Asia Pacific Journal of Health Law & Ethics
Vol.12 No.3, July 2019, pp.1-32

Informed Consent in Thailand: What Standard Is It? Which One Should It Be?

Khajorndej Direksoonthorn*

Abstract

The concept of informed consent has long been observed in the Thai medical community. However, an appropriate standard prescribing a physician's duty to disclose medical information has never been comprehensively discussed in Thailand. Moreover, to the best of my knowledge, the Supreme Court of Thailand has never decided any case where a party claims informed consent as a cause of action either. This paper seeks to fill that gap. I also anticipate that this kind of cause of action will definitely be the disputed issue for the Supreme Court to decide in the foreseeable future.

In this paper, I provide the analysis of the current statute governing informed consent in Thailand. More importantly, I argue that the appropriate standard of disclosure for Thailand should be the professional or physician-based standard. The physician has a duty to disclose only the information other reasonable physicians would reveal to their patients in similar circumstances. For Thailand, this standard is more suitable than the patient-centered standard in terms of both cultural and legal contexts. The standard can effectively safeguard the patient autonomy as well as work to his/her advantage in litigation. The U.S. doctrine of informed consent is comparatively discussed throughout the paper.

Keywords: Informed Consent, Standard of Disclosure, Standard of Causation, Standard for Disclosure, Comparative Informed Consent, Informed Consent in Thailand

I. The Concept of Informed Consent in Thailand

The doctrine of informed consent is integral to the physician-patient relationship. Before providing medical treatments or performing medical procedures, it is necessary that doctors obtain consent from their patients. Historically, such consent was a simple one; that is, provided that patients

* Judge of the Office of the President of the Supreme Court, Office of the Judiciary, Thailand; LL.M. Harvard University; LL.M. Assumption University, Thailand; M.D. Chulalongkorn University, Thailand; khajorndej.d@coj.go.th

merely learned of the basic nature of treatments or procedures and gave their consent, such consent would satisfy the legal duty of physicians. When the society has evolved, the simple consent then appeared inappropriate. Modern society has imposed on the physician the duty of additional disclosure regarding the risks associated with suggested treatment or procedure, the alternatives to that treatment/procedure and its relevant risks, and the consequences of undergoing or not undergoing such treatment/procedure. Such disclosure helps the patient decide what to be done to his body, and it has been widely accepted that it is the patient's authority to make such decision, not the physician's authority.

It was not until 2007 that the doctrine of informed consent was formally established in the Thai legal system. It is generally agreed, however, that the informed consent in Thailand had been respected by the physician for a long time before that. This doctrine has been incorporated in the teaching of medical ethics, and has been deemed as part of the right of bodily integrity enshrined in several Thai constitutions.[1] It can be said that the doctrine is one of the fundamental customs of medical practice in Thailand.[2] In 1998, the Medical Council of Thailand, which is the professional organization whose function is to oversee the medical practice, together with other health care professional organizations declared the right of the patient, one essential constituent of which is the right for patients to obtain sufficient health information before consenting to the medical treatment. Then it was in 2007 that the National Health Act, B.E. 2550 (2007) was promulgated, which officially established the doctrine of informed consent in the Thai statute for the first time.

It is said in section 8 of that act, "In providing health service, a public health personnel shall provide health information in connection with the service to the service receiver as adequately as to decide the proper choice of service. In case he or she refuses to receive service, no person shall

---

[1] Section 28 of the current Constitution of Thailand (2017).

[2] Sakda Sathirareuangchai (ศักดา สถิรเรืองชัย), *Informed Consent in General Practice (ความยินยอมที่ได้รับการบอกกล่าวในเวชปฏิบัติทั่วไป)*, 7 Vejabuntuk Siriraj (เวชบันทึกศิริราช) [Siriraj Med. Bull.] 30, 31 (2014).

provide service to him or her." After the promulgation of the Act, no ascertainable court cases regarding the standard of disclosure that indicates the physician's duty to provide health information to her patients have occurred. No comprehensive discussion or analysis concerning the standard of disclosure has been documented in Thailand either. However, some scholars opine that Thailand has adopted the reasonable patient or patient-centered standard.[3] Although I believe that the statutory provision leaves the room for interpretation of the disclosure standard from the viewpoint of the physician, I propose that there should be the clarification in the statute concerning which standard Thailand decided to adopt. I also propose that the professional standard to be the suitable standard for Thailand and should be adopted. This paper will revolve around that argument and use the experiences of the United States as a vital part of discussion.

II. The Doctrine of Informed Consent in the United States

I will next discuss the doctrine of informed consent in the United States, particularly with respect to the standards of disclosure and causation. This is not only because the doctrine is highly developed in the United States, but also because Thailand derives this concept from the United States. This is clearly evidenced by the literal translation of "informed consent" into the Thai language, which is, "ความยนิยอมทไี่ดร้บัการบอกกลา่ว." Here, ทไี่ดร้บัการบอกกลา่ว means "informed."

1. The Principle and Development of the Doctrine of Informed Consent in the United States

The doctrine of informed consent is rooted in the patient's right of autonomy and self-determination. In the past, the doctor was the one who

[3] *See* Nopporn Pothirangsiyakorn (นพพร โพธิรังสิยากร), Patadkadeepat (ผ่าตัดคดีแพทย์) [Dissection of Medical Malpractice CAses] 95 (2017).

possessed and controlled all the medical information other than the basic data of the patient and was the only one who decided whether to disclose that information, how to reveal it, and the extent to which she would disclose it to the patient. The concept of "Doctor knows best" and medical paternalism is clearly shown in the Hippocratic oath, which is a vow a new comer in the medical profession makes before serving society as a physician. In fact, the fundamental duty of the doctor corresponds with the oath in that the doctor must take the well-being and benefit of the patient into consideration in every occasion. The beneficence doctrine often conflicts with the patient autonomy, especially when the patient refuses the treatment the doctor considered most beneficial to him or her. These contending concepts have engendered many difficult dilemmas in the medical practice and ethics. There is a good reason for the doctor to maintain her duty, which is to provide the most beneficial treatment for the patient. It is also true that the doctor possesses more theoretical and practical knowledge than the patient. However, patients are also entitled to all rights to choose her own destiny, no matter it is considered foolish, unreasonable or ungrounded decision by others. These competing notions have been discussed extensively and deeply over the past decades. Some contends that the principle of beneficence urges the physician to promote welfare whose goal is consistent with respecting patient autonomy.[4] Besides, Jay Katz, a physician who is also a scholar on the informed consent, argues that the beneficence principle "requires physicians to enhance patients' capacities to arrive at the best autonomous choices they are capable of making by clearly and respectfully providing them with the information they need."[5] Generally speaking, the principle of patient autonomy appears to prevail although striking a balance between two principles is often essential to the everyday medical practice and case analysis in court.

---

[4] *See* Lewis Vaughn, Bioethics: Principles, Issues, and Cases 196 (3d ed. 2017).

[5] Jay Katz, *Informed Consent - Must It Remain a Fairy Tale*, 10 J. Contemp. Health L. & Pol'y 69, 86 (1994).

The doctrine of informed consent has been shaped by the judiciary and developed out of "strong judicial deference toward individual autonomy."[6] This doctrine is also the powerful legal tool employed to ameliorate the "imbalance of power" and knowledge between the physician and the patient.[7] Nowadays the typical informed consent claim lies with the negligence claim in tort; only Pennsylvania still deploys the battery claim (intentional tort) when the physician failed to obtain the informed consent before performing a surgery.[8] In fact, changing a cause of action for informed consent claim from battery to negligence derived in part from the court's concern for the physician's liability. Negligence offers more defenses for the physician and is more onerous for the patient to prove.[9]

The principle of patient autonomy, which includes the right of self-determination, is so aptly and well said by Justice Cardozo in the 1914 U.S. case that it deserves a lengthy quotation:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.[10]

Nevertheless, Salgo became the first case to coin the term "informed consent"[11] and extend the physician duty to obtain the patient's merely simple consent to the consent after the physician discloses sufficient information. The court in Salgo held that, "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to

---

6 Barry R. Furrow et al., Health Law: Cases, Materials and Problems 132 (8th ed. 2018).

7 Mark A. Hall et al., Medical Liability and Treatment Relationships 194 (4th ed. 2018).

8 Barry R. Furrow et al., Health Law 122 (3d ed. 2015). The battery claim is still be a cause of action under such circumstances as no consent obtained at all and so forth. *See* Hall et al., *supra* note 7, at 215.

9 Evelyn M. Tenenbaum, *Revitalizing Informed Consent and Protecting Patient Autonomy: An Appeal to Abandon Objective Causation*, 64 Okla. L. Rev. 697, 708 (2012).

10 Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y. 1914).

11 Jessica W. Berg et al., Informed Consent: Legal Theory and Clinical Practice 44 (2d ed. 2001).

the proposed treatment."[12] The court adopted the informed consent language verbatim from the amicus brief submitted by the American College of Surgeons.[13] After Salgo, physicians in all states in the United States have been obligated to obtain informed consent from the patients either by common law or statute.[14]

2. The Standards of Disclosure: The Duty to Disclose Health Information Viewed from Different Perspectives

With regard to the elements of disclosure that the physician needs to tell the patient in order to obtain the informed consent, the doctor has to disclose diagnosis and prognosis, nature and purpose of the proposed treatment, risks of the treatment, treatment alternatives, consequences of patient refusal of tests or treatments, and the tradeoffs of treatment versus watchful waiting.[15] The aforementioned are the elements of conventional disclosure related to medical facts; however, courts and legal scholars have been inclined to extend the disclosure to other unconventional elements including financial interests and specific characteristics of physicians.[16] In this paper, I will focus only on the disclosure of the conventional elements which are directly associated with medical risks.

There are at least two standards of disclosure that determine the scope of disclosure. The first standard is the professional or malpractice standard. In Natanson v. Kline the court ruled, "the duty of the physician to disclose is limited to those disclosures which a reasonable medical practitioner

---

[12] Salgo v. Leland Stanford Jr. Board of Trustees, 317 P.2d 170, 181 (Cal. Ct. App. 1957).

[13] Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 Am. J.L. & Med. 429, 440 (2006).

[14] Tenenbaum, *supra* note 9, at 706.

[15] Furrow et al., *supra* note 6, at 143.

[16] *See* Nadia N. Sawicki, *Modernized Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. Ill. L. Rev. 821 (2016); Marc D. Ginsberg, *Informed Consent: No Longer Just What the Doctor Ordered? Revisited*, 52 Akron L. Rev. 49 (2019); Marc D. Ginsberg, *No Longer Just What the Doctor Ordered - The Contributions of Medical Associations and Courts to a More Patient Friendly Doctrine*, 15 Mich. St. U. J. Med. & L. 17 (2010).

would make under the same or similar circumstances."[17] This standard is currently employed by 23 states in the United States.[18] Twelve years after Natanson, the court in Canterbury v. Spence[19] expressed unwillingness to give deference to the medical community in setting its own standard for disclosure, and established the material risk or patient-based standard. Under this standard, the doctor is required to disclose all information material to the patient's need. "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."[20] The court in Canterbury was still afraid that the new standard would cause the physician unwarranted burden and liability from the idiosyncrasies of individual patients; therefore, the new objective standard was set from the perspective of the reasonable patient, not from the individual patient. Only the Oklahoma and West Virginia state courts have adopted the subjective patient-based standard that requires the physician to divulge the material risks of the treatment unique to the specific (regardless of whether reasonable or unreasonable) patient.[21]

There has been much discussion about advantages and disadvantages of those standards. The professional standard is the first standard that the U.S. courts adopted by deferring to the customary practices set by the medical community. This standard in informed consent cases also corresponds with the standard the courts use as a benchmark in medical malpractice cases. Many people believe that the doctor is the one who should intelligently determine which medically related risks and alternatives to the proposed treatment are those that the patient regards (or should meaningfully regard) as significant. If the doctor were to disclose all possible risks and

---

17 Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960).

18 David M. Studdert et al., *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. Empirical Legal Stud. 103, 105 (2007).

19 Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

20 *Id.* at 787.

21 Anthony Szczygiel, *Beyond Informed Consent*, 21 Ohio N.U. L. Rev. 171, 193 (1994).

alternatives to the offered treatment regardless of how trivial or negligible they are, it would, if not infeasible, be too onerous to the doctor. The time wasted in disclosing all such information should be devoted to diagnosing and treating the patient, the procedures that prove more helpful to the patient as well. In addition, the doctor should not be supposed to be the crystal gazer who is able to know the infinitely varied informational need of the patient.

However, many contend that the professional standard is inappropriate for the informed consent cases. The doctor's duty to reveal the risks or the alternative treatment as well as the patient's need for such information is not directly related to medical science, so the standard employed in malpractice cases is not necessarily adopted in the informed consent litigation. Adopting the standard regarding the informational need of the patient solely set by the medical community effectively reflects medical paternalism, depreciating the autonomy and the right to self-determination of the patient. What is more, allowing the doctor to determine which information should be divulged is also prone to the conspiracy of silence; that is, no doctors are willing to disclose certain information that may lead the patients to forgo the treatment preferred by their doctors, possibly just by reason of the doctors' convenience. The material risk or patient-based standard is therefore more appropriate. Many European countries as well as roughly half the jurisdictions in the United States have adopted this standard of disclosure.

With regard to the situation in Thailand, as the right of the patient concerning health care has been increasingly realized and discussed, so the number of malpractice court cases has been growing. Nevertheless, there has not been any informed consent issue arising in ascertainable Thai court cases thus far. It should be noted that the reasonable patient or material risk standard of disclosure has influenced the Thai legal community. However, the professional standard is less onerous to the physician and can save the time the physician may otherwise spend making more accurate diagnosis and providing better treatment. The Thai physician in particular

is now severely limited by time constraints. A research showed that the average time for the physician to encounter one general outpatient in Thailand was less than five minutes per visit. I also believe that the professional standard will effectively serve the purpose of protecting the patient's right and autonomy to the extent not less than the material risk standard can, and will be procedurally advantageous to the patient in informed consent litigation as well.

III. The Arguments in Favor of Deploying the Physician-Oriented Standard of Disclosure in Thailand

As mentioned earlier, I will argue for adopting the physician-oriented or professional standard of disclosure in Thailand. There are several reasons why Thailand should employ that standard:

1. This Standard Offers the Equivalent Protection for Patient Autonomy in Thailand

For the sake of my argument, it is reasonable to scrutinize the customary practice of the medical community in Thailand. To illustrate, if the Thai medical community as a whole is quite derelict in overseeing the medical practice, deferring to the customary practice is obviously inappropriate. Informed consent claim in the Thai courts has been very rare.[22] In fact, to the best of my knowledge, I cannot find any court cases that the plaintiff claimed the informed consent as a cause of action. The Supreme Court once alluded to informed consent as part of its dicta.[23] In spite of such rare incidence of court cases, in 1998 several health care professional organizations, which supervise the practice of relevant

[22] In the United States, only 1% of malpractice claims against doctors are based upon purely informed consent. *See* Robin Fretwell Wilson, *The Promise of Informed Consent, in* The Oxford Handbook of U.S. Health Law 213, 228 (I. Glenn Cohen et al. eds., 2017).

[23] The Judgment of the Supreme Court of Thailand No.292/2542 (1999).

professions including the Medical Council of Thailand, announced the Declaration of Patients' Rights. The article 3 of the Declaration deals with the informed consent doctrine.[24] That article provides, "Patients who seek medical services have the rights to receive their complete current information in order to thoroughly understand about their illness from their medical practitioner. Furthermore, the patient can either voluntarily consent or refuse treatment from the medical practitioner treating him/her except in case of emergency or life-threatening situation." Even though the given Declaration is not the law, it has reflected the initiative and the intention of those professions. Apart from the moral or administrative binding, the Thai Supreme Court usually cited their own regulations or initiatives of the professional organizations to make defendants liable in case their conducts contradicted those provisions.[25] These practices reflect that the Thai medical community's dereliction of duty should not be a cause for concern. Similarly, in the United States the Supreme Court of Indiana also held that the Code of Medical Ethics of the American Medical Association should allay the fear that the patient right of self-decision would be destroyed by the professional standard of disclosure.[26]

Another fear that the medical profession may or may not impose the duty of disclosure on themselves is also ungrounded, at least, in the Thai legal context. The professional standard that I propose is the reasonable physician standard. This standard by no means binds the court to the standard set by the medical community. As aptly said by one scholar, "the standard is already set by the law, and always will be so long as the courts have the final word in determining what is reasonable and what is unreasonable… it is perfectly possible to envisage the case where the standard accepted by most doctors is not necessarily that which would be accepted by the "reasonable" doctor."[27] The standard of disclosure is set by

[24] *The Declaration of Patients' Rights*, Fda Thailand, http://www.newsser.fda.moph.go.th/advancepharmacy/2009/_file/AX01.doc (last visited Apr. 2, 2019).

[25] *See* The Judgment of the Supreme Court of Thailand No.7634/2554 (2011).

[26] *See* Culbertson v. Mernitz, 602 N.E.2d 98, 103-04 (Ind. 1992).

[27] Kenneth McK. Norrie, *Medical Malpractice: The Scope of Informed Consent in Negligence,* 32 Int'l &

the law, not the medical profession. The court just gives tremendous weight to the expert testimony. This notion is also observed in many countries including Germany and Australia.[28] In Thailand, the Thai Supreme Court once held that the decision and opinion of the Medical Council is not the law, and no provision indicates that the court and the parties are bound by such decision and opinion. If the court considers that such decision is right and fair, the court will take it into account together with other evidence of the defendant.[29] As Kenneth McK. Norrie points out, "To say that the courts must have the final word as to the legal acceptability of a medical practice is not to suggest that the medical profession will abuse its position without such supervision, but simply to suggest that it must be as open to such supervision as anyone else."[30] In the informed consent court cases, moreover, "… 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."[31] (internal quotation omitted).

2. The Patient-Oriented Standard Is Difficult to Interpret in Thai Context

The patient-oriented standard, especially the objective one, is quite abstract and difficult to be deployed in Thailand both in medical practice and in litigation incourt. The standard of disclosure in the United States has been developed mostly through case law. The standard set by the court derived from the jury instruction in each case, and the main objective is to

---

Comp. L.Q. 229, 233-34 (1983).

[28] *See* Ben White et al., Health Law in Australia 290 (2d ed. 2014) (citing a court case and the Ipp Report of the Law of Negligence Review Panel).

[29] *See* The Judgment of the Supreme Court No.7634/2545 (2002).

[30] Kenneth McK. Norrie, *Medical Negligence: Who Sets the Standard?*, 11 J. Med. Ethics 135, 136 (1985).

[31] *Rogers v Whitaker* (1992) 175 CLR 479 (Austl.).

instruct a jury in that particular case, not to instruct how to practice medicine.[32] However, it is unavoidable, even in the Thai civil law system, that the court opinions guide the medical practice in some way through the outcomes of malpractice litigation. Oftentimes, apart from the two distinct categories of jargon, the medical and legal professions do not understand each other because of the different premises upon which their practices are based. According to some scholars, "disputes about fact are left to a jury or judge to decide, and the goal is to ensure fair process rather than fair outcome or truth…Juxtaposed to this, empirical evidence in medicine seeks to define a single unimpeachable truth that can stand on its own. Moreover, medical evidence often focuses on populations, while at the court level, the evidence must be relevant to the single injured patient."[33] This fundamental difference can also fit neatly into the Thai adversarial court system.

From the medical profession's perspective, the reasonable patient is just the imaginary being. The physician has to speculate what the hypothetical patient in the position of her real patients would need to know. The physician is not trained to be a mind reader. This standard can convey a wrong message, and this really happens in the practice. The doctor may get the message that she must "exhaustively lay out all possible risks as well as benefits and alternatives of the proposed procedure. If one remembers to discuss fifty possible risks, and the patient in a particular case suffers the fifty-first, the physician might subsequently be found liable for incomplete disclosure."[34] This encourages the doctor to disclose more superfluous information than that patients can understand.

From the legal perspective, the reasonable patient standard appears problematic as well. It is not squarely congruent with the very foundation of the doctrine of informed consent. Given different values and preferences, some patients may not be deemed reasonable by law. This notably

[32] *See* Berg et al., *supra* note 11, at 143.

[33] Valarie Blake, *Medicine, the Law, and Conceptions of Evidence*, 15 Virtual Mentor 46, 46 (2013).

[34] Howard Brody, *Transparency: Informed Consent in Primary Care*, 19 Hastings Ctr. Rep. 5, 6 (1989).

contradicts the notions of patient autonomy and self-determination. Those notions teach that the patient has the right to decide what to be done to his or her body for whatever reason regardless of whether it is reasonable. The one who must act reasonably is the physician, not the patient.

While some may think that precision medicine, the definition of which is "treatments targeted to the needs of individual patients on the basis of genetic, biomarker, phenotypic, or psychosocial characteristics that distinguish a given patient from other patients with similar clinical presentations," prefers the patient-centered standard of disclosure, I propose that it should instead encourage the adoption of the physician-centered standard in this current circumstance in Thailand. Only some biomarkers used in the United States have been used in Thailand and in some clinical settings, mostly tertiary care units. The court is hardly able to set the standard for which particular biomarker should be used or disclosed in the medical practice in order to satisfy the standard of reasonable patient. To illustrate, it is better for the court to shape the disclosure standard (professional standard) than to initiate the adoption of each particular biomarker in the medical community. The court can easily say, based on all the evidence presented to the court, that the disclosure of the medical community does not satisfy the legally accepted professional standard. However, the perception may not be the same if the court elects to state that the doctor must recommend the biomarker XY instead of biomarker XX despite the fact that biomarker XY is adopted by very few facilities due to good medical and medically related reasons. To elaborate on this respect, the clinician attaches more weight on randomized control trials, systemic evidence reviews, and cost-effectiveness, whereas the legal community attaches more significance to other peer review studies and litigation experts.[35] It should be the medical community that initiates the implementation of any medical procedure or practice in the first place. The paradigm shift in medical practice is within, or at least very close to, the

[35] Gary E. Marchant et al., *Contrasting Medical and Legal Standards of Evidence: A Precision Medicine Case Study*, 44 J.L. Med. & Ethics 194, 200 (2016).

province of medical profession, which in turn vitiates the justification of the reasonable patient standard so that the disclosure does not need any medical expertise or specialty. Medical expertise here embodies the customary criteria for adopting any medical practice for the first time.[36] The court may fly too close to the sun if it attempts to be a clinical practice guideline itself. That said, the court has full authority to shape the medical practice through professional standard when there is clear evidence showing that the medical community has been derelict in its own initiatives to bring changes. That also requires a broader view of public policy or health care policy at large.

With respect to the implication of the reasonable patient standard for good medical practice, it is doubtful that the material risk standard would make the doctor provide more meaningful information. Rather, the patient may be afforded a wealth of superfluous information without understanding the essential health information which is almost always prescribed by the customary practice, for the "physician is unlikely to be sued successfully for providing too much information."[37] There was some study in the United States demonstrating the similarity under both standards. The physician was the only one who determined the extent of disclosure and that person did not put much emphasis on discussing with the patient.[38] No significant disparity pertinent to the extent of the physician's disclosure was found between the states employing both standards.[39] Another study shows, "Even in the more complex decisions that required informed consent, the basic elements of informed consent were accomplished less than half of the time."[40] One commentator who holds dual degrees in medicine and law

[36] There are several possible approaches which courts can take to shape the professional standard for ordinary malpractice cases. Such approaches can also be applied to the disclosure standard. *See* Carter L. Williams, *Evidence-Based Medicine in the Law beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care*, 61 Wash. & Lee L. Rev. 479 (2004); Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. Health Pol. Pol'y & L. 327 (2001).

[37] Berg et al., *supra* note 11, at 53.

[38] *Id.* at 49.

[39] *Id.* at 52.

concludes that "the legal doctrine spelled out in Canterbury and Scaria of the informational elements necessary for informed consent was not the standard of medical practice, or if it were, it was one that was routinely neglected."[41] This is also highly likely to be true in Thailand. The constraint on the period during which the encounter between the physician and patient takes place is the vital factor indicating that result. The 2016 research showed that the average time for the doctor to encounter one general outpatient in Thailand was less than five minutes per visit and suggested that the doctor should spend five minutes with each patient.[42]

Adopting the reasonable patient standard in Thailand is also somewhat hindered by the scope of the governing informed consent statute. The current Thai informed consent statute governs any provision of health service, the statutory definition of which is "any service related to health promotion, prevention and control of diseases and health hazards, diagnosis and treatment of illness and rehabilitation of person, family and community."[43] Apparently, such a very capacious definition has made the Thai informed consent statute applicable to virtually all aspects of health care. In the United States, by comparison, the applicability of informed consent law is determined by common law or statutory provisions. At least one state court in the United States refused to specify or enumerate the procedures that require an informed consent by ruling, "After substantial research, this court has been unable to develop such a formulation. Perhaps it is best to allow the boundaries to develop on a case-by-case basis, as in so many other areas of the law. Physicians are by no means

---

[40] Arthur R. Derse, *Flying Too Close to the Sun: Lessons Learned from the Judicial Expansion of the Objective Patient Standard for Informed Consent in Wisconsin*, 45 J.L. Med. & Ethics 51, 54 (2017) (citing Clarence H. Braddock III et al., *Informed Decision Making in Outpatient Practice: Time to Get Back to Basics*, 282 JAMA 2313 (1999)).

[41] Derse, *supra* note 40, at 54.

[42] Suthunya Bunjongpak (สุธัญญา บรรจงภาค), *Guideline for Thai Physician's Work Time Regulation (แนวทางการกำหนดภาระงานของแพทย์)*, 35 Warasanpat Kate4-5 (วารสารแพทย์เขต 4-5) [Region 4-5 Med. J.] 28, 33 (2016). While in 2014, doctors in the United States spent between 8 and 15 minutes with each patient. Wilson, *supra* note 22, at 228.

[43] Section 3 of the National Health Act, B.E. 2550 (2007).

without guidance in the meantime, any more than they (or other citizens) are left rudderless in other areas involving potential liability."[44] Several states, on the other hand, limit informed consent to only some procedures or treatments, and doctors are required to disclose only some specified risks.[45] The applicable scope of the Thai informed consent law, therefore, is quite broad by including almost all medical procedures, that is, not only diagnosis and treatment of illness but also health promotion, prevention and rehabilitation. If the standard of reasonable patient is applied, Thai courts have to indicate what informational need of the reasonable patient for deciding whether to undergo every specific procedure, maneuver, or treatment is. Such a legal circumstance is more burdensome for the court and does not seem to be of greater benefit to the Thai patient than the situation that the court shapes the professional standard. In addition, there is a lesson that Thailand can learn from the situation in the United States. The Wisconsin Supreme Court, under the reasonable patient standard, extended the informed consent law in many respects. To illustrate, the Wisconsin's physician was once required to disclose alternative means, even unavailable at her institution, of diagnosis[46]; her experience[47]; the option of admission to the hospital instead of outpatient follow-up[48]; and differential diagnoses she thought of, including the availability of tests that can rule out those diagnoses.[49] Those judgments appeared, at least to many physicians and some critic[50], that the court had been encroaching upon the real realm of medicine, culminating in lobbying for a legislative intervention. At last, the amended informed consent statute was passed in

[44] Hanes v. Solgar, Inc., No. NHCV156054626S, 2017 Conn. Super. LEXIS 117, at *25 (Conn. Super. Ct. Jan. 12, 2017).

[45] Sawicki, *supra* note 16, at 832 (citing cases and statutes from New York, Pennsylvania, Iowa).

[46] *See* Martin v. Richards, 531 N.W.2d 70 (Wis. 1995).

[47] *See* Johnson v. Kokemoor, 545 N.W.2d 495 (Wis. 1996).

[48] *See* Bubb v. Brusky, 768 N.W.2d 903 (Wis. 2009).

[49] *See* Jandre v. Wisconsin Injured Patients & Families Compensation Fund, 813 N.W.2d 627 (Wis. 2012).

[50] *See* Michael Rohde, *Information Overload: How the Wisconsin Supreme Court Expanded the Doctrine of Informed Consent*, 46 J. Marshall L. Rev. 1097 (2013).

2013 in order to supersede those decisions and revert to the reasonable physician standard altogether.[51]

3. The Reasonable Patient Standard Is Inappropriate Under the Current Situation in Thailand

The doctrine of informed consent has evolved from the principles of patient autonomy and self-determination. Such principles are deeply embedded in American culture because it has "a long tradition of commitment to individuality that crystallized in the founding documents of its political system, the Declaration of Independence and the Constitution ."[52] It has been observed that the law in this area "represents an obsession with Western values and norms that seem less relevant to those from other cultures."[53] The appropriate application of this doctrine to other cultures, therefore, is not simple since "the effort to apply the doctrine in different societies other than those immediately derivative of American, and perhaps some European cultures, may well generate unsatisfactory or even counterproductive results."[54] The research studying the Navajo Indian reservation in northeast Arizona points out that advance care planning seriously contradicts the traditional Navajo value and the discussion of negative information is morally problematic.[55] Another study shows that Korean-American and Mexican-American subjects, when making a medical decision, cherish the collectivity of the family rather than the patient autonomy.[56] Therefore, if Thailand adopts the reasonable patient standard, it should be the reasonable Thai patient standard, not reasonable for other cultures' patients. There are good reason and supporting research to

51 Wis. Stat. § 448.30 (2013).

52 Berg et al., *supra* note 11, at 311.

53 Hall et al., *supra* note 7, at 200. The authors provide a number of examples from the literature to support this contention. *See id.*

54 Berg et al., *supra* note 11, at 313.

55 Joseph A. Carrese et al., *Western Bioethics on the Navajo Reservation: Benefit or Harm?*, 274 JAMA 826 (1995).

56 Leslie J. Blackhall et al., *Ethnicity and Attitudes Toward Patient Autonomy*, 274 JAMA 820 (1995).

contend that the Thai bioethics is quite different from the Western one. One study maintains that the Thais' end-of-life decisions are premised on the logic of karmic morality and the Buddhist principle of interdependence integral to most Thais.[57] The same study also adds, "Interdependence means that doctors, patients and relatives must think about the emotions and interests of all parties involved in a medical decision. This is in contrast to the Western concept of autonomy, which allows a patient to make decisions without consideration of the feelings and responsibilities of other people concerned."[58] Another research studying the end-of-life decisions of Thai Buddhist patients shows that 28.6% of participants elected to allow their physician or family to make the decision for them.[59] Additionally, one study suggests, "[Thai] Patients do not like to ask questions because they feel obligated to their physician."[60] Adopting the reasonable patient standard, the Thai courts have to determine the disputed issue that would be "whether the specific risk or alternative treatment is the one which the reasonable patient under the same or similar circumstances would want to know in order to make an intelligent decision." What if most patients in Thailand under the similar circumstances would let their doctors make the decisions or not to disclose some risks given that the doctors seriously and genuinely take such risks into consideration? On the contrary, there is a probability that a plaintiff patient will not be able to prove that the Thai reasonable patient would need to know that information. Certainly, the Thai courts have all the authority to set that (the reasonable Thai patient) standard; however, they may grapple with that task since it may not exactly square with the cultural perception or those aforementioned studies.

---

[57] Most people (94.5%) in Thailand are Buddhists. Nat'l Stat. Off. Thai., https://web.archive.org/web/20171210020110/http://web.nso.go.th/en/survey/popchan/data/2015-2016-Statistical%20tables%20PDF.pdf (last visited Apr. 2, 2019).

[58] Scott Stonington & Pinit Ratanakul, *Is There a Global Bioethics? End-of-Life in Thailand and the Case for Local Difference*, 3 PLoS Med. 1679, 1681 (2006).

[59] Manasurakarn J et al., *Values Underlying End-of-Life Decisions of Thai Buddhist Patients and Their Families*, 26 Songkla Med. J. 549, 557 (2008).

[60] Ungsinun Intarakamhang & Yuttapong Kwanchuen, *The Development and Application of the ABCDE-Health Literacy Scale for Thais*, 10 Asian Biomedicine 587, 589 (2016).

From my perspective adopting the subjective patient-centered standard, which pays attention to each patient's preferences and values instead of the hypothetical reasonable patient, it has been proved problematic also in Thailand. It has been rejected by vast majority of courts in the United States because of the high probability of patients' hindsight and bitterness, and the "inability of physicians to predict what information a patient would want."[61] If that statement is true, the court cases in Thailand are more prone to patients' retroactive bitterness. Such inference is drawn from the fact that American patients, by and large, are more active in receiving medical information and participating in a medical decision than their Thai counterparts. To put it another way, the Thai patients, who are not as keen on receiving and taking part in making medical decisions as the U.S. patients are, tend to be more influenced by their hindsight and bitterness. They are more inclined (than the U.S. patients) to allege that the undisclosed information is the one they had wanted to know before undergoing a procedure or a treatment at issue. Accordingly, the subjective material risk standard, if adopted in Thailand, will cause problems to both courts and patients.

As for courts, striking a balance between safeguarding the Thai patient autonomy and weighing the factual evidence, in accordance with the law, that entails taking the potential biased hindsight into account is not a walk in the park. In 2016, there was a heated argument between the judiciary and the medical profession in Thailand. Hardly had the Thai Supreme Court decided a medical malpractice case, where the girl had suffered permanent disability from tuberculous meningitis, when the President of the Medical Council of Thailand then and also President of the Asian Society of Pediatric Infectious Diseases, who gave an expert testimony for the defendant in the case, severely criticized the court's opinion that the judges did not have any medical knowledge and did not adhere to the rightness but instead heavily sympathized with the patient.[62] Even though no

[61] King & Moulton, *supra* note 13, at 445.

[62] *See* Chularat Saengpassa, *Battle between Courts and Doctors Benefits No One*, The Nation (Apr. 19,

informed consent claim was involved in the abovementioned case, the court should be aware of the allegation that sympathy for patients is prioritized over the factual evidence in the case. This allegation from the medical profession is bound to happen in informed consent claim sooner or later.

As far as the plaintiff patient is concerned, it is a patient's responsibility (both Thai and American) to prove and present evidence to the court that the risk undisclosed by the physician is the one to which the patient would attach significance when deciding whether to undergo the treatment. Oftentimes, this burden is quite tough, particularly if the risk that had actually occurred is not so serious and distinctive, which is why almost all patients are very careful with making such decision. For instance, it may be very hard for the patient to convince the court that a certain treatable complication from a treatment (e.g. cervical adhesion to a vaginal wall, a complication from cryosurgery which actually happened in Culbertson v. Mernitz) is the risk that she wanted to know before undergoing the surgery given that the court usually views the patient's testimony with caution due to the patient's potential hindsight. Furthermore, such difficulty is compounded by lack of circumstantial evidence. Unlike the decision of end-of-life care that the patient may express some values, preferences or moral attitudes to others, cervical adhesion to vaginal wall is unlikely to be mentioned or inferred from the everyday conversation. Hence, there are no relatives, teachers or friends who can testify to courts regarding the patient's relevant values or preferences as to that risk. The professional standard under the Thai legal context, however, helps ease such an onerous burden and difficulty of the patient. This will be discussed later in this paper.

Patients' understanding of the information disclosed by the physician is the important matter worth discussing. Although some theorists contend that an informed consent exists if and only if the patient understands the information disclosed by the doctor,[63] the doctrine of informed consent put

2016), http://www.nationmultimedia.com/news/national/aec/30284202.

[63] Vaughn, *supra* note 4, at 197.

emphasis on the disclosure on the part of the physician, not the understanding of the patient.[64] Canterbury is also cited by some scholars in order to argue that the doctrine of informed consent does not involve the understanding of the patient.[65] The U.S. courts usually focus on the physician's disclosure and discussion about the attendant risks and alternatives to the recommended treatment. The patient's comprehension of such discussion is not usually considered.[66] Perhaps it is necessary for the doctrine to impose physicians the particular duty rather than to expect patients to understand because this doctrine has been devised by the U.S. court to rectify the imbalance of power in the physician-patient relationship by means of compelling the physician to practice in a particular manner. Imposing on the physician the duty of assessing the understanding of the patient, however, may be too demanding and difficult to set the benchmark for such assessment. Moreover, some people are concerned that "patients who cannot comprehend the nature and risks of treatment or who choose to remain ignorant might be deprived of medical care."[67] Joseph Goldstein also expressed the concern that "uncomprehending patients would have their decisions made for them by others."[68]

Nevertheless, it is undisputed that the patient's understanding of information revealed by the physician plays a critical part in medical decision-making. If one cannot understand the information being told at all, how can he or she take that information into account while considering the risks or alternatives to the recommended treatment? How can she make decisions with wholly unintelligible data? She is ultimately unable to achieve

---

64 Thaddeus Mason Pope, *Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law*, 45 J.L. Med. & Ehics 12, 17 (2017).

65 *See* Marc D. Ginsberg, *Beyond Canterbury: Can Medicine and Law Agree about Informed Consent? And Does It Matter?*, 45 J.L. Med. & Ehics 106, 107 (2017); Ginsberg, *Informed Consent: No Longer Just What the Doctor Ordered? Revisited*, *supra* note 16, at 51.

66 Barry R. Furrow et al., Liability and Quality Issues in Health Care 201 (6th ed. 2008).

67 Berg et al., *supra* note 11, at 151.

68 *Id.* at 152.

the right of self-determination, at least meaningfully. Many studies show that a vast minority of patients have an acceptable level of understanding of their disease or the appropriate medical treatment for it.[69] In this regard, health literacy plays an important role. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy may be used as a tool for people to make meaningful and effective medical decisions. As for Thailand, there is the evidence showing that "the status of health literacy, especially functional level is considered as having the limited literacy, among Thai older people."[70] The reasonable patient standard, if adopted, is likely to encourage the doctors in Thailand to overwhelm the patient with the information of risks and alternatives. Moreover, doctors may disclose the information in the same manner as detailed information described in terms of all risks and their statistics printed on the drug's label or leaflet, however minuscule they are. Thanks to the advanced technology, such information can be printed out from the relevant website on the Internet. Doctors may hand out, without any specific discussion, documents containing such information to the patient despite the fact that such information is often even difficult to understand and interpret for the physician from other specialties or fields of practice. Oftentimes, frank discussion between doctors and patients that should be included in the process so that patients understand better, is grossly neglected. In contrast, the physician standard of disclosure can avert those undesirable practices of the physician and the Thai court can decide on the standard, which reasonable physicians should adopt. To illustrate, if the time is ripe, the court can require the physician to test the understanding of each patient after disclosing the required information as other reasonable fellow physicians under the same or similar circumstances would reveal. Indeed,

---

[69] Pope, *supra* note 64, at 12. For example, according to one study, "only 5% of cancer patients understood essential aspects of their diagnosis." *Id*.

[70] Wansiri Nilnate et al., *Level of Health Literacy in Thai Elders, Bangkok, Thailand*, 30 J. Health Res. 315, 315 (2016).

most doctors would argue that they practice individualized medicine[71], that is, giving each particular patient's needed care. Therefore, apart from the demanding duty imposed on doctors, the vagueness of how to define the requisite understanding, and what test should be used to gauge the understanding of the patient; it is not weird to set the reasonable physician standard of disclosure by imposing the duty to assess the understanding of the patient as part of the physician's duty.

4. The Patient Gains More Advantages from the Reasonable Physician Standard in Informed Consent Litigation in Thailand

In the United States, "plaintiffs in informed consent claims generally will be required to prove (1) that the medical procedure carried a specific risk that was not disclosed, (2) that the physician violated the applicable standard of disclosure, (3) that the undisclosed risk materialized, and (4) that the failure to disclose the information caused the patient's injury."[72] The Thai courts will also ascertain those four elements, but those elements in the Thai (civil law) legal system may differ from those of the United States in the party who bears the burden of proof.

From the perspective of the patients in the United States, one of the most obvious drawbacks of deploying the physician standard of disclosure is they have to provide expert testimony for the court in order to show that the undisclosed information would have been revealed by the reasonable physician under the same or similar circumstances.[73] This does not mean only the plaintiff patients has to bear additional expenses, but also means they have to bear the risk of losing the case. In other words, they have to persuade the fact-finder that the reasonable physician would have disclosed the information withheld or unrevealed by the defendant physician. If they

---

[71] J. Larry Jameson & Dan L. Longo, *Precision Medicine – Personalized, Problematic, and Promising*, 372 New Eng. J. Med. 2229, 2229 (2015).

[72] Hall et al., *supra* note 7, at 215.

[73] *See Culbertson*, 602 N.E.2d at 104.

fail to convince the fact-finder, they will lose the case. On the other hand, under the reasonable patient standard they do not have to present such expert testimony. The fact-finder can ascertain, without the assistance of experts, what risks the reasonable patient needs to know or attaches significance to when deciding whether to undergo the treatment. In contrast to the situation in the United States, the professional standard, if adopted in Thailand, gives advantage to the plaintiff patient in litigation.

If Thailand adopts the professional standard, the burden of such proof will shift to the defendant physician. In other words, the defendant physician must prove to the court that the reasonable physician under the same or similar circumstances would have withheld or would not have disclosed the risks or other information at issue as well. This phenomenon results from the specific Thai statute entitled "Consumer Case Procedure Act, B.E. 2551 (2008)." This Act governs the cases concerning civil liability between all health care and medical service providers and patients regardless of whether the services are provided by entirely public or private facilities or individuals.[74] Medical malpractice cases, therefore, are consumer cases governed by the Act. As such, the plaintiff patient can take advantage of Section 29 of the Act against the defendant physician.[75] Pursuant to Section 29, since the knowledge about what is the customary standard of disclosure in the field of medicine is the exclusive knowledge of the physician, the defendant physician bears the burden of proof in informed consent court cases. The physician has the duty to adduce evidence to the court so as to establish the customary or professional standard of practice dictating the information other reasonable physicians would disclose under the same or similar circumstances. To win the case,

[74] This has been determined, pursuant to Section 8 of the Act, by the decision of the President of the Court of Appeal. Section 8 reads, "In the case where there is a question whether or not a case is a Consumer Case, the President of the Court of Appeal shall decide thereupon…"

[75] Section 29 states, "Any point in dispute needs to be proved as to fact relating to the manufacture, assembly, design, or component of the goods, services, or any undertaking which the court is of an opinion that such fact is known to the party who is the Business Operator (health care provider) only, the burden of proof in such point in the dispute shall fall on the party who is the Business Operator (health care provider)." (parentheses added).

the physician has to convince the judges (the only fact-finder in Thailand) to believe that other reasonable physicians would not have disclosed the risk at issue either. If the physician did not succeed in either convincing the judges or exceeding the threshold for her task, she would lose the case although the patient did not adduce any evidence at all. Even if she can reach the threshold, the patient can still present the evidence to negate the physician's evidence.

On the other hand, the reasonable patient standard, if adopted in Thailand, would place a burden of proof on the plaintiff patient. Since the knowledge of what a reasonable patient needs to know in order to decide whether to forgo a certain treatment or procedure is not exclusive to the physician, Section 29 is irrelevant. In this regard, the burden of proof is simply governed by the Civil Procedure Code of Thailand. Section 84/1 of the Thai Civil Procedure Code reads, "Where a party alleges any fact in support of his pleading, the burden of proof of such fact falls on the party alleging it…" Suppose the plaintiff patient alleges in the complaint that the defendant physician did not disclose the materialized risk at issue. Then the defendant disputes that a reasonable patient would need to know and attach significance to the risk so as to make a medical decision. The onus is on the plaintiff, who alleges the fact in the first place, to prove that the risk mentioned earlier is the risk to which the reasonable patient would want to know and attach significance. This can cause tremendous difficulty, due to unique Thai culture and difference in preferences and values among patients, to both courts and plaintiff patients as discussed in detail above.

5. Thailand Will Adopt Subjective Causation, Not Objective Causation in Informed Consent Claims

In almost all states of the United States, apart from proving that the materialized undisclosed risk resulting from the proposed treatment caused the patient's injury (injury-causation), the plaintiff patient must prove that a reasonable patient would have refused the treatment had the unrevealed

risk been disclosed (decision-causation). This may be called an objective causation standard. Only four states employ a subjective causation standard. "Under this [a subjective causation] standard, the relevant decision-causation determination is whether the particular plaintiff patient would have chosen the procedure had the appropriate information been disclosed; whether an objectively reasonable person would have acted differently is irrelevant."[76] (internal quotation omitted). The subjective causation is squarely congruent with the underlying principles of informed consent. The patient can meaningfully exercise the right of self-determination and her autonomy by means of refusing any treatment or procedure, irrespective of the soundness of her decision. The patient does not need to be under the influence or pressure from the decisions of other so-called reasonable patients. The patient has the right to be wrong as well. The Oklahoma Supreme Court, which has deployed the subjective causation once stated, "To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is irrevocably lost."[77] (original emphasis). Moreover, under the objective causation standard, "a patient could be denied relief even if: (1) the information he received from the physician was totally deficient, (2) the patient himself would not have chosen the surgery if he had been informed of the risks and alternatives, and (3) he was severely injured."[78]

Aside from contradicting the theoretical underpinning of patient autonomy, Jay Katz also convincingly contends, "The belief that there is one "reasonable" or "prudent" response to every situation inviting medical intervention is nonsense, both from the point of view of the physician as well as that of the patient."[79] A decision to decline and a decision to accept the proposed treatment are sometimes equally reasonable. In fact,

76 Tenenbaum, *supra* note 9, at 716-17.

77 Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979).

78 Tenenbaum, *supra* note 9, at 712-13.

79 Jay Katz, *Informed Consent - A Fairy Tale - Law's Vision*, 39 U. Pitt. L. Rev. 137, 163 (1977).

the objective causation does not function as a test of causation at all, but rather "a test of the credibility and reliability of the plaintiff's own testimony."[80]

Nevertheless, most jurisdictions in the United States still employ the objective causation standard. The argument against the subjective causation revolves around the unfairness that may place the physician in jeopardy of the potential hindsight and bitterness of a person seeking recovery after experiencing a most undesirable result.[81] Some courts are concerned that "the adoption of a subjective standard could preclude recovery in an informed consent case in which the patient died as a result of an unforewarned collateral consequence."[82]

If Thailand adopts the professional or physician-centered standard, it will adopt the so-called subjective causation. This will again give a real advantage to the plaintiff patient in litigation, compared with the objective causation used in virtually all jurisdictions in the United States. The Thai courts, which are under the civil law system, also take the common law's concepts of actual and proximate causes into account when determining causation in delictual (tort) cases.[83] Once the causal link is established, the Thai courts will use the phrase "a direct consequence" to indicate the successfully established causality. If the plaintiff patient's injury is a direct consequence of the defendant physician's breach of duty, the latter could be held liable. By the same token, in case the plaintiff patient would have declined the suggested treatment had the defendant physician disclosed the risk at issue, the plaintiff patient's decision to have undergone such treatment is considered a direct consequence of the physician's breach of duty to sufficiently disclose. The U.S. objective causation is not deemed a

---

[80] Dieter Giesen, International Medical Malpractice Law 346 (1988). Giesen also cites Professor Robertson's statement to support this contention. *See id.*

[81] *See* Sard v. Hardy, 379 A.2d 1014, 1025 (Md. 1977).

[82] Ashe v. Radiation Oncology Assocs., 9 S.W.3d 119, 122 (Tenn. 1999).

[83] Section 420 of the Thai Civil and Commercial Code states, "A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom."

test of causation in Thailand for the same reason as earlier mentioned. Additionally, one of the reasons why the courts in the United States elect to employ the so-called objective causation is "concern that the jury will uncritically rest its decision on [the plaintiff's] testimony alone."[84] By contrast, without a jury system, the judge in Thailand decides on both factual and legal issues. The so-called objective causation is therefore simply one of the general approaches the Thai judge takes to weigh the plaintiff patient's testimony, that is, by weighing it against a reasonable patient's behavior. Likewise, several European courts have established the rule that "it is the individual patient who matters" rather than a hypothetical patient.[85] In Australia, the subjective causation has also been adopted among all states, by either the civil liability legislation or common law.[86] However, all the relevant statutes essentially prescribe that any statement regarding what he or she would have done, made by the plaintiff patient after suffering the harm is inadmissible except to the extent that the statement is against his or her interest.[87] Therefore, the matter is to be determined in light of all other relevant circumstances.

Even though there is no such exclusionary rule concerning the plaintiff patient's testimony in Thailand, the subjective standard is still far from perfect. As previously discussed, the plaintiff testimony could be given a little weight by the court. In preference-sensitive treatment cases, the plaintiff may find it difficult to present other circumstantial evidence from which can be inferred her preferences, values, beliefs, philosophy, moral attitudes or world view. To address uncertainty the physician faces caused by speculating the informational need of a particular patient (resulting from the subjective patient-based disclosure standard) and the patient's hindsight

84 Tenenbaum, *supra* note 9, at 730.

85 Giesen, *supra* note 80, at 299. Giesen cites several court decisions to support this contention, including those from the Federal Constitutional Court and Federal Supreme Court in Germany, the Swiss Federal Court, and the Austrian Supreme Court. *See id.*

86 White et al., *supra* note 28, at 331.

87 *See Civil Liability Act 2002* (N.S.W.) s 5D(3), *Civil Liability Act 2003* (Queensl.) s 11(3), *Civil Liability Act 2002* (Tas.) s 13(3), *Civil Liability Act 2002* (W. Austl.) s 5C(3).

(stemming from the subjective causation standard) and to reinforce the patient's self-determination in terms of her certain preferences, beliefs, values or concerns, the notion of shared decision making has been introduced. This notion is aimed at enhancing two-way physician-patient communication. To maximize the effectiveness of such communication, both sides have to mutually contribute information. The physician genuinely discloses the attendant risks, alternatives to the recommended treatment as well as their associated risks. Likewise, the patient willingly conveys her preferences, values or concerns with regard to certain treatments to the physician. Some commentators define shared decision making as "a process in which the physician shares with the patient all relevant risk and benefit information on all treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment or side effect more or less tolerable than others."[88] This process also pays immense heed to the patient's understanding, the persistent shortcoming of informed consent law, through using patient decision aids. "Decision aids, such as brochures, DVDs, or online tools, provide patients with detailed and specific information on treatment options and outcomes, help them clarify their values, and guide them through the decision-making process."[89] It has been suggested that shared decision making, through using decision aids, significantly helps promote patient autonomy as well as considers evidence-based medicine and a particular patient's values and preferences.[90] Decision aids are adopted by the U.S. Affordable Care Act for preference-sensitive care, and are required to be certified by relevant agencies.[91] However, Washington is the only state to finance a process for approving decision aids. "State law requires that decision aids be used, once developed and certified through a state agency, and it creates a presumption of informed consent if a practitioner used decision aids. The presumption can only be rebutted by clear and convincing evidence."[92] The

88 King & Moulton, *supra* note 13, at 431.

89 Furrow et al., *supra* note 6, at 144.

90 Pope, *supra* note 64, at 21.

91 Furrow et al., *supra* note 6, at 145.

U.S. Centers for Medicare & Medicaid Services (CMS) also endeavors to encourage shared decision making. Such an effort can be evidenced by its reimbursement "for annual lung cancer screening with low-dose computed tomography, provided that a counseling and shared decision-making visit has occurred and is documented in the medical record."[93]

I believe that we should encourage shared decision making and the enhancement of patients' understanding, whether by decision aids or other means. This can also reconcile the different emphases on informed consent placed by medicine and law. While the law put emphasis on physicians' disclosure, the medical profession regards effective informed consent as a process of communication entailing "disclosure, comprehension, voluntary choice, and authorization."[94] It would be naïve, however, to suppose that those processes could happen in Thailand in the very near future. Notwithstanding that there have been arguments for shared decision making in the United States over the past few decades, Washington State is the only state to fully adopt and implement the shared decision making. For the time being, however, Thailand should adopt the reasonable physician standard for informed consent claims. Once shared decision making or using decision aids has been prevalent among Thai physicians, the practice will become part of customary practice governed by the reasonable physician standard as well.

IV. Conclusion

Physicians in Thailand have understood the concept of informed consent for a long time. However, it is not certain that they grasp the fundamental premise upon which informed consent is based, nor can they apply it properly. Medical paternalism still plays a significant role in medical

92 *Id.* at 146.

93 Erica S. Spatz et al., *The New Era of Informed Consent: Getting to a Reasonable-Patient Standard Through Shared Decision Making,* 315 JAMA 2063, 2064 (2016).

94 Christine Grady, *Enduring and Emerging Challenges of Informed Consent*, 372 New Eng. J. Med. 855, 856 (2015).

practice and physician-patient relationships, especially compared with those situations in the United States. This is largely due to the difference in cultures, norms or moral values each society cherishes or place emphasis on. To be fair to the physicians, many Thai patients need the physicians to make medical decisions for them. That said, respecting cultural differences does not mean that respect for patient autonomy is not required.

Such informed consent in Thailand developed into a statutory provision in 2007, namely the National Health Act B.E. 2550 (2007). Since then, informed consent has not merely been a customary practice or a physician's duty dictated by a professional organization. It is a duty whose standard is set by law. More than a decade has now elapsed, but no comprehensive discussion about disclosure standard, either in scholarly articles or Supreme Court opinions, has been documented in Thailand. Although I believe that the statute provides room for adopting the physician-based standard of disclosure, there should be an amendment to the said provision for the purpose of clearest understanding. Thailand should adopt the professional disclosure standard. This standard is easier to be interpreted and implemented in the Thai context. It does not only protect the patient autonomy but also enables the court to shape the standard if it deems appropriate. In so doing, the court can take into consideration such factors as cultural difference of particular patients and the medical community's dereliction of duty to effect changes. Further, perhaps surprisingly, in Thailand plaintiff patients will enjoy taking advantage of the professional disclosure standard to lighten their burden in litigation by shifting the burden of proof to defendant physicians. Aside from proving the existing standard, the physicians must prove that they have met that standard as well. Moreover, it is difficult for Thailand to escape the advent of shared decision making in which the patient's participation and understanding is more and more encouraged. The reasonable physician standard of disclosure can accommodate the adoption of shared decision making by means of courts shaping the standard and taking the same approach before the shared decision making is successfully

established as a distinct standard itself. It should also be noted that the past decade has witnessed large numbers of foreign patients flocking to Thailand from burgeoning medical tourism. That poses real challenges of properly handling such patients to Thai physicians. How the concept or doctrine of informed consent should work or be applied to that situation merits further discussion in great depth.

Received: January 19, 2019

Revised: July 19, 2019

Accepted: August 16, 2019