PATIENT RIGHTS IN MALAYSIA – WHAT'S NEW ON THIS BUMPY RIDE?

By
Professor Norchaya Talib
Faculty of Law
University of Malaya
Kuala Lumpur
Malaysia
Email: norchaya@um.edu.my

Introduction

It is no surprise that generally in a doctor-patient relationship, the dynamics has always been that the doctor retains the upper hand and the patient at the same time willingly allows for this or even that he wants it to be that way. Perhaps this might be explained by the fact that the patient, when presenting himself at the doctor's surgery, is hoping and therefore trusting the doctor's professional judgment so as to be able to identify and diagnose what is ailing him, and then accordingly treat him so that his health is restored. This trust is what underlies the doctor-patient relationship.

The Law and Doctor-Patient Relationship

That there exists a duty of care between doctor and patient has long been the accepted law. Although the principle governing the standard of care is set by the law, in that doctors are expected to act in accordance with the skill of the reasonable and competent practitioner in the specialty, in practice it is determinable by the medical profession as the defendant doctor will be judged in accordance with what is deemed as acceptable professional conduct by his peers. The case from which this principle is derived is *Bolam v Friern Hospital Management Committee.*[1]

(It is now accepted that a physician's duty may be divided into three different aspects, that of arriving at a diagnosis, prescribing treatment and providing information and advice prior to (particularly) invasive treatment. Whereas the *Bolam* test prescribes that the standard to be applied is to be judged by the medical profession itself in all three aspects, case law in Canada and Australia indicate that in the provision of information and advice the standard applied should be one which is different from *Bolam*, measured from the patient's perspective and not from the medical perspective.)

This however changed on 29 December 2006, when the highest court in Malaysia, the Federal Court, delivered its long-awaited decision on the applicability of the *Bolam* principle in medical negligence cases.

The Question of Law

The Federal Court in the case of *Foo Fio Na v Dr Soo Fook Mun & Anor*[2] was to consider the following question of law - whether the *Bolam* test should apply in relation to all aspects of medical negligence. In this case, the particular aspect of medical negligence relates specifically to the duty and standard of care of a medical practitioner in providing information and advice to a patient on the inherent or material risks of the proposed treatment.

The Facts of Foo Fio Na

Miss Foo Fio Na the plaintiff sued Dr Soo Fook Mun (the second defendant) and Assunta Hospital (the hospital) alleging medical negligence on the part of the doctor while performing surgery on her which resulted in her paralysis.

On 11 July 1982 Miss Foo, who was then 24 years old and working as a clerk-cum-typist, together with two others, went out for supper in a car. The car collided into a tree. Post-collision, the plaintiff got out of the car and assisted her boyfriend and his sister out of the car. They then received help from some people and were taken to a nearby hospital (Assunta Hospital). At the entrance to the hospital the plaintiff got out from the car unaided and walked into the emergency room of the hospital.

A series of X-rays were taken after which she was admitted and warded. At that time, she was able to move her body and limbs although she did feel some pain at the neck. The plaintiff asserted that the defendant doctor (the second defendant) only came to see her for the first time the next morning (or afternoon) and after examining her, informed her that she had dislocated two of her neck bones. He informed her that the injury was minor and she was to rest in bed. A cervical collar was placed around her neck in order to contain the pain and the defendant doctor had also ordered

---

[1] [1957] 2 All ER 118.

[2] [2007] 1 MLJ 593.

traction to be done for two days. At the end of the two days the defendant doctor decided that the treatment was unsuccessful. It is pertinent to note that at that stage, the plaintiff was still able to move her body and limbs.

Thereafter, the defendant doctor tried close manipulation which also proved to be unsuccessful. He then recommended surgery. According to the plaintiff the defendant doctor did not explain the risks of the surgery, despite her asking about the dangers of the surgery should anything untoward happen to her. She claimed that the defendant doctor assured her that the procedure would be a minor and simple one. On this assurance, she consented to the operation (first operation).

The plaintiff was completely paralysed after this first operation. The defendant doctor informed the plaintiff that the paralysis was temporary and that she would recover in two weeks' time. After two weeks one Dr M, a neurosurgeon performed a myelogram test on the plaintiff in the presence of the defendant doctor. The plaintiff alleged that neither of the doctors explained to her why the test was carried out after which she was taken to the operating theatre and underwent another operation (second operation) performed by the defendant doctor. The plaintiff further contended that no explanation was given to her as to the reason for the second operation and that she never gave her consent for the operation. However, after the second operation she was able to move her hands. The defendant doctor assured her that her bones had been stabilized and that the paralysis would only last for about a month. Eleven months later the plaintiff's condition had not changed and she discharged herself.

The plaintiff claimed that after discharging herself from the hospital she had gone to see Dr M who had explained to her that the myelogram test which he had conducted revealed that the wire which was placed to correct her dislocated bones during the first operation was pressuring the spinal cord and that was the cause of the total paralysis. Consequently the second operation was necessary.

The case for the defendants was that the injuries suffered by the plaintiff came from the motor accident, and that the neck pains if unattended would have led to paralysis at some later stage, thus necessitating the first operation. The defendant doctor maintained that the plaintiff had given her consent for both operations and denied that there was any wire pressuring on the spinal cord as claimed by the plaintiff.

It was the plaintiff's case that although she gave her consent for the first operation, she was unaware of the risks as they were not explained to her by the doctor. She had given her consent as the doctor had informed her that it was a simple and minor procedure, and that had she been aware that it was a major surgery with high risks, she would not have consented. For the second operation, the plaintiff said she never gave her consent and did not know of the purpose of the operation.

The Findings of the High Court

The court found that the plaintiff had indeed signed a consent form upon admission. That was the standard admission form. This general consent was found to be not effective for the purposes of the first operation as at the time of signing the consent form, it was not known whether there was any necessity for the plaintiff to undergo an operation as the progress of the conservative treatments were not known. So an explanation of the procedure and any attendant risks ought to have been disclosed to the plaintiff. She was not told of the risk of paralysis. This failure by the defendant doctor showed that the prior consent which had been obtained, was not properly obtained.

The court also noted the fact that the plaintiff was not paralysed before the first operation and that the defendant doctor had contributed in causing the plaintiff's paralysis.

With regards to the second operation, there was a consent form duly signed by the plaintiff on the material date, in the form of her thumbprint. The court raised the question of how the plaintiff could have affixed the thumbprint herself as she was on that date totally paralysed. Thus the court found that the defendant doctor could not discharge the burden of proving the consent was given voluntarily.

The doctor was therefore negligent for the following acts and omissions - in tying the wire loop which caused compression to the spinal cord which led to the paralysis, in not doing anything immediately after the discovery of the paralysis to remedy it, having performed the laminectomy (or re-exploration, that is, the second operation) in the absence of the consultant who had pointed out the cause of the paralysis, and finally for failure to conduct the conservative treatments properly and sufficiently before the first operation, as proper administration would have meant applying the conservative treatments for a considerable period of time which could have meant several months, in order to produce any result. There was no necessity for the second defendant to do the open reduction within such a short period as there was no risk of paralysis setting in immediately.

Applying the principle in the case of *Christopher Rogers v Maree Lynett Whitaker*[3] the court held that it is for the court to decide on a doctor's negligence after weighing the standard of skills practiced by the relevant profession or trade, taking into account the fact that a person is entitled to make his own decision about his life. What is expected of a doctor is that he has given a fair and reasonable standard of care and skill expected of an ordinary competent medical practitioner as held by the Federal Court in the case of *Kow Nan Seng v Nagamah*[4]. The determination of whether a

[3] [1993] 1 CLJ 449.

[4] [1982] 1 MLJ 128.

doctor is negligent or not is for the court to consider, based entirely on the evidence of each case. Therefore, even though the normal or standard practice is followed a doctor may still be liable for negligence if something adverse were to take place subsequently, such as lack of proper observations during follow-up treatments.

The Case Against the First Defendant (The Hospital)

The hospital denied that the doctor was a servant or agent of the hospital, and so it disclaimed responsibility for the negligent act of the doctor. However the evidence showed that the defendant was in the employment of the hospital. Relying on the case of *Cassidy v Ministry of Health*[5] in relation to the selection of either hospital or doctor by the patient in order to determine liability, it was shown that the plaintiff sought treatment from the hospital rather than the defendant doctor specifically to attend to her. It was the hospital which assigned the defendant doctor to treat the plaintiff. Consequently, the defendant doctor was deemed to be a servant of the hospital and it was accordingly found to be vicariously liable for the wrongful act of the defendant doctor.

Damages

The plaintiff is a quadriplegic and is unable to do things for herself. RM180,000 was awarded as general damages and RM 315,462.97 as special damages.

The Findings of the Court of Appeal

The defendant doctor appealed to the Court of Appeal. In its judgment in the case of *Dr Soo Fook Mun v Foo Fio Na*[6], the Court of Appeal held that this was a case revolving around the issue of causation. The evidence showed that the cause of the plaintiff's paralysis was uncertain and so the plaintiff never discharged the burden of proof. Furthermore, despite the fact that there have been challenges to the *Bolam* test as being the determinative test in relation to the standard of care in a medical negligence action, the *Bolam* test does strike a fair balance between law and medicine and already places a high threshold for a plaintiff to cross in an action for medical negligence, and to change this would only lead to defensive medicine.[7] The Court of Appeal set aside the orders of the High Court.

The Plaintiff Appealed to the Federal Court

The Federal Court's Decision

The Federal Court drew distinctions between the facts of *Bolam* and the instant case as follows:

Firstly, Bolam was a mental patient unlike the plaintiff Foo Fio Na who was a mentally competent adult, secondly even if Bolam was warned of the risks of the treatment given to him, it would be doubtful whether he could comprehend the true nature of the risks involved, as compared to the plaintiff Foo Fio Na, who would be in a position to understand the risks and to give her consent, thirdly the risk of injury in Bolam's case was one in ten thousand whereas in the instant case the risk of paralysis was present and real, and fourthly in Bolam's case there was a conflicting body of medical opinion as to whether a warning ought to have been given. This was not the case here.

The Federal Court noted that although the *Bolam* principle has been adopted in many Malaysian cases, the opposing principle in the Australian case of *Rogers v Whitaker*[8] has also been applied in local decisions. Whereas under the *Bolam* test responsible medical judgment would set the standard and be the determinant of whether the defendant doctor has met the required standard of care, the *Whitaker* test does not necessarily accept that the final determination of a doctor's standard of care lies in the hands of the medical profession. It requires that that standard meets the standard of reasonableness imposed by the law.[9]

The court stated that if it can be shown that the professional opinion relied upon was not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion was not reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. However the court needs to be satisfied that in

---

[5] [1951] 1 All ER 574.

[6] [2001] 2 MLJ 201.

[7] The Court of Appeal also held the following - that there were procedural unfairness and oppression in the handling of the case by the High Court, that the defendant doctor and the hospital suffered serious prejudice during trial as there were unpleaded charges of negligence, and that there was a long delay (four years) before the High Court delivered judgment, which had the impact of lessening the weight of the views of the trial judge.

[8] [1992] 175 CLR 479.

[9] This test, like the *Bolam test*, has also been followed in some local decisions such as *Kamalam v Eastern Plantation Agency (Johore)* [1996] 4 MLJ 674 and *Tan Ah Kau v The Government of Malaysia* [1997] 2 AMR 1382.

forming those views, assessment of the relative as well as comparative risks and benefits of adopting a particular medical practice, has been weighed by the experts.

Thus it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the consideration that a person is entitled to make his own decisions about his life.

Having considered the development of the law in this area the Federal Court held that '...we are of the view that the *Rogers v Whitaker* test would be more appropriate and a viable test of this millennium than the *Bolam test*...[10]

The *Bolam* test is therefore no longer applicable to a medical practitioner in the context of the provision of advice to a patient on the inherent and material risks of the proposed treatment. The medical practitioner is duty-bound by law to inform his patient ***who is capable of understanding and appreciating such information of the risks involved in the proposed treatment*** (emphasis added). This is to enable the patient to make a decision as to whether to proceed with the proposed treatment, or refuse to be subjected to such treatment.

The two tests and early decisions adopting **Bolam** and **Whitaker.**

Perhaps the starting point should be a comparison between the two tests. The *Bolam* test reads as follows –

> *...that where you get the situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest skill at the risk of being found negligent...it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.*[11]

And later,

> *...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...*

Under the *Bolam* test it is clear that the standard of care of doctors is judged by the medical profession itself.

The *Bolam* test was adopted and followed in Malaysia as early as 1964 in the case of *Chin Keow v Government of the Federation of Malaya & Anor.*[12] Subsequent medical negligence cases too applied the same test and standard when assessing a defendant doctor's standard of practice. The Court of Appeal in *Foo Fio Na's* case itself in 2001 applied the *Bolam* test and found the defendant doctor not negligent. Other cases later than this also adopted the *Bolam* test.[13] It is a fair conclusion to say that prior to this latest Federal Court decision, that the *Bolam* test was the authority for determining the standard of care of medical practitioners in Malaysia.

The *Whitaker* test on the other hand, reads as follows:

> *The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"...*
>
> *...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...particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and... the principle is 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".*
>
> *...The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular*

---

[10] [2007] 1 MLJ 593 at p 611.

[11] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at ???, (QBD).

[12] (1964) 30 MLJ 322.

[13] See *Asiah bte Kamsah v Dr Rajinder Singh & Ors* [2002] 1 MLJ 484 and *Hor Sai Hong v University Hospital & Anor* [2002] 5 MLJ 167.

patient, if warned of the risk, would be likely to attach significance to it. ***This duty is subject to the therapeutic privilege.*** *(emphasis added)*

Thus under the *Whitaker* test it is clear that ultimately it is for the courts to determine whether the doctor has acted reasonably despite having acted in accordance with responsible professional practice.

The *Whitaker* test was first adopted in Malaysia in the case of *Tan Ah Kau v The Government of Malaysia.*[14] The plaintiff was suffering from pain in his back and had walking difficulties. He sought treatment at the defendant hospital where a few physicians attended to him. One of them advised him to undergo an operation which he did. However his spinal cord was damaged during surgery and the plaintiff became paralysed from the waist downwards. He sued the defendant hospital for negligence, one of the grounds being for failure to inform him of the risk of paralysis of the surgery. The court found that the plaintiff had signed blank consent forms and as such no consent had been obtained from him. Even if consent had been obtained, the content of the consent was never fully and comprehensively explained to the plaintiff. Applying *Rogers v Whitaker* the court adopted the principle that it is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant, and that a risk which entails a duty to warn is one which is foreseeable and real but not one which is far-fetched or fanciful.[15] In the instant case the risk of paralysis was real and it was essential for the surgeon to have warned the plaintiff of this foreseeable risk. The defendant hospital was accordingly found liable in negligence.[16]

Then in *Kamalam a/p Rahman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor*[17] the High Court applied the *Whitaker* test in a claim for negligence in diagnosis, and found the doctor liable; and stated 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. That standard of care however, 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 ultimate question is whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community. In the instant case, the doctor concerned was found to have failed in his duty to admit the patient into hospital when the plaintiff/deceased required it. The court held that the non-hospitalization caused and contributed to his death.

Hong Chuan Lay v Dr Eddie Soo Fook Mun[18] was a case in which the surgeon involved was alleged to be negligent in his diagnosis as well as for the failure to inform the patient of the risk of paralysis. The plaintiff in this case underwent four separate operations within a period of five years to cure the numbness in his fingers. At the end of these operations he was left with weakness in one hand and both legs, and was unable to stand unaided. He was also suffering from lack of urinary and bowel control. He sued the defendant the first surgeon, in failing to diagnose, treat and advise him on the first operation, contending that it was this first operation which has caused him his final condition. The first surgeon had operated on his cervical spine and for a brief period post-surgery he suffered from paralysis of both his upper and lower limbs as well as incontinence. On the issue of negligent diagnosis the court applied the *Bolam* test and found that the defendant was not negligent as another expert would also have made the same diagnosis. The allegation of negligence with regard to treatment was also dismissed on the *Bolam* test as the evidence showed that the defendant had reached the standard of care of a skilled and competent orthopaedic surgeon in similar circumstances.

With regard to the failure to inform him of the inherent risk in the operation, the defendant was found to have met the required standard following the *Whitaker* test. The court stated that in the provision of advice and information it is the court rather than a body of medical opinion which should judge the issue. A doctor has a duty to warn a patient of a material risk inherent in the proposed treatment and a risk is material if a reasonable person in the patient's position if warned of the risk, would be likely to attach significance to it, of if a practitioner should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is however, subject to the therapeutic privilege.

Thus the duty to warn arises from the patient's right to know of material risks and not from conforming to standard medical practice.

However, despite the (albeit short) flow of decisions supporting *Whitaker*, *Bolam* was not quite permanently shelved. In *Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors*[19] the plaintiff underwent three procedures to his right eye which was hit with a foreign object while he was cutting grass. The eye could not be saved and he lost it. The

---

[14] [1995] MLJU 183, [1997] 2 CLJ Supp 168.

[15] [1997] 2 CLJ Supp 168 at 187 para g.

[16] Damages however was assessed at 80% as the plaintiff had discharged himself against medical advise, which contributed to his pain and suffering.

[17] [1996] 4 MLJ 674.

[18] [1998] 7 MLJ 481 affirmed in [2006] 2 MLJ 218(CA).

[19] [2001] 3 MLJ 725.

plaintiff then filed an action against the two eye specialists, the hospital director and the government of Malaysia as the employer of the three parties. The court found that the specialists had acted professionally and were not liable in negligence. The court relied on the principle in *Bolam* in deciding that not only had the specialists acted within the parameters of what ordinary skilled professionals would have done, but that a mere failure to give a warning about the treatment which the first and second specialists had carried out on the plaintiff was not negligence per se. It was found that the plaintiff had been given sufficient warning of the risk before the treatment was carried out. The duty to warn arises when the risk is real and foreseeable but not 'far-fetched or fanciful'.[20] The allegation that there was negligence in their failure to send the plaintiff to another hospital was also rejected, as there was no proof that sending him to another hospital could have saved his eye. In this case the court acknowledged the duty to warn but decided that the discharge of that duty is to be determined by responsible medical practice and not by the reasonable patient test.

Where to, From Here?

The law as it is now is that doctors have to duty to provide information and advice with regard to inherent risks in the proposed treatment. This is not new and arguably has been part of the comprehensive duty which doctors owe to patients in any case. What is different is the perspective from which the standard of care as practiced is judged. Whereas before the *Foo Fio Na* case the standard is measured through accepted practice within the medical profession, since this decision of the Federal Court the standard is one of reasonableness, which is imposed by the law.

On the surface, it does seem that a major change has taken place. However in order to be more certain, perhaps the principle underlying the legal principle requiring disclosure might be reexamined.

The Underlying Rationale and Objective

The patient must be given information and advice so that he may weigh the whole circumstances including the risks and potential benefits of proceeding with or refusing the proposed procedure. This in turn rests on the principle that due regard must be given to patient autonomy. What information is to be given depends on the facts of each case.

Patient autonomy and correspondingly the right to be given information are not absolute rights because of the therapeutic privilege exception. This exception in fact allows for the retention of information by the doctor. However, whether it is autonomy or therapeutic privilege that should take priority at any one time, the constant in this interplay between the two seemingly opposing interests is that the doctor is to act in the best interest of the patient at all times (the patient of course, acts in his (perceived) best interests too). So does it really matter whether a doctor has to give some information because the patient would want to know of certain risks, or that the doctor withholds information because to disclose would cause distress to the patient and he might not consent to what is clearly a beneficial procedure? I argue not. It should not matter as long as it is the best interests of the patient which underlies and forms the foundation of this exchange of information between doctor and patient.

Conclusion

In *Chester v Afshar*[21] the House of Lords held that the law which imposed the duty to warn on the doctor had at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. The function of the law was to enable rights to be vindicated and to provide remedies when the duties had been breached. Unless that was done, the duty would be a hollow one, stripped of practical force and devoid of all content. It would have lost its ability to protect the patient and thus to fulfil the purpose for which it is brought into existence.

The doctor-patient relationship is not made out on just the provision of information and advice. It also involves diagnosis and so, appropriate treatment. In fact this is the aspect of duty which comes into play in most situations of medico-legal disputes. The patient does not really expect to be involved in the decision-making here. It is more a situation of one way reliance and trust – the patient relying upon and trusting the doctor to be skilled and competent enough to arrive at the correct diagnosis and to pursue curative treatment in his (the patient's) best interests. This is measured by responsible medical acceptance, as it should be. In the context of the provision of advice and information particularly in invasive procedures, one probable immediate reaction to the *Foo Fio Na* case is the feeling that patients are no longer relying and trusting their doctor. Even if this might be true of a selected few cases, whether justifiably or not, it should not be understood as the overall thrust of the decision.

In *Payremalu A/L Veerappan v Dr Amarjeet Kaur & Ors*[22] the learned judge made the observation that "...it would be sad if doctors just for the purpose of preventing themselves from being sued would thrust to a patient every possible risk, however remote and which may arguably include death, associated with a surgery with the result that the patient would rather not undergo an operation...."

---

[20] citing *Wyong Shire Council v Shirt* (1980) 146 CLR 40, which was adopted in *Rogers v Whitaker*.

[21] [2004] 4 All ER 587.

[22] [2001] 3 MLJ 725 at 744.

I advance the argument that this decision in *Foo Fio Na* should transcend the negative implications that are immediately obvious such as defensive medicine and the like, and should reach a higher level of human intercourse and in this case, the doctor-patient relationship. I believe this case may be viewed as a reminder of the concepts of respect and trust. The patient in this day and age, who would respect and trust the doctor for otherwise why would he seek treatment from that doctor; now wants to know what is intended to be done to his body. He would also like to know what the chances are of anything going wrong and what that might be and how it would impact on his life post-surgery. He might have other concerns and other worries. He would want to ask the doctor whether the intended procedure would have anything to do with these concerns of his. The doctor is the only one who can answer these questions. So it is because of the reliance and the trust and respect that the patient has of his doctor that he needs to know the answers to these questions from that doctor. The doctor who respects his patient and who wishes to sustain his patient's trust in him would want to involve the patient at every stage of the treatment.

Lord Steyn in *Chester v Afshar*[23] stated that the requirement for the doctor to warn his patients of risks tends to fulfil two purposes. The first is to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. Secondly it is to ensure that due respect is given to the autonomy and dignity of each patient. The explanation of these two concepts were given by Professor Ronald Dworkin in his work: Life's Dominion: An Argument about Abortion and Euthanasia (1993) at p 224 as follows:

> *'The most plausible [account] emphasizes the integrity rather than the welfare of the choosing agent; the value of autonomy, on this view, derives from the capacity it protects: the capacity to express one's own character-values, commitments, convictions, and critical as well as experiential interests-in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent-but, in any case, distinctive-personality. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.'*

The development of the law is merely reflective of the ever-growing strength of the concept of individual rights and in this context, patient rights. Individual rights has always been in the equation but in the past it was determinable from the perspective of the medical profession and only now the patient is recognized as being entitled to be given a bigger say on the issue. The shift from medical paternalism to individual autonomy should not be misused as a weapon of destruction of the doctor-patient relationship.

So what's new in this development of the law? Nothing, really. The fundamentals remain the same. What might be considered different but not new, is the call for a reexamination of the balancing of these values in the discharge of professional duties. And if proof must be given that the medical profession is *still* accorded reliance, trust and respect, it lies in the therapeutic privilege exception.

---

[23] See note 21 at para 18.