thus, it can be seen from this sole landmark case that the courts in Australia have rightfully categorised a doctor's duty into three: duty to diagnose, duty to warn, and duty to treat. However, there was still some confusion as to the application of the principle in *Rogers v Whitaker* as to whether it was only restricted to cases of negligence in duty to disclose. The case *Naxakis v Western General Hospital*[19] it was held by Gaudron J that the standard of care is not to be decided by the *Bolam* principle and that in Australia, the *Bolam* test is to be rejected for duty to treat, diagnose, and advise.

Despite the High Court's attempt to distinguish its approach from that taken by the American courts by mentioning the unsatisfactory use of the language in the cases and in particular from the approach in *Canterbury*, the legal duty described in *Rogers* is virtually identical to the patient-disclosure-oriented rule announced in *Canterbury*.[20] In *Rogers*, the law recognises that a doctor has a duty to warn the patient of a material risk inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. In *Canterbury*, it is mentioned that a risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy. It is almost verbatim.

Chalmers and Schwaltz (1993) opined that the principle derived from *Rogers* was unstable and leaves open to a number of questions as to its applicability as seen from the American jurisdictions that have adopted the same principle. That being said, the case has brought upon a number of implications. It has been

[19] *Naxakis v Western General Hospital* [1993] 73 ALJR 782
[20] Ibid. n 7

established that the duty of care is to be defined as a matter of law, and not by the professional peers of the defendant. However, questions arise as to *how* the courts are go about in making the definition and determining whether a duty has been breached in any particular case as well as the function of the judges. The High Court mentions that it will adopt the principle in the case of *F v R*[21] that what must be disclosed by the physician in any particular case "depends upon a complex of factors: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances" but how these factors are to be weighed is an issue that the courts will find themselves facing.

Next, an implication is that there is also an uncertainty over the extent of the duty to disclose - is a physician liable for failure to provide information even when a patient decides against a proposed treatment, or even when there is no treatment that has been proposed? An example is the American case of *Truman v Thomas*[22] where a physician was found negligent for failing to explain to an penniless patient the risk that was a consequence of deciding not to have a pap smear and who subsequently died of a cancer that would have been discovered earlier had she undergone this recommended procedure. An affirmative answer would bring about preventive medicine and attention to health maintenance by making those physicians who negligently fail to provide their patients with information necessary to keep themselves healthy liable for their patients' subsequent illnesses and injuries. Whether this is advantageous or not to the medical profession community is still up for debate.

On the issue of causation, although it was raised, was not a focal point in *Rogers*. Mr Rogers had argued that Ms Whitaker would have still undergone the procedure even if she were told that there was a one in 14,000 chance of sympathetic ophthalmia, while Ms Whitaker testified that "if someone had said one in a million chance, there would be no operation". However, Mr Rogers' counsel made no submission on that issue and was thus deemed to have waived the issue in the High Court. Nevertheless, both the trial court and the Court of Appeal had applied the subjective causation test that was ordinarily applied in tort cases as it was also the standard applied by the South Australia Supreme Court in *F v R* of which the judges had based their opinion for the Rogers decision. In the Court of Appeal Mahoney J.A. did not consider the nature of whether the test was subjective or objective, but in addressing the issue of causation, he found that although the failure to warn did not physically cause the sympathetic ophthalmia of the defendant, it was Mr Rogers' breach of duty to give sound advice when asked questions that was the cause of the plaintiff's decision to undergo the surgery, which ultimately caused the harm. As held by Handley J.A, the causative link provided in this case was the reliance Ms Whitaker had placed on the advice of Mr Rogers. While the Justice does not officially mention that the use of the subjective standard for causation was used, it was suggested that he assumed the test would be the subjective one as per usually used in negligence cases. This signifies that moving forward, if the High Court

[21] *F v R* (1983) 33 SASR 189

[22] *Truman v Thomas* (1980) 611 P. 2d 902 (Cal. Sup. Ct.).

decides to apply the subjective causation principle usually applied in negligence cases in regards to informed consent actions, Australian law would be considered more in favour of the plaintiffs than most other jurisdictions. Chalmers and Schwaltz (1993) also suggests that the absence of contingent fees in tort litigation, the existence of a high quality and universally accessible health care system, and the presence of a strong social safety net in Australia would not result in a barrage of informed consent cases.

In conclusion, Australia seems to have taken a far-right approach in terms of the duty to disclose in regards to informed consent. The decision of the High Court of Australia in *Rogers* to reject the English doctor-oriented test in *Sidaway* (and consequently, the *Bolam* principle) was not the first of its kind as can be seen in cases *Goode v. Nash*[23]; *Albrighton v. Royal Prince Alfred Hospital*[24]; and *F. v. R*[25]. Even though the judges had refused to use the language and justification in the formative American case of *Canterbury*, the principle adopted by the High Court was virtually identical, both applying the patient-oriented approach. Although leaving a few unanswered questions, the case of *Rogers* is instrumental in ensuring that physicians have a duty to disclose information to their patients and that this duty is independent of the duty to diagnose and treat.

3.4. Malaysia

In Malaysia the *Bolam* principle has been routinely applied by the courts to medical negligence cases in determining the physician's standard of care. Such cases include *Liew Sin Kiong v Dr Sharon M Paulraj*[26] and *Dato Dr. V. Thuraisingam v Sanmarkan A/L Ganapathy*[27] wherein the Justice had stated that if the *Bolam* test was not used, then the law would have intervened too much in the field of medical negligence, which would lead to the practice of defensive medicine, which is when a doctor is too afraid of being sued for wrongly diagnosing a patient. Nevertheless, the judge in *Kamalam a/p & Ors v Eastern Plantation Agency & Anor*[28] had stated that he was not bound by the *Bolam* principle. Similarly, in *Hong Chuan Lay v Dr Eddie Soo Fook Mun*[29] Justice James Foong departed from the *Bolam* test and followed the approach adopted in *Rogers v Whitaker* and even appraised the Australian High Court judges for their clarity, conciseness and comprehensibility in explaining the distinction between the *Bolam* test and the new approach.

Fifty years after *Bolam,* the Federal Court of Malaysia in the case of *Foo Fio Na v Dr Soo Fook Mun & Anor*[30] changed the scene for Malaysia's medico-legal community. The patient in this case suffered closed dislocation of her spine and had to undergo a surgery where the dislocated vertebrae were moved to their normal positions and secured by bone grafting and insertion of a loop of wire. The wire loop was found to cause total paralysis of the patient by pressing on the spinal cord. Although the patient signed a general consent form during admission, the patient claimed that she was not informed of the risk of paralysis from the particular surgery. The court found that

[23] *Goode v Nash* (1979) 21 S.A.S.R. 419
[24] *Albrighton v Royal Prince Alfred Hospital* (1980) 2 N.S.W.LR. 542
[25] Ibid. n 21
[26] [1996] 2 AMR 1403
[27] [2012] 3 MLJ 817
[28] [1996] 4 MLJ 674
[29] [1998] 5 CLJ 251
[30] [1999] 6 MLJ 738

the doctor was negligent in failing to inform her of the risk.

The court also decided that the *Bolam* principle should no longer be applied to a doctor's duty to disclose risks. The test in *Rogers v Whitaker*, according to the judge would be "a more appropriate and a viable test of this millennium." It was also mentioned in the Federal Court that the *Bolam* test "has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment." This goes to show that even a general consent form is meaningless if the patient is not informed of relevant risks of the procedure and that whether a particular information is relevant also depends on the point of view of the patient, and not necessarily the opinions of the doctors.

Thus, it can be said that there are two standards of care in Malaysia: in determining cases of duty to diagnose and treat, the previously mentioned *Bolam* test which was more doctor-oriented; and in cases regarding duty to disclose risks the principles underlined in *Rogers v Whitaker* would be used and would assessed in conjunction with the rule of law in *Canterbury* when it came to applying the test of materiality. The difference in application of these standards of care can be seen in more recent cases such as *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors*[31]. Although the decision was not in the plaintiff's favour, a clear distinction was brought about regarding the two standards of care that could be found in Malaysia, in regards to duty to diagnose and treat on the one hand and the duty to advise of risks on the other. Raus Sharif CJ held that:

> *"different consideration ought to apply to the duty to advise of risks as opposed to diagnosis and treatment. As decided by the Australian High Court in Rogers and followed by this Court in Foo Fio Na, it is now the courts' (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment. The courts would no longer look to what a body of respectable members of the medical profession would do as the yardstick to govern the standard of care expected in respect of the duty to advise."*

The presence of two standards of care in Malaysia and the use of two different tests brought upon various repercussions to the Malaysian healthcare system. For instance, the concept of patient autonomy triumphing over medical paternalism. With increasing public awareness in regards to patient autonomy and consumer rights, the medical profession needs to be ready to accept patients as no longer passive recipients in medical care.

In short, in my own personal opinion, there should not be a question as to which test is better as each test has been categorised into a specialised area which brings about its relativity when deciding cases. Furthermore, it widens the scope

[31] [2017] 5 MLJ 438

for Malaysian judges and to not be narrowed down to only one test to decide a case as there are a lot of precedents that could help in deciding.

3.5. Indonesia

After careful analysis of the four common law countries, we now look to Indonesia's position on this whole issue. As a country whose legal system is embedded in the civil legal system, the discussion on informed consent and the duty of disclosure will refer mainly to statutory provisions. Nonetheless, although judicial decisions are not binding, it is still important to note the case of *Muhidin* in *Sukabumi* which was a milestone in the development of the Informed Consent doctrine. Subsequent to this case, a fatwa was issued and adopted concerning Approval of Medical Measures.[32] The case involved a doctor who did not explain that one of the risks of eye surgery was that "the patient's eyes would look perforated." Muhidin sued the doctor in question.

In statutory provisions, the doctrine of informed consent in Indonesia is articulated in Law No. 36 of 2009 on Health and the Law No. 29 of 2004 on Medical Practice. It is also specifically regulated by the Health Ministerial Decree No. 290 of 2008 regarding Medical Informed Consent.[33] In Article 7b of Indonesia's official Medical Code of Ethics called the *Kode Etik Kedokteran Indonesia* (KODEKI), it states that the doctor's duty relating to information is to provide adequate and honest information to the patient about the need for the relevant medical treatment and the risks it may incur. The scope of 'information' mentioned is cross-referenced with Section 45 (3) of the Medical Practice Act 2004 which comprises diagnosis and medical treatment, the aim of the proposed treatment, alternatives of therapy and their risks, possible risks and complications, and prognosis.

This means that doctors in Indonesia are bound by codified law to expressly disclose information to the patients, which is in contrast to the countries previously mentioned above who are only bound to disclose once they consider the material risk of disclosure and the exception of therapeutic privilege. However, Indonesian law also recognizes therapeutic privilege in article 5 of the KODEKI which states "information should be provided in a complete and honest manner, unless the physician judges that the information may harm the interests or health of the patient or the patient refuses to be informed." Additionally, Indonesia law also provides that one of the hospital's obligations to the patient is to provide an explanation of what the patient suffered and what action to take. This can be found in Chapter III Article 10 of the *Kode Etik Rumah Sakit Indonesia* (KODERSI) or the hospital code of ethics. The relationship between the doctor and the patient is mostly referred to as a business relationship, between business actors and consumers[34]. As consumers, the patient has legal protection from possible negligence, and is also entitled to safety, security, and comfort to the service he receives. A patient also has a right to be heard as a consumer.

[32] Sugiarti, Ida. 2010. "Perbandingan Hukum Informed Consent Indonesia Dan Amerika Serikat". *Jurnal Ilmu Hukum UNISBA* 12 (3).

[33] Moein, Harustiati A. 2018. "Informed Consent in Indonesia". *Journal of Law, Policy And Globalization* 69: 66.

[34] Ibid.

In her article, Sugiarti (2010) mentions that a major element in the formation of informed consent or "the right to self- determination" which occurred in the US is due to the growth and progress of human rights as time goes on. She states that Indonesia, as a country with the most Muslims in the world, follows the precepts and teachings of Islam, which has differing perspectives with human rights oriented America. An example would be when the more specific regulations regarding informed consent were regulated in the Minister of Health Regulation No. 585 of 1989 concerning Approval of Medical Measures. The regulation was a doctrine imported from America which tends to promote individual human rights, which was incompatible with the culture of the Indonesian people, who cannot be separated from ties with their families, including in making decisions about health care. Due to that, a new regulation was introduced namely the Regulation of the Minister of Health of the Republic of Indonesia No. 290 / MENKES / PER / III / 2008 concerning Medical Informed Consent. The regulation states that consent must be taken after the patient has received informed explanation either via oral or written and the explanation must at least include diagnosis, prognosis, the risks and complications, the grounds of the treatment, and any alternative treatments. The relationship between health workers and patients is also regulated by criminal law. If a medical action is carried out without the patient's consent, it is considered to violate article 351 of the Penal Code.

In conclusion, it can be deduced that the laws of Indonesia pertaining to informed consent and the duty of disclosure can be found clearly in the codified laws. However, it can be said that as compared to the previous countries, the application of the laws could not really be seen clearly as there are a lack of recorded cases on the subject. However, in theory, the healthcare system in Indonesia, like all the other countries mentioned before, puts an emphasis on the rights of a patient. It is only in its implementation that we can see it is strongly influenced by the moral philosophy of the nation, based on its *Pancasila*.

4. Conclusion

Overall, this paper has discussed and compared the positions of four countries with Indonesia on the issue of informed consent with a focus on disclosure. At first, the doctrine was seen as two ends of the spectrum: the American rule or the British rule. But after the emergence of *Rogers v Whitaker* and the Australian High Court's persistence in creating their own unprecedented pathway in the legal fraternity, the doctrine of informed consent has branched into a concept that is just as relevant today. With that being said, it can also be concluded that even though the nature of each country's legal system is different and the application of the law is also not similar, each country's emphasis on the importance of the duty of disclosure by doctors towards patients is a step towards the right path in prioritising the involvement of patients in not only making decisions for their treatment, but also their right to receive information regarding their illnesses. The doctrine has also ensured that a person's rights rests with the courts, not with the medical professionals. The clear progress of society in moving away from medical paternalism to a more hands on participation in the

decision-making of their own health care reinforces the notion that patients are masters of their own destiny, not the doctors. After all, the central figure of consent is one's own self.

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