HOSPITAL'S DUTY OF CARE: RECENT DEVELOPMENTS AND IMPLICATIONS

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Are hospitals under a duty to routinely provide incidental abnormal findings to patients when no follow-up is required?

Introduction

While the topic of doctors' duty of care to patients has seen lively discussion among medical and legal practitioners alike, the nature and extent of the corresponding duty of care owed by hospitals has received less attention.

It may be interesting to note, in a recent judgement for a negligence action,[1] that a restructured hospital was found to have breached its duty of care to a plaintiff patient by not sending certain X-ray reports to her, notwithstanding that said reports had been reviewed and appropriately decided that follow-up was not required.

Hospital's duty of care – case study

The plaintiff, a 38-year-old lady, brought a negligence suit against a restructured hospital and three doctors for negligent failure to diagnose and treat a right lung nodule in her various consultations with them in the five years prior to being diagnosed with non-small cell lung cancer via biopsy in 2012.

The plaintiff failed in her suit against the defendants, as the court found that she did not make out all the elements of establishing a duty of care, breach of that duty, and a causal link between breach and the harm/loss suffered by the plaintiff against any of them.

However, the court found that the hospital had breached its duty of care to the plaintiff by not sending chest X-ray (CXR) reports done in the Emergency Department (ED) in 2010 and 2011, or otherwise informing her of the results. The circumstances surrounding these CXR reports are as follows:

a. The plaintiff presented to the ED in 2010 complaining of right-sided mechanical chest pain of one-hour duration, worse on deep inspiration and associated with shortness of breath. The defendant doctor who saw the patient noted the nodule on the unreported CXR and on comparing it with a previous CXR done in 2007, assessed it to be stable and unlikely to be the cause of the plaintiff's presenting complaint due to its acute onset. The patient was discharged from the ED;

b. The plaintiff presented to the ED again in 2011 complaining of one-month history of left lower ribcage pain. The defendant doctor who saw the plaintiff at that consultation also ordered and read the unreported CXR, but did not notice the nodule in the right lung. The Court found that the defendant doctor had not breached his duty of care to the patient despite not noticing the lung nodule, and accepted his evidence that he was focused on the left side of the CXR (ie, the area of the presenting complaint). The plaintiff was discharged from the ED;

c. While there was a system of routine (radiology) reporting in place at the time of both ED presentations, the formal reports of those CXRs were available only after the plaintiff was discharged from the ED;

d. After they became available, the CXR reports, having described an abnormal finding (such as a lung nodule), would have been sent back to the ED and reviewed by a senior doctor. The Court found that on the balance of probabilities, this had taken place, and that the senior doctor made a clinical decision to not recall the plaintiff (there was no record of said review and decision);

e. While the hospital was found to have breached its duty of care by not sending or informing the plaintiff of the CXR findings, the court found that the decision not to recall the plaintiff after either ED presentation did not breach the hospital's duty of care towards the plaintiff;

In explaining why the hospital was under a duty to send the CXR reports to the plaintiff, the Court held that it would be "reasonable for the plaintiff to be notified of the results of such reports

and of the clinical decision made as to her condition as part of the doctor's communication of his diagnosis, and so as to enable the patient to be informed of her condition and take the decision as to whether to return to the Hospital for consultation, seek a second opinion elsewhere or to do nothing".

Discussion

The consequences of the above are quite clear: hospitals (and possibly clinics and healthcare providers in general) are under a duty of care to inform patients of all tests with incidental findings to enable patients to act (or not) as they see fit, even if the clinician has appropriately decided that no follow-up is required – this is consistent with the ethical principle of enabling patients to exercise their autonomy.

This is significant for several reasons. Firstly, this duty to inform patients of incidental findings is usually considered to belong to the *doctor*, not the hospital. Secondly, the case study clearly states that this duty is a legal one on the part of the hospital, independent of whether the *standard* of care has been met. In the case study above, the duty still subsisted and was breached despite the provision of appropriate clinical care to the patient.

This may give rise to some uncertainty and several downstream implications for hospitals.

Does this mean that hospitals without a system ensuring that every patient is notified of every incidental finding is potentially in breach of their duty of care to that patient if such incidental findings are not brought to the patient's attention? From the Court's decision, this would appear to be the case.

While informing patients of incidental findings may be done quite easily at bedside during admission, how should hospitals ensure that this happens for outpatients? Reports can be sent electronically via email or SMS, but one cannot assume that every patient has access to those channels of communication. While informing a caregiver via those means may be an option, doing so while respecting patient confidentiality and minimising administrative overheads may have its own challenges.

How should hospitals deal with the possibility of increased workload caused by patients requesting further information when the clinical decision was that no further follow-up is needed (as was the case above)? As test and scan reports are written for readers who have had medical training, a patient is unlikely to be able to understand the technicalities and implications of its contents. If the patient's queries were directed to the clinician-in-charge (or even another clinician), allowances may have to be made for an overall increase in the doctor's workload.

Does this duty of care only extend to tests with abnormal findings? If part of the rationale behind this duty is to enable the patient to exercise their autonomy and seek a second opinion as described above, then patients seeking a second opinion in respect of normal test results may fall within its ambit.

In deciding whether and how to act on the above, there are at least two approaches a hospital might take. On one hand, a hospital might take a risk-calibrated approach and notify such patients only if their incidental finding falls into certain identified categories that are deemed "high-risk". On the other, it might choose to take the broader approach of notifying all such patients of every abnormal test result (or even every test result, normal or otherwise). One of these latter approaches may be more appropriate than the former, as they are more in line with the view that hospitals exist to serve the population by meeting a fundamental need (ie, healthcare).

The latter approach may therefore be perceived as holistic and aspirational, whereas the former risks being interpreted by the public as the hospital being in a position of conflict by selectively protecting its interests vis-a-vis that of patients', even if that was not intended.

In any case, it bears repeating that this applies only for patients with no further follow-up required, as those patients with follow-up can be informed of any test results at subsequent visits.

Conclusion

As the case centred on diagnosis and treatment, the Court applied the Bolam-Bolitho test. However, if a patient were to return to his/her doctor seeking to understand what an incidental finding means for them, the modified Montgomery test (which has been the subject of much recent discussion) would then be applicable, as there would be the element of advice and risk disclosure present.

Given the trend of shifting the balance between the ethical principles of patient autonomy and beneficence in favour of the former, it is perhaps unsurprising that the Court found as it did on issue of a hospital's duty of care.

However, now that this aspect of the duty of care has been explicitly articulated, there are further uncertainties and operational implications which are potentially far-reaching if hospitals are to avoid being found to be in breach in future disputes. ◆

Note: In a newspaper article regarding the matter, the plaintiff expressed her intention to appeal the decision of the High Court.

Reference

1. *Noor Azlin Bte Abdul Rahman v Changi General Hospital Pte Ltd and others [2018] SGHC 35.*

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