

TANGGUNGJAWAB DAN PIAWAIAN PENJAGAAN DAN RAWATAN

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MEDICAL NEGLIGENCE: DUTY OF CARE AND STANDARD OF CARE

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Negligence is the most important area in modern tort law. It covers nearly half of any textbook. The tort of negligence protects various interests such as interests in physical integrity, interest in property and economic interests.

Definition of “negligence”

- ▶ defined by *Winfield* as “**the breach of a legal duty to take care which results in damage, undesired by the defendant, to the plaintiff.**”
- ▶ In *Loghelly Iron & Coal v M’Mullan* [1934] - Lord Wright stated “Negligence means more than heedless or careless conduct...it properly connotes the complex **concept of duty, breach and damage** thereby suffered by the person to whom the duty was owing.”

Continuation...

Prof. Fleming: Negligence is the **conduct falling below the standard demanded for the protection of others** against unreasonable risk of harm.

Blyth v Birmingham Waterworks Co (1856) 11 Ex 781: Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs would do or doing something which a prudent and reasonable man would not do.

Not All Errors are Negligent

- **Medical negligence...**

- Failure to meet the standard of practice of an average qualified doctor practicing in the specialty in question
- ❖ *Occurs not merely when there is an error, but **when the degree of error exceeds the accepted norm***

Principal Elements of Negligence

- (a) **duty of care** or an existing legal duty on the part of the defendant to the plaintiff to exercise care in such conduct of the defendant as falls within the scope of the duty;
- (b) **breach of duty** or failure to conform to the standard of care which the defendant owes the plaintiff;
- (c) **causation or consequential damage** to the plaintiff , that is, the plaintiff suffers damage as a result of the defendant's breach of duty.

1. The Duty of Care

- **Definition: an obligation or a burden imposed by law**, which requires a person to conform to a certain standard of conduct. The existence of such a duty in a given set of circumstances has given rise to what is known in the law of torts as a “duty situation”.
- A person will owe a duty of care to those who are also within his contemplation who will suffer foreseeable loss.

When does a duty of care arise?

- *Obiter dictum* of Brett MR in *Heaven v Pender* [1883] 11 QBD 503 led to the formulation of the neighbour principle:
- **“Whenever one person is by circumstances placed in such a position with regard to another, that everyone of ordinary sense who did not think and would at once recognize that if he did not use ordinary care and skill in his own conduct with regard to those circumstances he would cause danger or injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger.”**

Donoghue v Stevenson [1932] AC 562

- **Facts:** A friend of the pff purchased a bottle of ginger beer at a café. The pff had consumed some of the drink but when she poured out the remainder of the contents of the bottle which was opaque, she found a decomposed snail. The pff suffered shock and subsequently became ill with gastro-enteritis. She could not sue the retailer of the ginger beer for breach of contract as she was not in contractual relationship with the retailer as the contract had been made between the retailer and her friend. Thus, she sued the manufacturers of the ginger beer in tort.
- **Held:** The House of Lords held that the defs, being manufacturers of the ginger beer, owed a duty of care to the pff, as the ultimate consumer or purchaser of the drink. This duty was to ensure that the bottle did not contain any substance which was likely to cause injury to anyone who purchases it in due cause.

Lord Atkin In *Donoghue* formulated a general principle for determining the existence of Duty of Care which came to be known as the “**Neighbour Principle**”.

The rule that you are to love your neighbour becomes, in law, you must not injure your neighbour, and the lawyer's question "who is my neighbour" receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then, in the law is my neighbour? The answer seems to be **persons who are so closely and directly affected by my act that I ought reasonably to have them in my contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.**

Taj Hospital v Ketua Pengarah KKM [2008] 7 MLJ 498

- **Facts:** The plaintiff was a private hospital and applied to the first defendant for renewal of its licence. After finally submitting all the documents required for renewal, the pff's licence was renewed. However, the pff brought a claim alleging there was a delay in the renewal and the failure to issue the licence promptly caused him not to be able to operate his hospital for nearly a year.
- **Held:** A duty of care at common law therefore exists on the part of the first defendant to ensure that the licence was issued to the plaintiff in due time as without the licence, it is foreseeable that the pff will not be able to operate its hosp legitimately.

Patient as doctor's legal neighbour

- If the doctor realises that the patient **might be affected by his act**, then it automatically establishes the neighbour principle – duty of care arises from the doctor-patient relationship.

Giving assistance to strangers

- Without the existence of a relationship i.e. a doctor patient status, there is no duty to act. There is no legal obligation on a doctor to play a **“Good Samaritan”** and render assistance to a stranger.

❖ Doctors' ability to help and moral obligation to do so make them vulnerable to expectations of the society.

❖ Hippocratic Oath, the medical professional swears to “act so as to preserve the finest traditions of my calling and experience the joy of healing those who seek my help”.

❖ However, should they render medical assistance to anyone in distress.....in other words, should they act as good samaritans?

GOOD SAMARITANS...who are they?

- Good Samaritan usually refers to the *Parable of the Good Samaritan*, a story in the Christian gospel of Luke that **encourages people to help others that are in danger.** (Luke 10:30-37).
- - “A compassionate person who unselfishly helps others, especially strangers.”
- - “A person who voluntarily gives help to those in distress or need”





MARVEL

DOCTOR
STRANGE

It is a *moral duty* to help those who are in need...

Lord Coleridge in *R v Instan [1893] 1 QB 453* – “It would not be correct to say that every moral obligation involves a legal duty but **every legal duty is founded on a moral obligation.**”

Strict confines of the common law

- ❖ **Common law** – strong reluctance of subjecting persons to such liability to those who fail to help others...if the distress is not caused by him.
- ❖ Reluctance founded on the jurisprudential distinction between **acts and omissions**.
- ❖ Common humanity does not impose positive obligation to assist.
- ❖ **Misfeasance** is actionable whereas generally **non-feasance** is not.

Windeyer J. in English case - *Hargrave v Goldman (1967)*

“He obviously was a person whom they had in contemplation and who was closely and directly affected by their action. **Yet the common law does not require a man to act as the Samaritan did.** The lawyer’s question must therefore be given a more restricted reply than is provided by asking simply who was, or ought to have been, in contemplation when something is done. **The dictates of charity and compassion do not constitute a duty of care.** The law casts no duty upon a man to go to the aid of another who is in peril or distress, not caused by him.”

**Therefore...there is No legal
obligation on a doctor to play
a Good Samaritan and render
assistance to a
stranger...under the English
Common Law**

Duty to emergency patients

- The common law does not impose a positive duty on a doctor to attend upon a person who is sick, or even in an emergency, if that person is one with whom the doctor is not and has never been in a professional relationship of doctor and patient
- **Doctor may owe duty if work in casualty/emergency department**

**The Departure from the strict confines
of the Australian common law**

**Lowns v Woods
(1996)**

Lowns v Woods (1996)

- opened up liability of medical practitioner for negligent failure to attend and treat non-patients in an emergency
- Patrick Woods – 11 yrs – epileptic seizures – Dr Lowns failed to attend to him upon request – his clinic was 300 metres away

Issue: Whether emergency request sufficient to create duty of care?

- Neither Patrick nor any members of his family were Dr L 's patients
- **No prior contact** between them
- **No circumstantial proximity** based on doctor-patient relationship
- Court held that **duty of care existed**

Reason 1 : Proximity

- relied on *The Council of the Shire of Sutherland v Heyman* (1985), where it decided that duty was founded to be based on **physical proximity, circumstantial proximity and causal proximity.**
- Three kinds of proximity exist in this case

Continuation....

- **Physical proximity** – P was 300 metres away from Dr L's clinic
- **Causal Proximity**- Dr L was apprised of P's condition and recognised it as medical emergency – he was competent to do something
- **Circumstantial proximity** – Dr L was in the place of practice when request was made

Reason 2 : Breach of statutory duty

- s27(1)(h) of the Medical Practitioners Act 1938 (NSW) - professional misconduct” in relation to a registered medical practitioner, includes the following:
- ... (h) **refusing or failing, without reasonable cause, to attend, within reasonable time after being requested to do so,** on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner.”

Continuation....

- There exist the required “proximity” to impose a doc in the above provision because there an expectation in society that the medical profession would comply with its terms and attend persons in need of urgent attention. **The law should generally accord with community’s expectations especially in assessing “reasonableness of conduct.”** It should further take into account social developments and public perception of the content of a particular duty when imposing a duty of care.

Further, there are some jurisdictions that imposes penalty on doctors for failure to render assistance to those who are in distress

In many European jurisdictions, failure to render assistance to those in need capable of attracting criminal sanctions...

French Law

The French Law punishes – both in criminal and civil law – the bystander who, directly witnessing a dangerous incident, **does not intervene even though to do so would pose no risk to him or a third party.**

Criminal Code Art 223-6

- **“Whoever voluntarily fails to provide to a person in danger the assistance that, without risk for himself or a third party, he could provide, either by his own actions, or by initiating a rescue may be punished by up to five years imprisonment and a fine of up to 75.000 Euro”.**
- **Such a failure to provide assistance to a person in danger, such a breach of the duty to rescue, constitutes not only a criminal offence, but also a civil wrong.**

German Law

The basis for the German Law's duty to rescue is codified in § 323c of the German criminal Code, the "Strafgesetzbuch" or "StGB":

Who fails to provide help in cases of disaster or imminent danger or distress, although this [help] is necessary and reasonable under the circumstances, [and is] especially without considerable danger for his own and without violation of other important duties possible, will be penalized with imprisonment up to one year or fined.

Belgian Law

The Belgian Law imposes on **anyone** who is capable to aid a legal duty to help a person, who is in great danger, without putting himself or others in **serious danger** (Article 422 Criminal Code)....however, only a minimum of altruism is required, but no heroism.



Online Exclusive

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In Your Face

Tuesday, 31 May 2016 | MYT 11:39 PM

Can we try to be good Samaritans?

BY TAN YI LIANG



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Tan Yi Liang believes that people have more positive power in their hands than they realise. He wants to prove this - and challenge readers by speaking to experts, and getting right "In Your Face".



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Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007]

- Adopted the judgment by Callaghan J. in **Hajgato v London Health Association** In my view however, a court has a right to strike down substandard approved practices when common sense dictates such a result. (1982) **“No profession is above the law and the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards.”**

Good Samaritan Law

- **Good Samaritan doctrine** - Black's Law 7th edition: 'The principle that a person who is injured while attempting to aid another in imminent danger and who then sues the one whose negligence created the danger, will not be charged with contributory negligence unless the rescue attempt is an unreasonable one or the rescuer acts unreasonably in performing the attempted rescue.'

- The Need for Good Samaritan Law in Malaysia

❖ Dr Chang Keng Wee, the honorary secretary of Federation of Private Medical Practitioners' Association of Malaysia (FPMPAM) has mooted the enactment of "Good Samaritan Clause" in relevant legislations, in particular, the Private Healthcare Facilities Act 1998 and Regulations 2006, which essentially should state that, **"short of gross negligence or professional incompetence, doctors providing free and voluntary emergency care for such patients that are brought to the clinics, should be protected from liability."** This would then be fair as the law is not only needed to protect those who need help, but also those who provide help – *New Straits Times, Sept 17, 2006.*

Duty to Third Parties

- **Doctor's negligence may have serious consequences not only to his patient but others as well.**
- **In certain circumstances, the doctor may owe duties to persons other than his patient - those coming within the "neighbour principle" formulated by Lord Atkin in *Donoghue v Stevenson*.**

Various situations – duty of care to third parties

- Third party suffering from an identifiable psychiatric injury through witnessing a trauma or its immediate aftermath
- Third party coming into contact with patients taking prescribed drugs with certain side effects
- Third party is the unborn child
- Third party in danger from harm or infectious disease by coming into contact with the patient

E.g - Third party suffering from psychiatric injuries

- To establish liability – distinguish between primary and secondary victims – different requirements
- Must suffer genuine psychiatric illness
- Requirements for secondary victims -*McLoughlin v O'Brian* [1983] 1 AC 410, *Alcock v Chief Constable of South Yorkshire* [1992] 1 AC 310 and *Page v Smith* [1995] 2 All ER 736

Requirements for secondary victims

- Relationship of love and affection with the victim
- Proximity of time and space – sudden appreciation of sight and sound of a horrifying event
- Means of how the shock was caused – through own senses

Kralj v McGrath [1986] 1 All ER 54

- P- to give birth to twins – first one born ok – 2nd twin in transverse position – D tried to do manual manipulation of the head – failed – delivered thro caesarian section – baby born severely disabled – later died – Mrs K was told what happen but later witness the death
- Held: Mrs K could recover

Taylor v Somerset Health Authority (1993) 16 BMLR 63

- D negligent in failing to diagnose and treat heart disease of Mr T
- Mr T had a heart attack – Mrs T rushed to hospital but too late Mr T died – Mrs T shocked and distressed later saw Mr T's body at the mortuary
- Held: Mrs T cannot recover – no external traumatic event

Sion v Hampstead Health Authority [1994] 5 Med LR 170

- A man of 23 yrs badly injured in a motorcycle accident – father stayed by his bedside for 14 days , watch him deteriorate and fall into coma – later died – father claimed suffer psychiatric illness due to negligent treatment of his son – failure to diagnose bleeding from kidney
- Held: Father cannot claim – 2nd element missing

2. Breach of Duty / The Standard of Care

- After proving D owe P a duty of care, P must further prove, on a balance of probabilities that the conduct of the D fell below the required standard of care.
- The standard of care, which the law demands of a person in a normal case, has been established to be the standard of “reasonable care” - standard satisfied by the hypothetical reasonable man.

The Test: The Bolam Principle

- The test to determine what is the standard of care demanded of a doctor was established by McNair J. in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 - subsequently became known as the *Bolam principle*

The Bolam principle

- ▶ “The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.... in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time.... I myself would prefer to put it this way, that **he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.....** Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that would take a contrary view. ”

Essential Elements

- 1. The doctor must have acted in accordance with “accepted medical practice” e.g. *Whitehouse v Jordan* [1981] 1 WLR 246
- 2. The accepted practice must be regarded as proper by “ a responsible body of medical men” skilled in that art

1. Accepted practice must be current practice

- The accepted practice must be the current practice. This requires the defendant to keep up with the latest developments in his field of medicine.- *Roe v Minister of Health &Anor* [1954] 2 QB 66

2. Responsible body of medical men skilled in that art

- What constituted “a responsible body of medical men” and whether this group had to be substantial? – *De Freitas v O’ Brien and Connolly* [1993] 4 Med LR 281 - “There was evidence ... that a small number of tertiary specialists could constitute a responsible body of medical opinion.... The issue whether or not to operate could not be determined by counting heads.... a small number of specialists [could constitute] a responsible body [which in fact found] ... the defendant’s decision justified.”

A Change of Attitude - Bolitho v City & Hackney HA

- Court not bound to hold D not liable just because a number of medical experts agree with him.
- The word **“responsible”** used by McNair J. in *Bolam* “show[s] that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that **such opinion has a logical basis.**”

Cont...*Bolitho*

- Even tho there exists a body of professional opinion sanctioning D's conduct, D can still be held negligent if “it cannot be demonstrated to the judge's satisfaction that the opinion relied on is reasonable or responsible.”
- But court acknowledged that it would be a “rare” or “exceptional” case where judicial intervention will be justified
- Approved in *Penney, Palmer and Cannon v East Kent HA* [2000]

Therefore in...

- The Federal court case of *Foo Fio Na v Dr Soo Fook Mun & Anor* (2007)...applying *Bolitho v City & Hackney Health Authority* [1997] 4 All ER 771

“The court is at liberty to reject medical expert evidence which does not stand up to logical analysis. The court must scrutinise and evaluate the relevant evidence in order to adjudicate the appropriate standard of care.”

Present Essential Elements

1. The doctor must have acted in accordance with “accepted medical practice”
2. The accepted practice must be regarded as proper by “ a responsible body of medical men” skilled in that art
3. The court will decide which **medical opinion reaches up to a logical analysis...**

High Court in *Ku Jia Shiuen* (2013)

- However, in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 (FC) the Federal Court adopted the **Rogers v Whitaker test** (**Rogers v Whitaker** (1992) 16 BMLR 148;(1992) 175 CLR 479) in preference to the Bolam test. Accordingly, the standard of care applicable in such cases is not determined solely or primarily by reference to the practice **followed or supported by a responsible body of opinion in the medical profession**. Thus, while evidence of acceptable medical practice is a useful guide, it is ultimately for the court to adjudicate on what is the appropriate standard of care, drawing upon the totality of the evidence presented.

Egs of Clear Breach of Standard of Care

- **Chin Keow v Govt of Msia [1967]** – Failure to inquire on the medical history of the patient – whether the patient was allergic to any drugs.
- **Kow Nan Seng v Nagamah & Ors [1982]** – Failure to ensure proper monitoring of blood circulation after plaster of paris has been applied.
- **Chelliah Manickam v Govt of Msia [1997]** – Failure to diagnose between appendicitis and pancreatitis ang gave wrong treatment

Ku Jia Shiuen (suing thru mother, Tay Pei Hoon) & Anor v Govt of Malaysia & Ors (2013)

- **Facts:** Mother's first pregnancy – encountered complications – prolonged second stage labour as she had difficulty pushing the baby out due to a congenital deformity of bending her right knee – should not have been required to give birth in lithotomy position
- Fetal distress – deprivation of adequate oxygen – baby suffered spastic quadriplegia secondary to HIE
- Failure to provide immediate after care – delay contributed to aggravation of HIE and development of cerebral palsy

The Decision – *Ku Jia Shiu*en...

- Held: The defendants were held liable:
- Mother's first pregnancy – should not have been admitted to Birthing Centre contrary to the policy by Ministry of Health – no qualified and suitable O & G specialists available there
- Delivery should be performed under Caesarian section instead of vacuum due to her congenital deformity – failure to recognise the deformity
- Relevant documents relating to mother's birth went missing – infer deficiencies in the institutions ... to rely on oral evidences

Lim Zi Hong v Pengarah Hosp Selayang & Ors (2013)

- **Facts:** Mother – pregnant with twins – high risk case – not advised for caesarian section...mother requested the same...long labour...by the time caesarian was conducted – pff’s head deeply engaged - no specialist attended to the delivery of the twins despite the pff’s mother, **being a high risk case**. The delivery of the pff, was instead attended to, by a medical officer until the MO sought help from the specialist at the end
- Pff suffered cerebral palsy secondary to perinatal asphyxia epilepsy and left hemiplegia

The Decision – *Lim Zi Hong*

- **Held:** The court finds on a balance of probabilities proved that the cerebral palsy suffered by the pff, was caused by the defs. The failure to carry out an elective caesarian section on the pff’s mother early and the delay in delivery of the pff showed that the defendants were in breach of their duty.
- “It is reasonable to infer that a safe obstetric system would require an emergency lower segment caesarian particularly to a high risk patient, such as the pff’s mother, to be attended to promptly, anticipate difficulties and have a specialist to conduct the delivery or to be immediately available to prevent any injury to the baby” – paragraph 53.

Turkyah Abdul Rahman v Dr Seri Suniza & Prince Court

- Facts: Pff – Saudi Arabia national – requested for induction of labour – induction was done using Cytotec tablets – membranes burst spontaneously – poor dilation – delivery by vacuum and forceps – baby died
- Pff heavy menstrual bleeding given blood transfusion - laparotomy surgery and hysterectomy done - she suffered hyper stimulation of the uterus - uterine rupture / uterine wall tear - post-partum haemorrhage - rectovaginal fistula which required colostomy.

The Decision - *Turkyah*

- Held: The defendant was negligent in carrying out induction with Cytotecs tablets – **did not take into account her previous history of pregnancies had put her on high risk to suffer from a uterine rupture from the induction** - The baby died from uterine rupture caused by the use of cytotec tablets in the dose of 100mcg used for induction of labour - the intensity of contractions caused by cytotec caused a partial rupture of the uterus and this was aggravated by the failed vacuum delivery that caused the vaginal tear.

Doctor's duty is actually one single indivisible duty but for the purposes of standard of care....the duty is divided into 3:

1. **DUTY TO DIAGNOSE**
2. **DUTY TO TREAT**
3. **DUTY TO WARN/DISCLOSE RISKS** – *Bolam* principle rejected, replaced by *Rogers v Whitaker* test in which circumstances surrounding the patient becomes paramount

Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017]

- The test propounded by the Australian case in *Rogers v Whitaker* and followed by this Court in *Foo Fio Na* in regard to standard of care in medical negligence is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis or treatment, the Bolam test still applies, subject to qualifications as decided by the House of Lords in *Bolitho*.

Facts of *Zulhasminar* (2017)

- Zulhasminar, pregnant, chose Dr Kuppu to be her O&G. When she was 36 weeks, came to the hospital complaining of abdominal pain, admitted to hosp (pulse 108, blood pressure 122/68). Given Pethidine and Phernegan (pulse n bp came down).
- Later that morning, Zulhasminar suddenly collapsed – severe bleeding – Code Blue alarm sounded – resuscitated – rushed to the operation theatre – her baby was delivered alive – hysterectomy done due to ruptured blood vessel at placenta.
- Baby suffered severe birth asphyxia causing cerebral injury.

THE CLAIM

- 1. Zulhasminar claimed that she was in labour shortly after admission, if Caesarian Section (CS) had been performed without delay, her baby would not have suffered her present disability.
- Dr Kuppu and nursing staff were negligent in failing to diagnose that she was in labour, instead drugs were given to lessen her pains.
- 3. Dr Kuppu should have foreseen that Zulhasminar might suffer a uterine rupture if CS was delayed as she knew she had a condition called cephalo-pelvic disproportion after delivering her first baby.
- 4. If Zulhasminar was adequately resuscitated, her baby would not have suffered cerebral injury.

THE DECISION – Doctors, staff and hospital were found not liable...

- 1. Failure to prove that she was in labour and merited an earlier CS to be performed on her as it can be shown that she was **closely monitored** and there were **no signs of being in labour..**
- Failure to show that uterine rupture was foreseeable and preventable as given her obstetric history, **an elective CS would have been done if she was at 38 weeks gestation.**
- 2. She suffered an **abnormal presentation** namely, **placenta percreta** which was not detectable during the normal check up...this condition led to the vessels on the outer surface of the uterus to rupture.
- 3. From the time of her collapse, **the delivery of the baby was within 30 minutes which was internationally accepted standard.**

i. Duty to Diagnose

- ▶ An error of diagnosis will not necessarily amount to negligence, unless the patient can establish that the doctor failed to carry out an examination or a test which the patient's symptoms called for or his conclusion was one that no reasonable, competent doctor would arrive at. In the area of negligent diagnosis.

Basic duties

- ▶ Doctor must consider the patient's medical history as the patient may, eg allergic to a particular drug, pre-existing illness – *Chin Keow v Govt of Malaysia* (1967)
- ▶ Doctor must ask the patient relevant questions and listen to his account of the illness. *Maynard v West Midlands RHA* [1984] 1 WLR 634
- ▶ In cases of doubtful diagnosis, it is good practice for the patient to be referred to a specialist for further consideration of the case. *Gordon v Wilson* [1992] 3 Med LR401

CASE STUDY – BREACH OF DUTY TO DIAGNOSE

**Chien Tham Kong v Excellent
Strategy Sdn Bhd & Ors
[2009] 7 MLJ 261**

Facts of the Case...

- Plaintiff – 41 year old diabetic patient – 3 week history of lower back pain.
- Admitted to hospital (1st def), seen by consultant orthopaedic surgeon (2nd def) and also 3rd def (consultant physician for management of diabetes).
- Discharged after 3 days...returned to see 2nd def for pain at the neck – did conservative treatment included physiotherapy

Continue ---Facts...

- Admitted to hosp 4 days later – experienced weakness of the right limbs, sweating at night and fever
- Examined by 3rd def...neurological condition worsened...became paraplegic
- First MRI scan revealed pff did not suffer stroke...subsequent MRI revealed cervical epidural abscess – a rare type of infection in the epidural spine

THE CLAIM

- ❑ Against the second defendant - **Failure to take any proper precaution to prevent injury to the pff's spinal cord.**
- ❑ Against the third defendant – **Negligence in making initial diagnosis of stroke without considering alternative diagnosis**

THE DECISION

Cervical epidural abscess is a very rare type of infection in the cervical epidural spine which defies early diagnosis and treatment. In the instant case, it would have been very difficult to even consider the possibility of cervical epidural abscess when the plaintiff presented signs and symptoms consistent with a stroke. It was unreasonable for a doctor to first suspect a rare condition when the symptoms and signs presented by a patient pointed to a different but much more common condition

2nd and 3rd Defs did not breach the standard of care and 1st Def not vicariously liable.

ii. Duty to Treat

- ▶ A medical mistake is something that the courts will accept as part of the ordinary human fallibility whereas medical negligence encompasses conducts that transgresses beyond what is expected of a reasonably skilful and competent doctor or nurse.
- ▶ is no doubt in finding negligence in cases of gross medical mistakes. For instance, removal of the wrong limb, the use of the wrong drug or administering the wrong gas during the course of an anaesthetic or leaving operating equipments inside the patient's body. **In such cases, the doctrine *res ipsa loquitor* (the thing speaks for itself) can be invoked in determining negligence.**

RES IPSA LOQUITUR

- This doctrine permits the court in certain cases to draw an inference of negligence at an early stage in the trial on the basis of circumstantial evidence of a highly suggestive nature.
- This doctrine relieves the plaintiff, who usually has insufficient knowledge of how the accident occurred, from bringing evidence to show the precise way in which the negligence occurred.

Definition

- literally means “**the thing speak for itself**”. In legal terms, **it means that the fact of the accident by itself is sufficient (in the absence of an explanation by the defendant) to justify the conclusion that most probably the defendant was negligent and that his negligence caused the plaintiff’s injury.**
- The doctrine first appears to have surface in ***Byrne v Boadle (1863)***
- The classic exposition of the doctrine appeared two years later when the doctrine was laid down succinctly by Erle CJ in *Scott v London and St Katherine Docks (1865)*

The doctrine

- Erle CJ in *Scott v London and St Katherine Docks* stated:

“...where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.”

Objective

- The principal objective of this maxim is **to prevent injustice to the plaintiff**, which would be the case if the plaintiff were required to prove the precise cause of the accident and the defendant's responsibility for it. In medical cases particularly, where the treatment and operation is complex and the patient may be unconscious at the time, this doctrine can be of particular significance

Requirements to be satisfied

1. The Defendant must be in control of the thing which caused the injury to the plaintiff

Gee v Metropolitan Railway (1873) LR 8 QB 161 – Station in control as train just left the station

Easson v LNE Rrailway [1944] 2 KB 421 – station not in control – train 7 miles from station

Requirements...cont...

- **2. The accident must be of such nature that it would not have occurred in the ordinary course of events**
- *Byrne v Boadle* (1863) 2 H & C 722 – barrel of flour would not have fallen in absence of negligence
- *Mahon v Osborne* [1939] 2 KB 14 – swab would not have been left in abdomen in absence of negligence

Requirements...cont...

- *Barkway v South Wales Transport Co Ltd* [1950] 1 All ER 392 – “...[t]he doctrine [of *res ipsa loquitor*] is dependant on the absence of explanation, and, although it is the duty of the defendants, if they desire to protect themselves, to give an adequate explanation of the cause of the accident, yet, if the facts are sufficiently known, the question ceases to be one where the facts speak for themselves, and the solution is to be found by determining whether, on the facts as established, negligence is to be inferred or not”
- **3. There must be no explanation for the accident**

iii. Duty to Inform/ Warn/ Disclose Material Risks

- Vital prior to getting consent for medical treatment
- The development of the Law of Informed Consent in Malaysia (to be discussed in the next lecture)

3. Causation in Fact and Law

- ▶ Once the plaintiff has overcome the difficulties posed by the *Bolam principle*, he has yet to face another difficulty, that is, the problem of proving causation.
- ▶ According to *Giesen*, “...establishing a causal connection between medical negligence and the damage alleged is often the most difficult task for a plaintiff in medical malpractice litigation...”

Definition

- There must be a **causal link between the defendant's breach of duty and the damage sustained by the plaintiff.**
- Therefore, in order for the plaintiff to overcome the issue of causation, he must show that the damage he suffered was caused by the defendant's negligence.

Causation in fact

- ▶ *The “but for” test* – whether the damage would not have occurred “but for” the defendant’s negligence? If yes, the defendant will be liable
- ▶ *Cork v Kirby Maclean Ltd* [1952] 2 All ER 402 – if the damage would not have happened but for a particular fault, then that fault is the cause of the damage, if it would have happened just the same, fault or no fault, is not the cause of the damage.
- ▶ *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428

CASE STUDY – FAILURE TO TREAT

**Azizah Abd Manan & Ors v Dr Norlelawati
Ab Latip & Ors (2013) – High Court JB**

Chronology of Events:

- 13 Feb 2009 – Admitted to hosp after bleeding for 6 days...urine test confirm that she is pregnant...scan showed uterus was empty.....suspected ectopic pregnancy
- 17 February 2009 – diagnosis of right tubal ectopic pregnancy was made but despite this continued with conservative management and wait for the ectopic pregnancy to rupture
- 18 February 2009 – Bleeding and abdominal pain

Facts...continue...

- 20 February 2009 – Another scan showed empty uterus with right adnexal mass with irregular gestation ----failing ectopic pregnancy of unknown location...patient request for discharged and was allowed.
- 24 February 2009 – Patient at Emergency Department – abdominal pain, nausea, shortness of breath and palpitation
- 25 February 2009 was scheduled for emergency laparotomy as a leaking ectopic pregnancy case

Facts...continue

- Anaesthetist assessed her as having throat irritation and non-productive cough...she was explained the danger of anaesthesia due to her upper respiratory throat infection...she consented to the surgery....during anaesthesia difficulty in intubation encountered...developed bronchospasm and then pneumonia.
- Managed in ICU – suffered left lung collapse – condition worsened
- 4th March 2009 – transferred to private hospital diagnosed as having post-operative nosocomial pneumonia with septicaemia...later she developed complications of pulmonary fibrosis, pneumothorax and pleural effusion

The problem – causative link?

- The deceased died not due to leaking or ruptured ectopic pregnancy but complications from bronchospasm developed during anaesthesia.

Decision by the court

- The court held that there was negligence by omission.
- doctors at has did not manage the deceased case properly...**she suffered the consequences of a lost chance**...doctors failed to conduct the surgery before 20 February. If this was done, the anaesthetic complications would not have arisen.
- Further, the throat irritation and non-productive cough for two days should have been observed prior to the surgery.

Decision...continue....

- The fact that bronchospasm was a risk of operation which has been explained to the deceased and she consented to the operation could not absolve the defendants from liability.
- The deceased received **RM484,990.55** in damages inclusive of **RM150,000** for pain and suffering and **RM142,515.55** for the private hospital expenses.

Causation in Law

- ▶ **The foreseeable consequences test: *The Wagon Mound (No 1)* [1961]**
- ▶ Test: the defendant is liable for all the damage of a certain type which is reasonably foreseeable.
- ▶ ***The Wagon Mound (No 1)* [1961] AC 388** – In order to recover for damages, the **plaintiff must prove that the kind or type of damage which he incurred must be foreseeable**. The kind of damage must be reasonably foreseeable although neither the extent of the damage nor the precise manner of its occurrence need be reasonably foreseeable.

IMPORTANCE OF GOOD DOCUMENTATION

When things go wrong- the importance of good and proper documentation?

- Proper documentation of case notes, lab results, x-ray etc.
- In the event that they are required to release these documents when the case goes for trial, non-production will be detrimental to the case - court may invoke— **Section 114 (g) of the Evidence Act 1950** - evidence which could be and is not produced would if produced be unfavourable to the person who withholds it.

Provides documentary evidence

Written evidence carries more weight than oral evidence

❖ Good Record = Good Defence

❖ Bad Record = Bad Defence

❖ No Record = **NO DEFENCE**

FUTURE CHALLENGES

Promoting Safer medical practice in all aspects of healthcare...building greater trust between patients and healthcare providers;

- ❑ Encouraging **Transparency, Reporting and Open Disclosure** amongst Healthcare Providers – Legislative Protection through proper Legal Framework;
- ❑ The Importance of **Educating Law and Ethics** to the Medical Profession...starting from the undergraduate level;
- ❑ Assisting the medical profession to **adhere to the developments of law through a variety of channels.**

Thank you...

- If you need more details on medical law, please purchase my books on
 1. **Nursing Law and Ethics”**
 2. **Medical Negligence Law in Malaysia**
 3. **Cases and Commentary on Medical Negligence**
 4. **Law and Ethics relating to Medical Profession**
- Email: nemie@iium.edu.my