

# Medical Negligence: Duty of Care By Suresh Nair



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## Editor's Note:

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The steep rise in medical litigation in recent years has left many medical practitioners feeling besieged and has raised the specter of the practise of defensive medicine. Against this background it has become essential that doctors be informed about the nature and extent of the duty that they owe to their patients and other parties.

## THE GENERAL DUTY OF CARE

The rules as to the duty of care in medical negligence cases are the same as the rules applicable to all other kinds of negligence. Before it can be said that a party is under a duty of care to prevent the occurrence of any damage, 3 requirements must be met:

- (1) The damage in question must be a reasonably foreseeable consequence of the negligence;
- (2) There must be a relationship of proximity between victim and tortfeasor; and
- (3) The imposition of liability must in all the circumstances be just and convenient.

In most medical cases, there is no difficulty in finding a duty of care. For instance, a doctor certainly owes a duty of care to his patient. But a doctor sometimes owes duties to third parties as well, and questions sometimes arise in relation to a doctor's duty after hours.

In general, it may be said that there are 3 limbs to a doctor's duty of care - to diagnose, treat and advise.

## THE DUTY TO ADVISE OF RISKS

The nature of the duty to advise of risks has been explained variously. In the American decision of *Canterbury v Spence*<sup>(1)</sup>, the duty was based on a doctrine recognising a patient's "right to know" of material risks<sup>(2)</sup>. The Canadian courts in the case of *Riebl v Hughes*<sup>(3)</sup> appeared broadly to accept the doctrine outlined in *Canterbury v Spence*.

The doctrine has however not been accepted in other courts of the Commonwealth, but the courts of Australia<sup>(4)</sup> and Malaysia<sup>(5)</sup> stand with the courts of Canada<sup>(6)</sup> and the USA<sup>(7)</sup> in asserting the primacy of the courts in deciding what risks should be disclosed by a medical practitioner to his patient. The real issue, on the view taken in these jurisdictions, is whether a patient has been told of all risks to which he may attach significance<sup>(8)</sup>.

This approach appears to be open to the criticism that it does not sufficiently recognise the medical judgment involved in deciding whether or not to disclose a particular risk to a patient. In the case of *Sidaway v Bethlehem Royal Hospital Governors*<sup>(9)</sup>, Lord Diplock pointed out that the disclosure of risks can only have the effect of deterring a patient from accepting treatment, and that, therefore, deciding what risks ought to be disclosed in particular circumstances "is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence in this matter should be treated in just the same way. The Bolam test should be applied."

The "Bolam test" is of course a reference to the test for standard of care set down by the House of Lords in the case of *Bolam v Friern Hospital Management Committee*<sup>(10)</sup>. It has been formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice<sup>(11)</sup>.

The result is that, by and large, applying English law, a doctor is only obliged to advise of risks to the extent that his brethren (or a responsible part of it) would. There are, however, caveats to this rule.

First, it was recognised in *Sidaway's* case that, while a doctor may decline to voluntarily disclose all conceivable risks, he cannot decline to do so when he is specifically asked about them by his patient<sup>(12)</sup>.

Second, where a doctor fails to disclose to a patient of a substantial risk of grave

adverse consequences, then the Court would be at liberty to find that the doctor breached his duty to advise, even if no expert medical evidence is led to condemn the non-disclosure<sup>(13)</sup>. However, the failure to lead evidence to condemn non-disclosure may of itself indicate that no such risk exists. For instance, in the case of *Denis Mathew Harte v Dr Tan Hun Hoe & Singapore General Hospital Ltd*<sup>(14)</sup>, the Singapore High Court held that the absence of expert evidence condemning a certain non-disclosure indicated that, probably, the majority of practitioners in the relevant field did not think that disclosure was necessary.

Third, the Court may reject expert medical evidence if it cannot be demonstrated to the Court's satisfaction that the body of opinion relied upon is reasonable or responsible<sup>(15)</sup>.

Finally, where high-risk measures are to be undertaken, the onus to advise appears to be higher. In such cases, when circumstances permit, the doctor must give "adequate and unambiguous information, explanation and warning to the patient in the presence of those close to the patient and give the patient ample opportunity to make the decision and give his informed consent in response to the advice"<sup>(16)</sup>.

The Singapore High Court has adopted the English position on the issue of the duty to advise of risks<sup>(17)</sup>. As matters stand, therefore, under Singapore law, the extent of the duty to advise of risk is largely a matter for medical judgment.

## THE DUTY TO THIRD PARTIES

Doctors may sometimes fall under a duty of care to parties other than their patients. There are 2 principal circumstances when this may happen: first, in "nervous shock" cases; and second, in cases where the doctor's services are commissioned not by the "patient", but by another party, for a specific purpose.

The Singapore case of *Pang Koi Fah v Lim Djoe Phing*<sup>(18)</sup> involved a claim for "nervous shock" to a third party arising out of medical negligence.

In that case, the mother of a young lady was wrongly told by a neurosurgeon that, if her daughter did not have an operation immediately, she would die. For obvious reasons, the mother consented to the operation, which went terribly wrong. The neurosurgeon removed healthy tissue and in the process caused a tear in the patient's arachnoid membrane. The patient began to leak cerebro-spinal fluid through her nose and then developed meningitis and ultimately passed away after much pain and suffering, witnessed by her mother. The mother was understandably traumatised by the episode and sued the doctor for the psychiatric illness she contracted as a result of her witnessing her daughter's deterioration.

The learned Judicial Commissioner Amerjeet Singh decided that the doctor was liable to the mother for damages for the negligent infliction of psychiatric illness. The mother was awarded general damages of \$30,000, plus reimbursement of medical expenses and a sum for future medical expenses.

It must be noted that there is little that a doctor can do to avoid this kind of liability - he obviously cannot prevent the patient's nearest and dearest from witnessing the patient's gradual deterioration. Professional counselling, however, may be helpful.

Sometimes, a doctor may be commissioned by a third party to examine or evaluate a "patient" for a specific purpose. In such cases, the doctor has a primary duty to the third party, and a secondary duty to the patient.

One such case is where a doctor is asked to examine an applicant for a life insurance policy. In such cases, the doctor "does not, by examining the applicant, come under any general duty of medical care to the applicant. He is under a duty not to damage the patient in the course of his examination: but beyond that his duties are owed to the insurance company and not to the applicant"<sup>(19)</sup>.

It is suggested that the same principle would apply to doctors conducting statutory examinations in Singapore - for example, when they examine foreign maids at the direction of the Ministry of Manpower.

## DUTY AFTER HOURS

Sometimes a doctor may be called upon after hours. In considering a doctor's duty to attend in such circumstances, 2 situations should be looked at - the situation where the person in question is his patient; and the situation where the person in question is a stranger. In either case, the essence of the duty is the voluntary assumption of responsibility<sup>(20)</sup>.

There is little doubt that a doctor accepts responsibility for the care of his patient. Accordingly, where a doctor-patient relationship exists, the doctor falls under a duty to attend. This duty exists even if the doctor is contacted after hours. This does not mean that a doctor is bound to drop what he is doing and scurry off to make house calls whenever his phone rings. Much will depend on the precise circumstances of the case<sup>(21)</sup>. It is suggested that the doctor would at the very least fall under a duty to enquire as to the nature of the complaint and to make arrangements if necessary for his patient to be attended to.

It cannot however be said that there has been such an assumption of responsibility where no doctor-patient relationship exists. It follows that a doctor is entitled at law to refuse medical attention to a stranger<sup>(22)</sup>.

Once, however, the doctor chooses to attend to a "patient" in circumstances that indicate a genuine undertaking of responsibility, the ordinary rules as to duty of care apply. It must however be borne in mind that the applicable standard of care varies with the situation that the doctor might find himself in. Accordingly, the law recognises that a doctor attending to an accident victim in the middle of a road will not be able to render the same quality of care as if he were in his clinic.

## CONCLUSION

The following basic propositions may be extracted from the authorities:-

1. The general rules as to a doctor's duty of care are the same as the rules applicable in other kinds of negligence.
2. The law in Singapore is that, in general, the extent of the duty to advise a patient of risks is a matter for medical judgment.

3. A doctor may in certain circumstances have a duty of care to parties other than the party being examined. These parties include near relatives who may suffer psychiatric inquiry from witnessing the deteriorating condition of the patient and parties, such as insurers, who appoint a doctor to conduct examinations for specific purposes.
4. A doctor only falls under a duty of care when he voluntarily accepts responsibility for a patient's care. That duty does not cease when the doctor's clinic is closed for the day.

Recent events have shown that Singaporeans have become increasingly likely to take issue with the standard of medical care given to them. Doctors must be prepared to deal with this growing litigiousness not only by continuing to bring their best to their work, but also by continuously informing themselves of what the law expects of them. Thus prepared, doctors will be able to proceed without fear of liability. ■

## References:

1. 464 F 2nd 772 (1972) USCA, District of Columbia.
2. *such as Canterbury v Spence and Crain v Allison* (1982) 443 A. 2d 558.
3. 3 (1980) 114 DLR (3d) 1.
4. *Rogers v Whitaker* (1992) 175 CLR 479.
5. *Kamalam v Eastern Plantation Agency* (1996) 4 MLJ 674.
6. *Riebl v Hughes*, *supra*.
7. *Canterbury v Spence*, *supra*.
8. *see, for example, Rogers v Whitaker*, *supra*, at 490.
9. (1985) 1 AC 871 at 895.
10. (1957) 1 WLR 582.
11. *Sidaway v Bethlehem Royal Hospital Governors* at 881.
12. *ibid* p895.
13. *ibid* p900.
14. *Suit No 1691 of 1999*, 24 Nov 2000 (unreported) at p7.
15. *see Bollitho v City and Hackney H.A* (1998) AC 232 at 241-242; *Denis Mathew Harte v Dr Tan Hun Hoe & Gleneagles Hospital Ltd*, *supra*, at 44.
16. *Gunapathy Muniandy v Dr James Khoo & ors* (Suit No 1768 of 1999), 4 July 2001, unreported.
17. *see Jason Carlos Francisco v Dr LM Thng & Singapore General Hospital Ltd*, Suit No 1573 of 1998, 6 August 1998 (unreported); *Denis Mathew Harte v Dr Tan Hun Hoe & Gleneagles Hospital Ltd*, *ibid* and *supra*.
18. (1993) 3 SLR 317; *see also Tredget v Bexley Health Authority* (1994) 5 Med LR 178.
19. *X Minors v Bedfordshire County Council* (1995) 3 WLR 152 at 186.
20. *R v Bateman* (1925) 94 LKB 791 at 794.
21. *See Smith v Rae* (1919) 51 DLR 323 (Ont.S.C). Note however that in that case, the surgeon had undertaken to attend to the patient during confinement.
22. although the medical disciplinary bodies such as the Singapore Medical Council may impose a duty to attend nonetheless, and have indeed done so. *See also Michael Jones, Medical Negligence*, 2nd ed, p 34.