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**CITY UNIVERSITY OF HONG KONG**  
**香港城市大學**

**Medical Negligence in Hong Kong**  
**香港醫療疏忽**

**Submitted to**  
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**by**

**Lam Sau Ping**  
**林秀萍**

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## **ABSTRACT**

Medical negligence has begun an increasing concern recently. In Hong Kong, perhaps the awareness of medical negligence can be explained by the improved education of the general public as well as the increasingly easy accession to medical information. This relatively high degree of awareness inevitably leads to frequent challenges to doctors for their suspected malpractice. This is a striking contrast with the past perception of doctors, whom had been viewed as an elite group of academics with absolute power and knowledge. The rising numbers of tabloid newspapers and magazines like Oriental Daily and Next magazine which like to report medical blunders as attractive stories even increase such challenges. Of course, the increase in compensation after verdict from the court of appeal in 1996 contributes to the complaint culture of Hong Kong public as well.

With the increasing medical blunders, our legal profession will inevitably involve in representing either party in court or, more commonly, giving medical-legal advice to the plaintiffs or defendants concerned. In order to prove medical negligence and claim for compensation, legal profession will have to refer to Tort Law, which forms the foundation for dealing with those issues. When this thesis points out that the three elements for proving medical negligence in a medical litigation should be duty of care, breach of duty and causation, it further points out that the Bolam and Bolitho tests should be considered as the cornerstone in relevant judgments. Through necessary investigations, this thesis further reveals that legal and medical professions in Hong Kong have not properly implemented those principles. This is especially a true case in Hong Kong because some of the Ordinance related to Health Care was made years before and amendments are needed to them in order to keep in pace with the rapidly changing society.

As one of the methodologies apply in this thesis, interviews have been conducted in order to evaluate the different views on medical negligence in Hong Kong and to discover ways of improving the imperfect healthcare system. Both physicians and the public who have been interviewed believed that medical errors are one of the most serious problems in health care today. The issues cited most frequently by physicians were the costs of malpractice insurance and lawsuits. As for the public, however, the most frequently cited problems were the cost of health care in the private sector and the tremendously long waiting list for operations in public hospitals. That could a reason why the public cannot tolerate any medical error.

Ultimately, the saying that prevention is better than cure is true for all problems. This wise statement not only applies to the medical profession, but also to legal profession alike. Even though medical negligence cannot be totally avoided by medical professionals, as legal advisers, we have the responsibility not only defend them but also to advice them the specific ways to minimize medical negligence. One of the contributions of this thesis is to offer many recommendations to doctors after analyzing in depth common causes of errors from cases of medical blunders in Hong Kong. Several of my recommendations are crucial because they could enable medical practitioners to minimize the chance of being complained or even sued for medical negligence.

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## TABLE OF ABBREVIATIONS

Accident and Emergency	A & E
Alternative dispute resolution	ADR
Appeal Cases	AC
Australian Law Journal Reports	ALJR
All England Law Reports	ALLER
Community Health Council	CHC
Community Rehabilitation Network	CRN
Department of Health	DH
General Medical Council	GMC
The Hospital Authority	HA
Hospital Chief Executive	HCE
Health Maintenance Organisations	HMO
Patients Complaints Mediation Committee	PCMC
Public Complaints Committee	PCC
Pharmacy and Poisons Ordinance	PPO
Preliminary Investigation Committee	PIC



## **CHAPTER 1 INTRODUCTION**

### **1.1 A General Overview**

The law concerning “negligence” applies generally to everyone when engaging in his or her daily activities and carrying out his or her jobs.<sup>1</sup> In a strict legal sense no distinction is drawn between the negligence of a doctor, plumber or window-cleaner. The general principles of tort law apply also to doctors. The fundamental idea of the tort law is the existence of a duty of care, i.e., one owes a duty of care to his neighbors, which will be discussed in detail in the following chapter. Most legal actions arising from the professional conduct of a doctor in relation to his patient are brought based on the theory of negligence, which is a key concept of the tort law. These actions are often referred to as “medical malpractice”. “Medical malpractice”, or “negligence”, could be defined broadly as any unjustified act or failure to act upon the part of a doctor or other health care worker which results in harm to the patients.

In order to establish a case of medical negligence, the patients must prove that he/she was owed a legal duty of care by the defendant (health care provider). For any claim to be substantiated, the plaintiff (patient) has to prove that the doctor has

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<sup>1</sup> Negligence is the omission to do something which a reasonable man guided by 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 discharged his duty to exercise all reasonable skill and care that the law requires. It must be proved that the doctor was in breach of the appropriate level of skill and competency imposed by the law. In other words, the defendant has breached the duty of care by failing to reach the standard required by law; the breach of duty caused or materially contributed to the damage suffered and the damage was not 'too remote' in legal terms. Lastly, the patient must prove that the doctor's mismanagement caused damage, one that is recognized by law as meriting compensation, which means that the plaintiff must have actually suffered some degree of harm from the physician's carelessness.<sup>2</sup> Except in a case of *res ipsa loquitor*, which literally means "the thing speaks for itself", the plaintiff has the legal burden of proving each of the above elements on a balance of probabilities, and otherwise the entire claim will fail. It has to be emphasized that the practice of medicine is full of uncertainties. Doctors and health care providers must therefore exercise special caution and diligence in the management of patients. Suggestions have been made in this regard to help them to act carefully.

In every day conversation, the word "negligence" is invariably and synonymously used with "carelessness". The accusation of negligence may be applied to any conduct that falls short of the standard expected by of a person whom a duty of care is owed and which causes foreseeable damage to that person. In a legal context, it is important to note that negligence has a specific and concrete meaning. It must be

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<sup>2</sup> T Thirumorthy, 'Understanding the Basis of Medical Negligence' (2006) *June Medical Grapevine* 30.

proved that the defendant owed the plaintiff a duty of care under the described circumstances and that the defendant breached this duty by failing to conform to the requirements of the law. Only then is the plaintiff able to claim that the injuries or loss (damage) suffered are a result of the defendant's actions either directly or as part of a transaction. According to *Lochgelly Iron and Coal Co. v M' Mullan*<sup>3</sup> per Dillon, L.J:

“it is now elementary that the tort of negligence involves three factors: a duty of care, breach of that duty and consequent damage”.

When medical negligence occurs, legal action will be taken to protect the victims and prevent recurrence of the event. The background to take actions against a medical malpractice is explained by Margaret Brazier in *Medicine, Patients and the Law* (pp 53-54)<sup>4</sup> :

“[The patient] ... may feel that he has not been fully consulted or properly counseled about the nature and risks of the treatment. He may have agreed to treatment and ended up worse, not better. Consequently a patient may seek compensation from the courts. Or he may simply want an investigation of what went wrong, and to ensure that his experience is not suffered by others. ”

From the womb to the tomb, health concerns arise in each and every different stage of a person's life. Most people are fortunate enough to receive the benefit of health

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<sup>3</sup> *Lochgelly Iron and Coal Co. v M' Mullan* [1934] AC1, 28.

<sup>4</sup> Brazier Margaret, *Medicine, Patients and the Law* (2<sup>nd</sup> edn Penguin, 1992) 117-118.

care services, especially those living in a modern city. Expectant mothers seek prenatal services to ensure the well-being of their infants inside the womb. After birth, babies go through rigorous health check up and undergo immunizations<sup>5</sup>. Infants are bound to catch a cold or the flu, and their parents will seek the aid of medical professionals from time to time. In addition, adults are also not exempted, as they could be injured at work, on the street or even when performing routine tasks at home to the extent that they could require hospitalization. Adolescents need health care provisions for their specific needs, some of an extreme nature. The elderly are especially susceptible to health issues, and when one suffers a terminal illness, tertiary health care service may be necessary. Therefore, it is fair to say that health care workers play a very important role in everyone's life.<sup>6</sup> Undoubtedly, ensuring the accountability of medical professionals is a matter of concern for every society. In Hong Kong, people usually have a high expectation of the medical health care system because the society is relatively developed and the awareness of rights is high.

Peter Drycker, a management expert and thinker who had proposed several types of societies or economies, coined the term "knowledge society" and theorized this to

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<sup>5</sup> For discussion of the contemporary role of doctors, see Brazier M., *Medicine, Patients and the Law*, (Harmondsworth, Penguin 1987), particularly at p.5, where she notes 'Few professions stand so high in general public esteem as that of medicine. Yet few individuals attract greater public odium than the doctor or nurse who falls from the pedestal.'

<sup>6</sup> Cheung A, 'Medical and Health', in D.H.McMillen and S.W.Man (eds) *The Other Hong Kong Report 1994* (The Chinese University Press, Hong Kong 1994) 351-65.

be characteristic of the 21st century.<sup>7</sup> This could explain what has been happening in Hong Kong. There has been a considerable increase in press interest in the medical profession and also an increase in readership in the tabloid newspapers in Hong Kong. People are able to access to knowledge in whatever format they please, including the Internet, Reader's Digest, Time Magazine, and even gossip columns owing to their increased material affluence and technological advancement. In this regard, an interview survey has been conducted in order to evaluate the real situation in Hong Kong. In the interview, the public has expressed concern about the credibility and transparency of the current medical mechanism. Both the public and most doctors believe that reports of serious medical errors should be made public (10% of doctors believe that reports of errors should be kept confidential). 90% of the public interviewee thought that the health professionals should take all reasonable steps to protect patients and, should harm occur, disclose it to the patient immediately. While all public interviewee regard reports of medical blunders by mass media as being fair and thus should be encouraged; all medical professional hold the view that the mass media exaggerate events and is unfair to medical professionals.<sup>8</sup>

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<sup>7</sup> CH Leong, 'Gerald Choa Memorial Lecture 2005- Beyond the Practise of Medicine' (2006) January Synapse 12.

<sup>8</sup> Annex of Thesis : Views of Medical Profession and the Public on medical negligence : An Interview

Hong Kong, like anywhere in the world has faced numerous challenges over the past few years. The recent drug prescription blunder, in which a mislabeled diabetes drug was wrongly dispensed to patients with stomach ailments at a private doctor's clinic in Wong Tai Sin, has, regrettably, cost the lives of four people.<sup>9</sup> This blunder was echoed by the recent incidents reported by the Hospital Authority in the regular publication "Risk Alert"<sup>10</sup>. All these medical mishaps are open to litigations by the victims including the recent death of a 21-year old cancer patient with acute lymphoblastic leukemia at Prince of Wales Hospital after receiving a chemotherapeutic agent by a spinal route instead of intravenously.<sup>11</sup> All these reveal one common theme - the importance of managing potential risks and minimizing or eliminating the factors which could tarnish the reputation of Hong Kong's medical services and put patients' lives in danger. In this sense, Hong Kong people are becoming more aware of medical matters and have become more vocal with their expectations. They are more assertive in terms of services provided for them, as they are fully aware that they use their own resources to avail themselves upon such goods as medical facilities. As consumers, they explore every means to ensure that they are getting their money's worth. Armed with insufficient information that could be partly biased due to the sensationalized slant that the

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<sup>9</sup> Matthew Leung, 'Drug Blunder Spurs Review' *The Standard China's Business Newspaper* (Hong Kong 1 June 2005).

<sup>10</sup> The Hospital Authority today published two regular publications to promote risk management among healthcare professionals in public hospitals –the 'HA Risk Alert,' and the 'Medication Incident Reporting Programme' <[http:// www: ha.org.hk/visitor/ha\\_visitor\\_index.asp?content\\_id = 697](http://www.ha.org.hk/visitor/ha_visitor_index.asp?content_id=697)> accessed 11 August 2008.

<sup>11</sup> Mary Ann Benitez, 'Fatal Injection Shows Change Needed, Says Probe Leader' *South China Morning Post* (Hong Kong 29 July 2007).

media uses to sell their stories, consumers start to demand and consider all the details in their experiences to ensure that quality standards are thoroughly followed. The people in Hong Kong demand to know why certain investigations or critical examinations are not done and demand to know other alternative treatment modalities and question the range of choices being offered to them. An accurate projection of the degree of success, the percentage of side effects, the period of recovery, the level of return to normal functioning of physical and mental health are also demanded.

The increase in medical claims in Hong Kong has had significant economic and psychosocial impact on the medical profession, as well as on society. For instance, the premium for medical protection and insurance coverage has risen dramatically over the years. This is especially true for high-risk fields of specializations such as Obstetrics and Gynecology Obstetricians whose jobs hold higher risks and who may face larger compensation claims have to pay as much as HK\$ 190,000 a year in premiums.<sup>12</sup> Medical professions have decided to take a “safer route” by practicing defensive medicine and performing excessive, one might even argue unnecessary, health investigations to protect themselves. “Clinical guidelines” have been put in

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<sup>12</sup> Matthew Lee, ‘Malpractice Claims Push up Insurance’ *Hong Kong Standard* (Hong Kong 19 January 2005) A12.

place, which sometimes overrule sound clinical judgments or personal considerations.<sup>13</sup> The lack of trust between the profession and the public is not only detrimental to the job satisfaction of health care professionals but also to the health and well-being of the clients.

The nature of most complaints and related lawsuits against doctors are results of the failure of the medical practitioners in communication or their inadequate ability to comprehend and resolve dilemmas in clinical settings. As patients, one must believe that our doctors, nurses, surgeons, and pharmacists are ethical, properly trained and trustworthy. One has to admit that, despite their extensive experience, these medical professionals sometimes make mistakes because of occasional poor judgments, are overworked or under-assisted, or are negligent or malicious. On the other hand, whatever the reasons for these mistakes, they are always unacceptable, and often punishable by law. One of the most controversial cases highlighting medical negligence, breaking the ideal relationship between doctor and patient, happened recently in Hong Kong. In 2001, the infamous case of the “phone-call surgeon”<sup>14</sup> happened at Queen Mary’s Hospital during a colonoscopy operation surgery, which led to a serious erosion of public trust in the rules governing the ethics of the medical community and brought about demands for its reform. In this incident, a

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<sup>13</sup> Hospital Authority [Professional Resources] – A collection of useful information for health care professionals including clinical guidelines, on-line professional knowledge and links to professional organisations <[http://www. Ha.org.hk/hesd/nsapi/ ?MIval = ha group index & group= PRS](http://www.Ha.org.hk/hesd/nsapi/?MIval=ha%20group%20index%20&%20group=PRS)>accessed 11 August 2009.

<sup>14</sup> Dr Tung Hiu Ming. Disciplinary Inquiry. Medical Registration Ordinance, Cap.161. 11 April 2001.



surgeon was disciplined by the Hospital Authority for answering a hands-free personal telephone call while performing an operation, a contravention of the Authority's rules intended to prevent distractions to doctors and interference with delicate medical equipment. During the operation, the patient's colon was accidentally perforated. The Medical Council found the doctor innocent on the grounds that he had not intended to take the telephone call, and that the patient's injury was not caused by taking said call. The doctor's argument was that he must keep the pager with him at all times, and he might be summoned for an emergency.<sup>15</sup> Also, an endoscopist called by the Medical Council, Dr Yuen Hon said that the complications arising from the incident were in no way related to the telephone conversation. The bowel perforation was not a result of negligence but was the well-recognized complications of colonoscopy.<sup>16</sup> The public was outraged, and put emphasis on the fact that such an action, i.e., taking calls during surgery, ran counter to a doctor's ethical obligation to exercise his best efforts when treating patients. This led the Hong Kong Medical Association (HKMA) and the Public Doctors Association demanding that the Hospital Authority reverse its disciplinary decision.<sup>17</sup> The clean slate provided to the doctor aroused much concern about the public's health care protection and the responsiveness and the transparency of the regulatory mechanisms.

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<sup>15</sup> Mary Ann Benitez, 'Doctor who spoke on mobile during operation did not behave unprofessionally' *South China Morning Post* (Hong Kong 12 April 2001).

<sup>16</sup> Adam Slivka, 'Patient Information : Colonoscopy' < [http // www: UptoDate.com](http://www.UptoDate.com) > accessed May 2009.

<sup>17</sup> Marcal Joanilho and Matthew, 'Lawmaker to tell of medical blunders' *South China Morning Post* (Hong Kong 22 March 2004).

The confidence of the public is further jeopardized by witnessing a remarkably turbulent year for the health care industry of Hong Kong. Three cardiac patients – aged 46, 80 and 99 died at Queen Elizabeth Hospital within 10 days. They received an angioplasty in late May 2007 and were operated by the same cardiologist with more than 10 years' experience.<sup>18</sup> The hospital carries out 1200 to 1300 Cardiac Catheterization (PCI) operations every year, more than half of which are categorized as emergency and semi-urgent cases. The overall mortality rate of PCI procedure was 0.6 percent according to the clinical audit last year. Meanwhile, the cases have been referred to the Coroner for follow-up action.

For now, medical errors and scandals are given great prominence by the media, from common medical errors in health care including misadministration of medication, mismatching of blood types, image misinterpretation and inappropriate medical technology used, to the disclosure of the scandal of Queen Elizabeth Hospital and the patient care malpractices in large hospitals, like Tuen Mun Hospital and Prince of Wales Hospitals. The hospital managers simplified the

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<sup>18</sup> A hospital management source said in *South China Morning Post* on 20 June 2007. "The three reported cases were operated on under emergency and high-risk conditions. The procedures were done with the patients' and relatives' consent after thorough explanation including its impact and potential risk. Relatives of the deceased were interviewed by our cardiologist and thorough explanations given." The Hospital Authority has been called on to review the above case. The hospital said the cases had been emergencies and the operations had taken place under high-risk conditions. The three fatal cases were the "tip of the iceberg" of problems arising from the overburdened public health system which was "about to collapse." It was a coincidence only. They don't think they were medical blunders."

matter by promoting junior doctors to fill the senior posts and recruiting more trainee doctors to maintain the head count. But four or five junior doctors won't be able to replace the four senior doctors, accounted for a total of 60 years' experience which is a very precious intangible asset to the hospital.<sup>19</sup> A serious brain drain of key staff also had plagued the team. The workload was overwhelming. Their stress was great which jeopardized the safety of patients. The senior doctors have to supervise the junior doctors and train them and this will reduce their concentration on treating patients. The management put many limitations on the medical health care professionals. In the interview conducted by the author, a majority of interviewees viewed medical errors as one of the most important problems in health care today.<sup>20</sup> When asked whether mistakes made are related to understaffing, overwork, stress or fatigue of medical personnel in hospitals, a majority of interviewees in both groups thought that all the above mentioned problems were very important causes to medical errors. Most doctors believe that they make mistakes in day to day practice from oversight, neglect, tiredness from a 32 working hours shift <sup>21</sup>. However, in the eyes of the public, their mistakes are less tolerable. There is definite need for an increase in the number of nursing staff to provide more reasonable medical care to patients.

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<sup>19</sup> Public Doctor's Association President Duncan Ho Hung-kwong, a cardiologist at the hospital commented, the overall morale of public doctors had been very low in recent years which affected the quality of services and become a crisis for the Hospital Authority. *South China Morning Post* (Hong Kong 20 June 2007).

<sup>20</sup> Annex of Thesis : Views of Medical Profession and the Public on medical negligence : An interview.

<sup>21</sup> Tara Parker-Pope, 'What If the Doctor Doesn't Want to Nap?' (2009) August The New York Times.

All these problems have heightened the concerns of the community. It is essential to take every action to alleviate the potential of medical errors re-occurring by preventing medical incidents from happening. Then the number of complaints may be greatly reduced and the service quality may be improved. As Bogner points out that the consequences of an error may be serious injury or death for the very individuals (the staff) intends to help.<sup>22</sup> The common reaction to an error in medical care is to blame the apparent perpetrator of the error. Blaming the person does not necessarily solve the problem; more likely, it merely changes the players in the error-conducive situation. The error will occur again, only to be associated with another provider. This will continue until the conditions that induce the error are identified and changed.

## **1.2 Hypothesis**

This dissertation is being written at a time when the structure and delivery of healthcare is in a state of perpetual flux in Hong Kong, especially in the aftermath of major medical-related events which has put the medical practice and medical negligence in the spotlight. Both receivers and providers of health care services are adapting to changing healthcare systems and shifts in the expectations and perceptions about the roles and corresponding obligations of all parties involved.

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<sup>22</sup> Bogner, Marilyn S. (ed), *Human Error in Medicine*. (Lawrence Erlbaum Associates Publishers , New Jersey 1994 ).

The trust, and consequently, the relationship between doctors and their patients have seriously undermined the existence of medical malpractice and its widespread coverage. It is not an easy time to be a doctor. Private patients who enjoy a contractual relationship with their doctors may also base a claim according to the law of contract. Doctors are often accused for over-investigating, over-diagnosing, over-treatment and cronyism for cross referrals. Although this may be the case for only some members of the medical community, it has led to patients entertaining grave misgivings on the general conduct of the health professionals. Furthermore, the increasing cost of medical insurance and litigation cause heavy financial burden to the medical profession and government. Even though medical negligence cannot be totally avoided by medical professionals, nevertheless, legal advisers have the responsibility to advise them the ways to minimize medical negligence, hence this thesis offers as many as possible recommendations to doctors after analyzing in depth common causes of errors from cases of medical blunders in Hong Kong. Certain areas of the Ordinances are critically evaluated in the thesis, with suggestions of various improvements. Firstly, the Clinic Ordinance in Hong Kong should incorporate requirements for the professional standard of clinic assistant. It is not infrequent in Hong Kong cases of medical negligence where clinic assistants actually directly or indirectly contribute to the occurrence of medical errors although medical practitioners are held to be main responsible. The solution proposed in this thesis is basically a strict control of educational level and continuous medical education for clinic assistants. Secondly, another source of

improvement is in the Medical Registration Ordinance. This thesis suggests further that there should be a health or age limit requirement for doctors as well as a continuous medical education assessment before renewal of annual practicing certificate so as to ensure that the public is under the care of a knowledgeable and healthy doctor. The third solution is concerning the running and constitution of Hong Kong Medical Council. Medical Council aims to maintain the standard of practicing doctors by giving advice, guidelines, surveillance of registration and if necessary, disciplinary hearings and judgment. The judgment on involved doctors through hearing is of major concern to doctors as Medical Council has the right to remove medical registration of the doctors for life. Furthermore, the decision may lead the way for further claiming of damages by the victims and, in extreme cases, possible criminal proceeding. Thus, the hearing by Medical Council should be under strict regulation and viewed as criminal proceeding rather than civil proceeding while punishments should only be given with evidence beyond reasonable doubt. In usual criminal proceedings, the defendant should not be judged by the same judge for separate offences. However, for Medical Council hearings, the same Council Members are allowed to judge same doctor for different offences. This is unfair for the defendant as prejudice may occur and so there should be change in the setting. Moreover, the Dangerous Drug Ordinance requires doctors to

keep record of stock and prescription details of all dangerous drugs in a fixed format. However, computer record is not accepted as illustrated by a recent case.<sup>23</sup>

This is in sharp contrast to the promotion of digitalization and electronic record by the Hong Kong Special Administrative Region. More and more of the Health Care Related Ordinances may face challenges from the public. Regular reviews and adjustment are necessary in order to keep abreast of time and ensure fairness and justice.

Therefore, the purpose of this thesis is to acquire fundamental knowledge about the situation of medical negligence in Hong Kong. It aims to investigate the different points of views regarding medical negligence. It hopes to further clarify the legal background concerning medical malpractice, and hence seek opportunities and recommendations for improvement. It does not intend to alter the basic principles of tort law which laid down the foundation for judgment of medical negligence. As these principles has been standing in English Legal System for more than 100 years upholding justice impressively. Rather, this thesis aims to critically evaluate implementation of these laws in Hong Kong mirroring the flaws which could have been prevented. Through case analysis, some of the factors which contribute to litigations in medical malpractice are highlighted and countermeasures are suggested, in the areas of co-operation between public and private services, the procedure and constitution of Hong Kong Medical and Dental Council which may

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<sup>23</sup>The above order was published in The Government of the Hong Kong Special Administrative Region Gazette on 18 November 2005 (G.N 5974).

be unfair, the inadequacy in control of clinic by the Clinic Ordinance and lack of control for renewal of annual practicing certificate by medical practitioner. All the above issues will be carefully analyzed and criticized with constructive recommendations made. Through this thesis, the author hopes to increase the awareness of the problems concerned and prevent further wasting of resources in unnecessary litigations. On the contrary, money can be put in meaningful ways like patient education and provision of better health care services. The findings of this thesis will lay down a stepping stone for later detailed study of the current problematic areas of medical negligence in Hong Kong and rethink the manner in which they deal with human mistakes.

### **1.3 Research Methodology**

In studying the above issues relating to medical negligence in the health care sector, multiple sources of evidence are used in order to achieve the research outcome.<sup>24</sup> This dissertation thus adopts a unique approach by applying qualitative methods. Furthermore, other research methodologies such as literature review, case analysis and interview have been adopted as well.

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<sup>24</sup>Hayllar, M.R, 'The Importance and Attributes of Effective Accountability Relationships', Paper presented at the EROPA Hong Kong Conference 2000: Developing Asia's Public Services: Sharing Best Practices October 2000.



An interview was conducted at the beginning of research and aim to evaluate the view point of the public and service provider to justify further investigation into the issue. Indeed, methodology for issues like medical negligence, inevitably involve investigation into its social and cultural background. Nevertheless, the emphasis is still on legal principle with analysis of UK and HK cases while suggestions are derived to avoid medical negligent practice. The aim of interview is not to formulate a legal argument but to have firsthand information from the public and service provider concerning their view on medical negligence. Legal professional were not interviewed as they may have a bias viewpoint due to their training and victims of medical negligence were not chosen in order not to expose the information about the event after compensation and negotiation. In fact, I had also tried to contact members of Medical Council for their comment but was refuted by them for the fright of breaching confidentiality. Medical Personnel and public hold different view on ways to handle medical blunders when it occur and my thesis serve to find a way that is acceptable for both parties. Although the number of interviewee involved is 30, it nevertheless gives a first-hand and direct view point from individuals. Their response support the view that medical blunders is common and it is an important issue in their life, so it is worth to explore into the issue and find ways to improve it.

To better understand the issues involved, books, periodicals, articles and journals are the main sources for obtaining background information about concepts and theories of medical malpractice. In order to provide a credible analysis of the subject matter, the study will utilize factual reports from newspapers, official publications, available documents from the Hospital Authority, including annual reports, press releases, operation manuals and guidelines together with academic journals published by medical organizations, such as the Hong Kong Medical Association, the Hong Kong Academy.

To supplement the literature review, reference has been made to decide medical malpractices cases which give an overview of the relevant principles of law – causes of action; medical malpractice; damages and practical aspect of this type of litigation. In particular, the cases are also supplemented by the local statutory provisions which are essential for reviewing and analyzing the idea about medical negligence. Violation of these statutes or health regulations may render doctors liable. The importance of case study lay down essential principles, which have binding force. A review of statistical data, such as the amount paid for malpractice insurance involved in out-of-court settlements for medical blunders over the past five years in the Hospital Authority, will also be included. The frequency of complaints by hospital type with different medical specialty and category of complaints will be highlighted as well. Meanwhile, statistics on disciplinary cases

handled by the Medical Council would also be examined. In order to achieve the aim of this dissertation, the library research and internet resources have also been used as tools to gather information and data.

For making a qualitative research, government hospital doctors, nurses and general practitioners as well as the university students were interviewed for their views about medical negligence. Interviewing facilitates access for immediate follow-up information collection for clarification and identification of omissions. As Mark Hughes indicates, the strengths of interviewing arise from face-to-face encounters with informants so that large amounts of expansive and contextual information can be obtained quickly.<sup>25</sup> By conducting these interviews, a clearer understanding of the views of the public and medical profession has been gained. To avoid any possible tension during the process of interviews, cassette tape recording was not adopted. A semi-structured approach was used in the interviews since the key questions might be asked to all interviewees in a standard format <sup>26</sup>(See Annex of Thesis ) .

During the study, half of interviews were conducted face-to-face while another half interviews were conducted through the telephone. University students were able to

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<sup>25</sup> Hughes, O.E, *New Public Management : Public Management and Administration* (Hampshire Macmillan Press, 1994)58-87.

<sup>26</sup> Annex of Thesis : Views of Medical Profession and the Public on medical negligence : An Interview.

spare time for face-to-face interviews during daytime whereas the General Practitioner and other informants were interviewed by telephone late in the evening. This might be due to the fact that those are busy working in the day-time. These people were tied up with their work and preferred to be interviewed by telephone after office hours. In particular, by using semi-structured, open-ended questions, interviews have been held with individuals as shown in Table 1 below: When the subjects were interviewed, they were told that the purpose of the interview was to ask their valuable opinions concerning the possible ways to lessen the medical negligence in Hong Kong, and their responses would be compared with those obtained from another interviewees. This approach let the interviewer retain reasonable control and allow flexibility during the interview. Finally, some valuable opinions concerning the possible ways to lessen the medical negligence in Hong Kong have been successfully obtained.

TABLE 1 DISTRIBUTION OF KEY INFORMANTS

Interviewees	General practitioner	Hospital Staff including nurses	Government Hospital Doctors	The University Student	The Public :	Total
Number	10	10	10	20	10	60

#### 1.4 Limitations of the Research

Yin<sup>27</sup> suggests six sources of evidence that can be adopted for conducting reliable and high quality research including documentation, archival records, interviews, direct observations, participant- observation and physical artifacts.<sup>28</sup> However, due to limited time and resources and probably the busy nature of work in hospitals with respect to the analysis of medical negligence, only the first three techniques are applicable. Apart from international literature on the concepts of medical negligence, limited local data/ literature is available on the particular focus of this thesis. Most sources of information on medical negligence are taken from Hospital Authority's official documents, release from the Medical Protection Society, Newsletters and Press Releases etc. However, these documents mainly reflect official views.

Without conducting interviews, it is difficult to gain the view of people on medical negligence. Yin outlines the advantages of interviews as a means to gather information for research as they "focus directly" on the topic and, most important of all, can lead to "insightful" findings by providing "perceived causal inference".<sup>29</sup> While observing the benefits of interviews, one must be aware of a number of limitations they bring, such as the possibility of "bias due to poorly constructed questions....inaccuracies due to poor recall and reflexivity (whereby) the

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<sup>27</sup>Yin, R.K, *Case Study Research: Design and Methods* ( 2<sup>nd</sup> edn Sage, London 1994 ).

<sup>28</sup> *ibid* : 80

<sup>29</sup> *ibid* : 80

interviewee gives what interviewer wants to hear".<sup>30</sup> Another limitation of the telephone interviews were that the interviewees could choose to be interviewed at their comfort while the interviewer did not need to travel either. However, disadvantages may include the possibility of losing the chance to observe the facial expression of the interviewees which may sometimes reflect their deeper thoughts. Another limitation is the number of interviews conducted and the small sample size. Due to the constraints in the resources of time, manpower and finance, this research method is by no means comprehensive and deep enough to be a perfect one.

As mentioned above, a purposive sample of informants was selected and this was done through a network of friends, colleagues and my nursing professors. Having briefly explained the purpose of my research and the objectives of the interviews, most of them agreed to be interviewed because of their friendly relationship with me. Of course, in some occasions people were reluctant to be interviewed and turned down my request without giving any reasons. Fortunately, the interviewed informants have provided much useful and insightful information and ideas regarding the medical negligence. The informants are also appeared to be very open in revealing their thoughts and ideas on recent medical blunders.

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<sup>30</sup> *ibid* : 80

## **1.5 Outline of Dissertation**

This dissertation contains 9 chapters, which are closely related to each other. The first eight chapters set out in detail the circumstances surrounding negligence in the medical profession. Chapter 1 serves as an introduction, which includes the background, hypothesis/statement of the problem, methodology and outline of the chapters. Following this introductory chapter, the social cultural background of the healthcare system as well as the legal system in Hong Kong is broadly discussed in Chapter 2. A brief summary of the health-related provisions of the Basic Law (so called “mini-constitution” of the Hong Kong SAR) which have some specific bearing on the operation of the health care services are also discussed. This background is crucial to our understanding of medical negligence and litigation in Hong Kong.

The six elements a patient must prove in order to win a malpractice case are thoroughly discussed from Chapter 3 to Chapter 6. It is fundamental that a plaintiff must prove the existence of the following key elements these include (i) a physician-patient relationship (ii) a duty of care owed to the patient by the care provider (iii) evidence must be presented there was a failure in some part of the duty of care (iv) there must` proof that the lack of care was the proximate cause of harm (v) proof of evidence that harm occurred. (vi) the plaintiff must also prove his or her assessment of damages. While Chapter 3 is the essence of this thesis which examines the case law where no proper communication between patients and

medical staff regarding the inherent risks prior to medical treatment, and patient consents were given without full knowledge of significant facts.

In Chapter 4, there will be a thorough discussion of the duty of care. Accordingly, the duty of care is also frequently owed by the treating institution such as a hospital which may be vicariously liable for the negligent acts of its servants and agents.<sup>31</sup> It is generally accepted that hospital authorities owe certain duties of care directly to patients in respect of supervising them so that they do not come to harm. Once it has been established that a duty of care is owed, the next question would be “how much care is required?” Whether there has been a breach of the standard care is a matter of fact which requires careful analysis in each case. The standard of care is therefore discussed in Chapter 5 which deals with the incidents concerning allegations of substandard treatment arose in cases involving retained swabs and other instruments after operations, burns, anesthetic mishaps and cases where the wrong operation was performed. It is imperative that the doctor must observe these duties within the ambit of professional ethics, the failure of which may move the doctor liable to negligence.

Chapter 5 paves the way for chapter 6, the key to justify compensation for patient is highlighted and the plaintiff needs to prove that negligence, doctor’s mismanagement must have resulted from the careless act or omission. A medical

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<sup>31</sup> *Cassidy v Ministry of Health* [1951] 2 KB 343, p 272.



malpractice defendant cannot be held liable if the injury could not have been foreseen or reasonably anticipated as the probable result of an act of negligence. It must be determined whether a doctor's negligence is sufficiently likely to have caused the damage to justify compensating the patient. Chapter 7 is a topic that provokes doctor's anxiety and disdain about medical negligence claim. There is a description of the general principles concerning medical litigation and claim for compensation with special reference to Hong Kong. The limitation of prosecution, the role of Medical Protection Society and alternative to litigation including alternative dispute resolution (ADR) and mediation have been discussed in this chapter.

While Chapter 8 reviews the situation of medical negligence in Hong Kong and draws together the different threads of the thesis and offers recommendations about how improvements could be made in the future. The final Chapter 9 gives the overall conclusion of this paper in which the key points of different chapters will be summarized and the significance of the topic will be highlighted.

The Annex reports the views of medical profession and the public on medical negligence through interview and the results is analyzed and discussed. This qualitative research supplements the thesis by adding subjective information in addition to objective principles.

## **CHAPTER 2 GENERAL VIEWS ON THE SOCIAL-CULTURAL BACKGROUND OF THE HEALTH CARE SYSTEM AND THE LEGAL SYSTEM IN HONG KONG**

### **Chapter Summary**

This chapter is a thorough analysis of the historical and cultural characteristics of the legal system in Hong Kong concerning the medical field. Aiding this analysis will be a brief examination of the Hong Kong Common Law system and Health Care System. Undeniably, there are occasions when patients became unhappy with their treatment and wish to make a complaint or initiate legal proceedings for medical negligence. It may not be the best option for the victim to go to court and commence legal action immediately. Court procedures are costly and time consuming, and may not be able to recover the entire amount of legal costs, even if the case is won. The complainant is instead recommended to complain to the Medical Council, which can impose punishments that range from a warning, a reprimand to removal of the doctor's right to practice (in serious cases). On the other hand, if the victim does not want to contact with the Medical Council, other existing organizations such as Patients Rights Association<sup>32</sup> can also help them take legal action or lodge a complaint. Regarding the complaint systems in Hong Kong,

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<sup>32</sup>The Patient's Right Association was established in 1992. It is under the supervision of Society for Community Organization. The objective of the Association is to advocate patients' rights in Hong Kong. Their staff assists victims of medical incidents to launch complaints and claims for compensation individually. Following this, the HKMA in conjunction with the Consumer Council produced a pamphlet on patients' rights which included a telephone number specifically dedicated to patients requesting further information or assistance.

the interview we conducted show that the public has expressed concern about the credibility and transparency of handling mechanisms in receiving complaints. Both public and private doctors believe that reporting of serious medical errors should be made to public whereas only 10 % of doctors believe that reports of errors should be kept confidential. 90 % of the public interviewed thought that the health professionals should take all reasonable steps to prevent harm to patients and should harm occur, disclose it to the patient immediately. Both parties regard an effective complaints system as an essential part of good health care management and would reinforce trust and openness between doctor and patient. This chapter is crucial to our understanding of medical negligence and complaint procedures in Hong Kong and, hopefully, through our discussion, will benefit patients who presently may still remain unaware of their deserving rights as well as their expected responsibilities.

## **2.1. Historical and Cultural Characteristics of the Legal System in Hong Kong**

The medical profession is an ancient one as the Hippocratic Oath itself dates back to ancient Greece. The relationship between physicians and the law also goes back more than 3000 years ago. Hammurabi was a ruler and lawmaker in Babylon around the year 1800 BC and his code of laws were carved upon a black stone monument rearing eight feet high so that all could read and know the law. The articles are instructive and are mostly concerned with payment of fees to physicians.

Accordingly, there is a balance between public interest and the interest of the professions. The professions are given statutory recognition and a monopoly to practise in their area of expertise while they must maintain the integrity and standards of professional service to the public whom they serve.<sup>33</sup> In Hong Kong, the practice of medicine is influenced by the West. Doctors can practice after graduation from University with internship completed. They are licensed by the Medical Board and under scrutiny by the Hong Kong Medical Council. Their practice is protected by the Basic Law and under the control of the Common Law in Hong Kong.

The association of medical profession and law can be further exemplified by the Coroner Court. The office of the Coroner is one of the oldest in the English legal system dating back at least to the twelfth century<sup>34</sup>. The function of the Coroner is perhaps new to most of us, but it has existed since the Middle Ages. The Coroner's Office was established in England after the Norman Conquest as a form of medieval

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<sup>33</sup> Davies Michael, *Textbook on Medical Law* (London : Blackstone 1996).

<sup>34</sup> In accordance with the Coroner's Ordinance, there are 19 categories of reportable deaths for which the Coroner may consider opening an inquest. These categories cover: uncertain death; sudden or unattended death not including a person diagnosed with terminal illness before death; death resulting from an accident or injury; death caused by crime; death caused by an anaesthetic or which happened within 24 hours of the administration of anaesthetic; death caused by an operation or within 48 hours after an operation; death caused by an occupational disease or death directly or indirectly related to previous job; still birth; maternal death; death caused by septicaemia with unknown cause; suicide; death in official custody; any death of a person while under arrest or detention in a government department or where the death occurred during discharge of duty of an officer having statutory powers of arrest or detention; death in mental hospitals and foster homes; death in private residential care homes; homicide; death caused by a drug or poison; death caused by ill-treatment, starvation or neglect; death which occurred outside Hong Kong.

tax collection. However, the Coroner acquired the power to investigate deaths because of the tendency of local communities to kill Normans. A heavy fine was levied on any village where a body was found on the presumption it was Norman. This lay down the foundation basis for Coroner Inquiry<sup>35</sup> A Coroner's inquest may be called under the provisions of the Coroner's Ordinance<sup>36</sup> in case of a death of a patient. The jurisdiction of the Coroner's court is principally contained in Chapter 14 of the Coroner's Ordinance:

“Wherever any person dies suddenly or by accident or violence, or under suspicious circumstances, or whenever the dead body of any person is found in Hong Kong or is brought into Hong Kong, a coroner may, if he considers that an inquiry is necessary, inquire into the cause of and circumstances connected with the death of such person, with or without a view of the body as he may think fit and may determine the cause of death”<sup>37</sup>

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<sup>35</sup> Johnson L, 'The Power of Expertise: Medical Treatment and the Coroner's Court.' 21 Hong Kong Law Journal 253-268.

<sup>36</sup> The *Coroner's Ordinance* has a provision in which the Coroner and jury are not allowed to report the findings in such a way that would identify the question of civil liability. The details may be disclosed in the flow of legal proceedings. Consequently, the report of the findings at legal proceedings could lead to civil and criminal litigation of the involved party. These legal proceedings may be brought as a result of revelation of evidence of malpractice during the Coroner's inquiry. The inquiry acts as a fact-finding mission to determine the cause of death of the deceased.

<sup>37</sup> Wacks R, *The Future of the Law in Hong Kong* (Hong Kong : Oxford University Press, 1989)15-36.

In the Coroner's Court, the Coroner may hold an inquest either with a jury or without a jury.<sup>38</sup> A Coroner has a duty to investigate every unnatural death by holding an inquest open to the public, and at which relatives and their legal representatives are allowed to ask questions. In the Coroner's court, no one is being sued. While this long historical background laid down the foundation for legal system in Western World. People in Hong Kong are equally affected by the Chinese Culture. In ancient China, the law was usually used by the ruler to punish people. Appearing at court usually meant that one was at fault for some reasons. Therefore, common people could not readily challenge officials or those with good standing in society. In this sense, the Chinese culture did not and does not encourage people to go to the court to settle disputes or air their grievances. Even now in modern China, settling disputes by means of mediation and arbitration are the preferred methods strongly encouraged by the Chinese Government<sup>39</sup> Confucian ethics states that in order to be a man or a sage, it is necessary to first perform one's duties and not to claim one's rights. In addition to this, human relationships in a society should be governed by rules of propriety. This traditional thinking implies that a Chinese person should not claim his rights by taking civil action.

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<sup>38</sup> In such cases, an inquest is helpful as the coroner can push for finding material which would not otherwise so readily available. A coroner can, by subpoena, order materials to be supplied to him. Without an inquest, if you wanted a patient's records, while you could write to the hospital, which has a performance pledge to produce such materials within a certain amount of time, you are still dependant on the hospital's co-operation.

<sup>39</sup> Wu Chien-chang, 'Medical Malpractice in the People's Republic of China'(2005) October The Journal of Law, Medicine & Ethics.

Hong Kong is a basically a Chinese society with respect for traditional Chinese virtue. One of the virtues is “strict for self but lenient for others.” Thence, they tend not to complain but to tolerate injustice. Also, Chinese prefer to settle their disputes through the rules of propriety rather than bringing their cases to court. In short, as the Chinese saying goes, “you don’t enter the door of the official when you are living and you don’t go to hell after death.”<sup>40</sup> Although the concepts become blurred with westernization, it nevertheless affects the behavior of the public and limits the scale of litigation and complaints on medical blunders.

After 1997, the application of English case law including the Common Law system in Hong Kong<sup>41</sup> continues notwithstanding the transfer of sovereignty to the People’s Republic of China on 30 June 1997.<sup>42</sup> With regards to medical

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<sup>40</sup> D. Jiang, ‘Thoughts on the Practice of the Regulation on the Handling of Medical Accidents’ (2002) 11National Judges College Law Journal 55.

<sup>41</sup> English case law also provides a source for Hong Kong tort law. Common law (or case law) is based on precedent. A precedent is a previous decision made by a judge which sets out a principle binding on another court deciding on a similar case.

<sup>42</sup>There are some requirements for eligibility to become a juror. Section 4 of the Jury Ordinance stipulates that every person “between the ages of 21 and 65 years, being of sound mind and not afflicted with deafness, blindness or other such infirmity, who is a good and sufficient person resident within the Colony, and who has a knowledge of the English language sufficient to enable him to understand the evidence of witness, the address of counsel and the judge’s summing up” can be a juror. However, there are some people listed in the Ordinance as exempted from jury service such as members of the Executive, Legislative, Urban or Regional Councils, civil servants related with the administration of justice and some kinds of criminal offenders. There is no provision for a jury in a civil case but any party may apply for one if so ordered by the Judge. The jury is a representative of the community and its impartiality needs to be assured. Jurors are less susceptible to political pressures as they are not dependent on the Government for their salary or for career promotion. In addition, there is a smaller chance to bribe a decision maker in a jury trial, as it would be relatively more difficult to bribe a number of jurors than a judge. Moreover, the jury is comprised of a number of individuals. The bias of an individual juror would not likely have a

malpractice, the legislation is governed by (which has been imposed and will continue to be used under the Basic Law), originated from the tort law of the English Legal System and a full understanding of it is certainly essential in medical-legal practice. This traditional Law governs a vast variety of medical negligence cases, examples may include undertaking surgery without obtaining any form of consent from the patient, and failing to monitor oxygen levels during an operation and causing the patient to suffer from brain damage (negligence) .

On the other hand, there are some new laws imposed on Hong Kong following its reunion with China: the Basic Law, Hong Kong's new "constitution" effective from 1 July 1997, provides that the English Common Law system shall continue in Hong Kong, and that socialist systems and policies shall not be practised here. This maintenance is mirrored in Article 8 of the Basic Law of the Hong Kong Special Administrative Region (HKSAR) of the People's Republic of China (PRC) which was adopted at the Third Session of the Seventh National People's Congress in April 1990:

"The laws previously in force in Hong Kong, that is the Common Law, the rules of equity, ordinances, subordinate legislation and customary law shall be maintained, except for any that contravene this Law, and subject to any amendment by the legislature of the Hong Kong Special Administrative Region."

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strong influence in the group to make it an unfair judgment. In addition to this, the jury can assess the case more objectively as jurors can use their common sense to apply their knowledge and experience collectively. In criminal cases, a judge sits with a jury of usually seven to nine persons.



As well, Article 139 of the Basic Law provides that the HKSAR shall decide on scientific and technological standards and specifications applied to Hong Kong and this provided a ground on which both lawyers and physicians can work together to make Hong Kong a better place for our families to live in. Under the Basic Law, references to cases from other common law jurisdictions can continue to be made in Hong Kong courts. This allowance is important because prominent cases from the highest courts of these jurisdictions are of persuasive value in Hong Kong.<sup>43</sup> However, one must note that courts in the HKSAR exercise independent judicial power, including the power of final adjudication, and are not subject to any other superior courts including those in the Mainland. In other words, judgments of Mainland courts are not binding on the courts of the HKSAR and the law enforcement departments of the Mainland cannot exercise any jurisdiction in the HKSAR.<sup>44</sup>

Most Hong Kong people welcome this provision as stipulated in the Basic Law because they fear that any changes to the system after handover to the Mainland government may jeopardize Hong Kong's stability and sacrifice the rights previously enjoyed by local citizens. Hong Kong, like other developed jurisdictions,

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<sup>43</sup>Consultative Committee for the Basic Law. *The Basic Law of the Hong Kong Special Administrative Region of the People's Republic of China* C&C Offset Printing Co Ltd Hong Kong 1990.

<sup>44</sup> One Country Two Systems Economic Research Institute, *Hong Kong in Transition* (Hong Kong, 1993); M Davis, *Constitutional Confrontation in Hong Kong* (London: Macmillan Press, 1989); N Miners, *The Government and Politics of Hong Kong* (5<sup>th</sup> edn Hong Kong: Oxford University Press, 1991).

has a wealth of primary and secondary legislation (ordinances and regulations) that sets standards (and imposes penalties in the event of failure to meet those standards) for a range of activities. However, tension exists in Hong Kong as its legislations are of foreign origin (in prominent contrast to traditional rules and customs followed during the Qing Dynasty by Chinese people in Hong Kong). The tension between the existing system and Chinese society in Hong Kong is unavoidable and expected. On the other hand, fortunately, this formidable tension has diminished considerably after years of colonial governing and westernisation in Hong Kong.<sup>45</sup>

## **2.2. The Health Care System in Hong Kong**

Hong Kong has a relatively simple health care financing system in which services provided by the public sector are funded almost entirely from general revenue. All Hong Kong residents are eligible to receive care, either free or at a heavily subsidized rate from institutions under the Department of Health or the Hospital Authority.<sup>46</sup> There are no national health insurance contributions or any other hypothecated health tax. Services provided by the public sector include almost 90% of inpatient care, 15% of outpatient care, and most of the preventive and rehabilitative care. On the other hand, services provided by the private sector include around 10% of inpatient care, 85% of outpatient care, and the bulk of dental care and optometry of services.<sup>47</sup> The Bauhinia Report<sup>48</sup> has rightly pointed out

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<sup>45</sup> Siu Kai Lau and Hsin-chi Kuan., *The Echo of the Hong Kong Chinese* (CU Press, 1989)119 .

<sup>46</sup> Yuen P P, 'Medical and Health Issues' in *The Other Hong Kong Report 1997* Cheng J Y S (ed)(The Chinese University Press Hong Kong 1997) 393-410.

<sup>47</sup> Yuen P P, 'The Hong Kong Health Care Industry by the Year 2001: A Focus Group Discussion'

that despite the publication of the four consultation documents : Towards Better Health , <sup>49</sup> Improving Hong Kong's Health Care System: Why and For Whom<sup>50</sup>, Lifelong Investment in Health <sup>51</sup>, and Building a healthy Tomorrow<sup>52</sup> , citizens still prefer to maintain the current tax-based financing system as the major source of health care financing. However, the Report of the Working Party on Primary Health Care pointed out: "Public Health is Public Wealth"<sup>53</sup> The healthier the people, the more likely they are able to contribute to the social and economic development of the territory and recently, there are hot discussions on health care financing through encouraging private medical insurance and the levy of health care taxation from the public.<sup>54</sup>

The Hospital Authority (HA) of Hong Kong was established under the Hospital Authority Ordinance<sup>55</sup> and began overseeing all Hong Kong public hospitals in

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(1996) 1 Asian Journal of Business & Information Systems 97-103.

<sup>48</sup> The report of the Health Care Study Group of the Bauhinia Foundation Research Centre published in June 2007.

<sup>49</sup>Health and Welfare Branch 1993. 'Towards Better Health.' Hong Kong Printing Department of the Hong Kong Government.

<sup>50</sup>Harvard Team 1999. *Improving Hong Kong's Health Care System: Why and For Whom* HKSAR Printing Department; Leung G.2006. Hong Kong's health spending – 1989 to 2033.

<sup>51</sup>Health and Welfare Bureau 2000. Life Investment in Health: Consultation Document on Health Care Reform .Hong Kong: Printing Department of the Government of the Hong Kong Special Administrative Region.< [http:// www.hwfb.gov.hk/statistics/en/dha.htm](http://www.hwfb.gov.hk/statistics/en/dha.htm)>.accessed 11 Sept 2008.

<sup>52</sup>Health and Medical Development Advisory Committee 2005. Building a Healthy Tomorrow: Discussion Paper on the Future Service Delivery Model for our Health Care System.

<sup>53</sup>Wacks R. *The Future of the Law in Hong Kong*(Hong Kong: Oxford University Press, 1989)15-36.

<sup>54</sup>Huque, A.S., Tao Lai, P.W. and Wilding P, *Understanding Hong Kong*, in P.Wilding, A.S. Huque and P.W. Tao Lai (eds), *Social Policy in Hong Kong* (Edward Elgar, United Kingdom 1997).

<sup>55</sup> Hong Kong Department of Justice. Bilingual Laws Information System, chapter 113.

December 1991. It is governed by the HA Board that consists of a chairman and more than 20 members appointed by the Government. The Chief Executive of Hospital Authority is responsible for the overall management of the HA's day-to-day operations under the policy direction of the HA Board. The Hospital Authority also has in-house clinical management teams and disease-based and specialised committees. It has medication incident reports and 55 quality standards for hospitals. Modeled on the Citizen's Charter concept brought from the UK by Governor Chris Patten, the Hospital Authority introduced a 'Patients Charter' in mid 1994, as did the Department of Health<sup>56</sup>. In this way, the government has attempted to educate the community with regard to patient rights as an alternative or supplement to professional self-regulation.

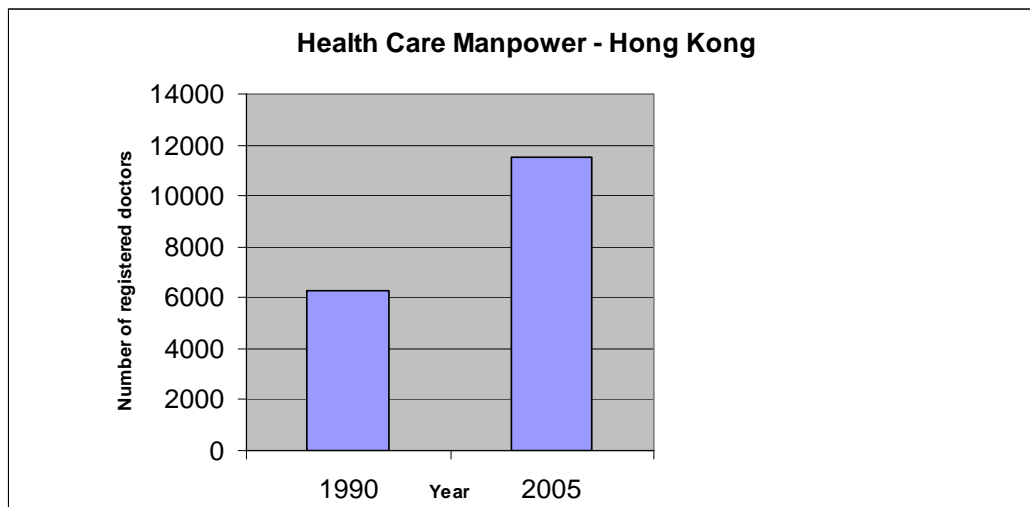
As at 31 March 2006, the Hospital Authority (HA) employed 52,000 staff and managed 41 hospitals and institutions. The total number of HA doctors were increased from 2240 in Dec 91 to 4607 in Dec 2005 respectively: (See Table 2 Healthcare Manpower – Hong Kong).

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<[http // www:justice.gov.hk](http://www.justice.gov.hk)> accessed 4 May 2004.

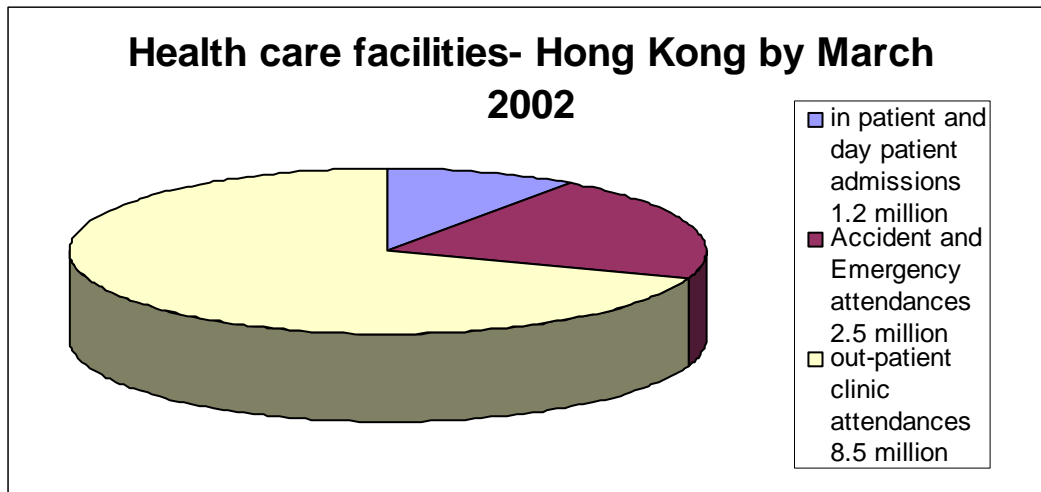
<sup>56</sup> Cooray, Anton.' Toward More Efficient Administration :Citizen's Charter in the United Kingdom and Hong Kong's Performance Pledge' (1993) 2 Hong Kong Public Administration(2):159-76.

**TABLE 2 HEALTH CARE MANPOWER - Hong Kong**



The figures show that in 1990 about 85% of sick people who need hospitalization were admitted to Hospital Authority beds. By March 2002, the Hospital Authority had catered to more than 1.2 million in-patient and day-patient admissions, 2.5 million Accident and Emergency (A&E) attendances, and 8.5 million out-patient clinic attendances. Hospital bed per 1000 population was 4.4 in 1990 whereas 4.9 in 2005. (See Table 3: Health Care Facilities Hong Kong)

**TABLE 3 HEALTH CARE FACILITIES IN HONG KONG**



These hospitals and institutions are grouped into seven clusters to enhance the coordination, planning and management of medical services. Hospitals and institutions in each cluster complement and support one another through cross-referral of patients, and sharing of major medical equipment and other clinical support services. Each cluster is headed by a Cluster Chief Executive and each hospital is headed by a Hospital Chief Executive (HCE).<sup>57</sup> The public healthcare fees for the main services of the HA and the number of patients served in 2006 are set out in the following chart.<sup>58</sup> For inpatient service, Accident and Emergency service and Specialist out-patient service, HK\$100/day for acute bed, first consultation and each consultation, \$60 for each follow-up consultation and

<sup>57</sup> Hospital Authority Health, Welfare and Food Bureau Hospital Authority: Management of outstanding medical fees Chapter 5.

<sup>58</sup> The 2006-07 Budget. The Government of HKSAR. Health Welfare and Food Bureau 2007. <<http://www.hwfb.gov.hk/statistics/en/dha.htm>>. accessed 11 Aug 2009.

\$68/day for convalescent rehabilitation / infirmary / psychiatric bed ( less, or even waived, if you are assessed to be at financial risk).<sup>59</sup>

Types of services Public Hospitals/ Clinics	Amount of fees	No. of patients served	Government subsidy (%)

(See Table 4 Types of Services and Amount of Fees for No. of Patients Served in 2006).

**TABLE 4 TYPES OF SERVICES AND AMOUNT OF FEES FOR NO. OF PATIENTS SERVED IN 2006**

The principle of the health authority is to ensure that no citizen will suffer ill health because of lack of means.<sup>60</sup> To uphold this policy, recipients of Comprehensive Social Security Assistance (CSSA)<sup>61</sup> are entitled to free medical treatment at hospitals. For patients who are not CSSA recipients but have difficulties in paying

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<sup>59</sup> Fees and Charges for Health care Services.

<<http://www.ha.org.hk/hosperv/index.htm>>accessed 15 Sept 2008

<sup>60</sup> CH Leong, 'Practise of Medicine' (2006) January Synapse12.

In-patient service ( General Ward/day )	\$100/day for acute bed; \$68/day for convalescent/ rehabilitation/infirmarary/ psychiatric bed	580 000	96.9%
Accident and emergency service	\$100 for each consultation	1.71 million	85.5%
Specialist out-patient service	\$100 for first consultation; \$60 for each follow-up consultation	1.51 million	91.2%
General out-patient service	\$45 for each consultation	1.28 million	81.3%

fees, the HA and the Social Welfare Department have jointly put in place a fee waiver mechanism to provide them with protection from undue financial burden. Whatever the complaint is, it must be correctly handled. The complainants are then advised of the appropriate mechanism for appeal. The Hospital Authority has formed a two-tier system of handling complaints since its establishment in 1991. The first-tier at the individual hospital level and the second at the level of the Public Complaint Committee (PCC). All complaints are managed firstly by the concerned hospital(s).

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<sup>61</sup> The CSSA Scheme provides a safety net for those who cannot support themselves financially. It is designed to bring their income up to a prescribed level to meet their basic. <<http://www.swd.gov.hk/en/index/site>> accessed 12 August 2009.



## **2.2.1 Hospital Complaints Procedures**

### **2.2.1.1 First – tier Complaints System – Patient Relation Officer**

In the first-tier system, a complainant may lodge a complaint to a Patient Relation Officer who is responsible for acting as a communication channel between hospitals and patients.<sup>62</sup> The Chief of Services will be involved in investigating the case thoroughly. The complainant may be interviewed if necessary. At the first-tier level, hospitals are committed to deal with the complaint within 3 weeks for normal cases and within 3 months for complicated cases. The complained cases handled in the hospital mainly include medical service, staff attitude and administrative procedures. However, they rarely investigate cases on clinical judgment. On the contrary, hospitals only investigate cases performed by the medical professionals in order to make sure that they are comply with the procedures and rules required in the medical profession. External experts will be invited to conduct an interview with the medical professionals if the complaint involves clinical judgment. An Independent Expert Group (IEG) will be appointed by the Hospital Chief Executive of the hospital to decide which follow up measures can be taken.<sup>63</sup>

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<sup>62</sup> The Patient Relation Officer is designated by the Hospital Chief Executive (HCE) in each public hospital. The associated functional units will be requested to write in detail about the events constitutive of the complaint

<sup>63</sup> The IEG runs on ad hoc basis. It is composed of both experts from HA and has lay membership. It serves the function of investigation and does not impose any sanction on medical professionals except through the action of Hong Kong

### **2.2.1.2 Second –tier Complaints System –Public Complaints Committee**

In recent years, the workload of hospital management and the Hospital Authority's Public Committee has been rising significantly. Consequently, the hospital staffs are subjected to mounting pressure due to the increase in the number of complaints. The Public Complaints Committee (PCC) was formed under the HA Board to independently review and resolve all appeal cases. Thirteen members sit on the Committee, including 10 lay members. If complainants are not satisfied with the outcomes at the hospital level, they could lodge an appeal at the HA Head Office or to the Authority's Public Complaints Committee (PCC). There is no time limit for complaints in Hong Kong. The target response time for handling public complaints is 3 months for normal cases and within 6 months for complex cases at the PCC level. Some of which could be very complex involving more than one hospital or department and encompassing comments relating to varied aspects of hospital care. In the course of investigation, the PCC will conduct separate interview sessions with the complainant and the defense as necessary.

As an example, there was a case against a public hospital for causing a burn injury to the patient during an emergency appendectomy operation. The PCC noted that the patient was suffering from acute appendicitis. Emergency appendectomy under general anesthesia was arranged. After induction of an intubation, Hibitane, a disinfectant was used to prepare the patient for operation. Bleeding was noted during the operation. Coagulation diathermy was applied to stop the bleeding.

However a longitudinal burn was subsequently found on the patient's right loin and upper part of the right buttock. The Committee considered that the patient's injury was caused by accidental diathermy burns as a result of accidental collection of excessive Hibitane beneath the drapes covering the patient. Following the Committee's discussion, the hospital reviewed and considered the use of an alternative and less flammable disinfectant other than Hibitane for preoperative preparation of patients to prevent future recurrence of similar incidents.<sup>64</sup>

Over the years, the hospitals and the PCC have built up a valuable and substantial collection of thousands of cases, derived from all areas of HA operations. Discussions of cases are conducted in closed sessions. Experts from the HA hospital or private practitioners may be invited to conduct independent review. The PCC has been tasked to manage a fair and effective handling system within the HA in which all public and appeals are dealt with reasonably and promptly. It will make regular account of its work to the Hospital Authority Board, the public and at the press briefings as a means to make sure there is public transparency. The decision of the PCC represents the final decision of the HA on a particular complaint. No further appeal can be made at the hospitals and HA level. However, if no settlement can be made and further arguments arise, the victim can complain to the Medical Council for further judgment. After that, further appeal can be made to the High Court.

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<sup>64</sup>The evolution of complaint management in the Hong Kong Hospital Authority. Part 2: The 'complaints' iceberg ?' (2004) October Hong Kong Medical Journal No. 5.

### **2.2.1.3 Characteristics and Numbers of Complaints**

According to the Hong Kong Hospital Authority, the total complaints by patients have increased dramatically. The Authority reports that patient complaints rose from 1,642 to 2,148 between 2000 and 2005. A total of 241 cases involving medico-legal matters from the years 2000-2002 were reviewed. Nearly 1,000 of the additional complaints concerned unsatisfactory medical services. The remainder related to poor staff attitude or administrative procedures. The consolidated results are as follows. The frequencies of different categories of complaints are shown in Table 5, the audit showed that 80 ( 33.2%) of the 241 cases involved medico-legal matters, 57 ( 23.7%) cases had PCC members interviewing the complainant or representative, 39 (16.2%) had PCC members interviewing the staff and 79 (32.8%) needed at least one independent expert review of the case. Among the complaints studied, 14 (5.8%) were substantiated and 43 (17.8%) were partially substantiated. The majority, 184 (76.3%) however were not substantiated after full deliberation by the PCC. Overall, 108 (44.8%) of the complaints were made by the patient whereas the other 133 (55.2%) were made by others on behalf of the patient.<sup>65</sup>(See Table 5: Frequency of Complaints by Category of Complaint).

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<sup>65</sup> ‘The evolution of complaint management in the Hong Kong Hospital Authority. Part 1: Complaints management - a tool for system change?’ (2004) October 10 Hong Kong Medical Journal.

**TABLE 5 FREQUENCY OF COMPLAINTS, BY CATEGORY  
OF COMPLAINT**

Category	3-yearcohort (2000– 2002) n= 241	2-yearcohort (2001-2002) n=169	1-year cohort (2001) n=86
Clinical services	220 ( 91.3)	151 ( 89.3)	77 ( 89.5)
Staff Attitude /communication	77 ( 32.0)	61 (36.1)	26 ( 30.2 )
Administration	61 (25.3)	55 ( 32.5)	25 ( 29.1 )
Environment (e.g. cleanliness) and others	5 (2.1)	5 ( 3.0)	4 ( 4.7)
Total	363	272	132

Because a case may involve more than one category of complaint, the total percentage exceeds 100% and the total number exceeds that of each cohort.

In Table 6, most of the complaints were centered in large acute general hospitals with A&E services, which is not surprising in view of the greater throughput and complexity of cases seen in these hospitals compared with other institutions. After correction for the varying activity levels in the five categories of hospitals (after weighting by discharges and death), psychiatric hospitals and non-acute or infirmary hospitals attracted the most per patient discharged.

**TABLE 6 FREQUENCY OF COMPLAINTS BY HOSPITAL TYPE** <sup>66</sup>

Hospital type	No. (%)	Weighted frequency*
General acute hospitals with Accident and Emergency Department	143 (84.6%)	0.89
Mixed acute/non acute	12 ( 7.0)	0.91
Non-acute/infirmarary	4 ( 2.4)	3.01
Psychiatric	5 (3.0)	5.00
Special –nature hospitals	5 ( 3.0)	0.73
Total	169	Not Applicable

**Table 7 FREQUENCY OF COMPLAINTS BY MEDICAL SPECIALTY**

The breakdown of incidence of complainants by medical specialty is shown in **Table 7** the six specialties most complained about were general medicine (27.8%), surgery (15.4%), A&E (13.3%), orthopedics and traumatology (10.3%), obstetrics and gynecology (9.5%), and psychiatry (8.3%).

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<sup>66</sup> ‘The evolution of complaint management in the Hong Kong Hospital Authority. Part 1 : Complaints management – a tool for system change?’(2004) August Hong Kong Medical Journal 291

Specialties	No (%)
General Medicine	67 (27.8)
Surgery	37 (15.4)
Accident and emergency	32(13.3)
Orthopedics and traumatology	25(10.3)
Obstetrics and gynecology	23(9.5)
Psychiatry	20(8.3)
Oncology	7 (2.9)
Neurosurgery	5 (2.1)
Pediatrics	5 (2.1)
Otorhinolaryngology	4 (1.7)
Physiotherapy	4(1.7)
Rehabilitation	3(1.2)
Hospice	2(0.8)
Intensive Care	2(0.8)
Ophthalmology	2(0.8)
Others	3 (1.2)
Total	241

Characteristics of patients: Nearly one half (49.0%) of patients who complained (or had a complaint lodged on their behalf) were female, and the overall mean age of the patients was 50.4 years (standard deviation, 21.8years), with a median of 48.0 years; at the time of discharge home, 172 (71.4%) of patients were alive.

### **2.2.2 External Redress System**

Besides the Hospital Authority's handling system, complainants can lodge their complaints to other redress organizations. They include: Office of the Chief Executive of the HKSAR, Secretariat of the Legislative Council, Health and Welfare Bureau, Office of the Ombudsman, Consumer Council, Equal Opportunity Commission and Officer of the Privacy Commissioner for Personal Data. In addition to the existing mechanisms, these redress systems may not adequately reply to particularly concerned individual. The systems would be enhanced if an Independent Ombudsman be designated to handle medical complaints filed against private and public health care providers as well as concerned institutions. This would enable the complainants to access expert and impartial support as they do not always have the means to do so. Complaints against medical groups and health insurance companies have been on the rise. Society for Community Organization statistics show that no. of complaints from the public increased from 10 in 2003 to 51 in 2005.



### 2.2.3 The Medical Council of Hong Kong<sup>67</sup>

Most professionals are regulated by organizations in maintaining professional standards and ethics. Medical professionals are no exception. Professional organizations such as Hong Kong Academy of Medicine and Hong Kong Medical Association are the organizations regulating medical practitioners in Hong Kong. Among these bodies in Hong Kong, Hong Kong Medical Council (MCHK) is the leading professional body since it has delegated authority to maintain the registration of all medical professionals in Hong Kong.<sup>68</sup> Empowered by the Medical Registration Ordinance (Chapter 161), MCHK's functions cover the registration of medical practitioners, the conduct of licentiate examination and the maintenance of ethics, professional standards and discipline in the profession.<sup>69</sup> Other medical professional bodies which register regulate training, hold examinations leading to registration or enrolment and exercise disciplinary powers include the Dental Council, Pharmacy Board, Nursing Board and Midwives Board.

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<sup>67</sup> The Medical Council of Hong Kong is the regulatory body established under the *Medical Registration Ordinance (Cap.161)* to assure and promote quality in the medical profession in order to protect patients, foster ethical conduct and maintain high professional standards. The code of conduct published states that its task is not only to 'discipline its members but to protect the public where necessary; and to seek to maintain public confidence in the profession; and in its widest sense to maintain the integrity of the profession. It is composed of 28 members four are lay (non-medical) members.

<sup>68</sup> Medical Council of Hong Kong (2001), *Professional Code and Conduct for the Guidance of Registered Medical Practitioners*, Hong Kong Medical Council.

<sup>69</sup> Medical Council of Hong Kong, 2002, 'How the Medical Council Deals with Complaint' < [http:// www.mchk.org.hk/draft/b.htm](http://www.mchk.org.hk/draft/b.htm)>accessed 11 Jan 2002.

In May 2001, Hong Kong formed a Working Group to review the Medical Council's structure, composition and functions aiming to strengthen its accountability, transparency and fairness.<sup>70</sup> Since January 2005, the MCHK has been updating the Professional Code and Conduct (the Code) issued in November 2000 to incorporate previously approved changes to improve clarity and remove ambiguities and to re-arrange the provisions in a more systematic manner. The Code will be renamed as the "Code of Professional Conduct" (the updated Code) upon promulgation.<sup>71</sup> If there were to be civil or criminal proceedings against the involved party, these disciplinary actions would be made with reference to the legal outcome. These actions include revocation or suspension of the practicing license, reprimand and issuance of a warning letter.<sup>72</sup>

The efforts of the Council to improve their systems and conduct in a more transparent manner have been said to be working well. Concerned institutions and the public can monitor the Council and ensure that all be carefully examined in the shortest time possible. The complainant must be kept informed of the progress of the investigation. Members of staff should have full information regarding accusations made against them and be advised of their right to seek counsel from

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<sup>70</sup> Medical Council of Hong Kong, 'Role and Functions of the Medical Council of Hong Kong' <[http:// www.mchk.org.hk/draft/b.htm](http://www.mchk.org.hk/draft/b.htm) > accessed 11 Jan 2002.

<sup>71</sup>The Professional Code and Conduct imposes on every doctor a personal responsibility to ensure compliance with the Code. A doctor must take reasonably adequate steps to prevent violation of the Code. It has been emphasized that every doctor has special duty to ensure that his conduct complies with the established rules of medical ethics.

<sup>72</sup> Medical Council of Hong Kong, , Professional Code and Conduct for the Guidance of Registered Medical Practitioners 2001.

their professional association. The survey on the reform of the Medical Council revealed that the majority of the respondents did not think the council was representative and called for its financial independence.<sup>73</sup> The present arrangement contrasts with those of other professions like the solicitor, barrister and accountant which enjoy professional independence from the government and allow their members to vote for their representatives. It is about time for the government to carry out dialogue with the profession to reform the structure of the present Medical Council.<sup>74</sup>

On receipt of a complaint, the Chairman of a Preliminary Investigation Committee (PIC) of MCHK will review the case and decide whether it is necessary to call for PIC meeting or dismiss the case.<sup>75</sup> The MCHK has influence to command that all or any of the information relating to the hearing must not be disclosed. However, if a complaint is upheld, the Council has various actions available to give the doctor concerned a public warning or reprimand. These actions include revocation or suspension of the practicing license, reprimand and issuance of a warning letter. It

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<sup>73</sup>Subcommittee on Improvements to the Medical Complaints Mechanism, Legco Panel on Health Services. Subcommittee Meeting on 27 June 2001.

<sup>74</sup> Dr Hon Kwok Ka Ki,(2007) June .A Newsletter from Legislative Councillor 8.

<sup>75</sup> The composition of the PIC is 7 members including 1 of the 4 lay members of the MCHK. Those cases regarded by the PIC to warrant disciplinary action will be referred to the Council for disciplinary inquiry. If an inquiry hearing is recommended, the Council will carry on like a tribunal in conducting its disciplinary inquiries in accordance with a set of statutory disciplinary procedures. All hearings are mostly held in public.

can suspend the doctor's registration for a period that the Council thinks fit. A doctor will be struck off the General Register in the most serious cases.<sup>76</sup>

Table 8 BREAKDOWN ON THE COMPLAINTS RECEIVED IN 2006  
WHICH WERE DISMISSED BY THE PIC CHAIRMAN AND  
THE PIC DEPUTY CHAIRMAN AND THE LAY MEMBER

Reasons for Dismissal	No of Cases
Doctor's attitude	13
Complications of treatment	2
Unsatisfactory results of treatment	3
Differences in medical opinion	2
Misdiagnosis	6
Groundless	119
Total	145

Various sanctions given by the Medical Council are (1) warning letter (not gazette), (2) warning letter (gazette), reprimand (gazette) and suspension/ removal from register (gazette).

With reference to the number of cases handled by the MCHK in the past 10 years, it is observed that there was 35.1% increase from 1996 to 2000. In 2000, the Council processed a total of 227 cases. All cases were considered by the PIC Chairman. Of these, 77 cases (34%) were dismissed by the PIC Chairman and Deputy Chairman. Thirty-four cases (15%) could not be pursued more as the complainants failed to give further information or statutory declaration, or the complaints were

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<sup>76</sup>How to deal with Complaints, <[http:// www.mchk.org.hk/complain /index.htm](http://www.mchk.org.hk/complain/index.htm)> accessed 11 Jan 2002.

unidentified; 49 cases (21%) are awaiting further information or statutory declaration. Sixty-seven cases (30%) were referred to the PIC meeting. Some of them were carried forward to the PIC meetings held in 2001. In 2000, the PIC considered a total of 58 cases. Some of these cases were carried forward from 1999. Of these 58 cases 39 cases were dismissed by the PIC, 15 cases were referred to the Council for inquiry, and 4 cases were under consideration pending further investigation.

There are 3 main categories of disregard to professional responsibilities in 2006 include: Failure/unsatisfactory result of surgery =7 %; Inappropriate prescriptions of drugs = 38%; Failure to properly/timely diagnose of illness = 17%. The verdicts of 297 cases heard by Medical Council relating to Disregard to Professional Responsibilities to Patients: 16 cases are found guilty, one case is not guilty and 6 cases are to be continued. Of these 23 cases, 22 cases were referred for inquiry by the PIC meetings held in /before 2005. The total no of appeal cases in progress from 5 to 7 since 2002 till 2006. Of the 465 complaints received in 2006, 14 cases (3%) were not taken action as the complainants failed to provide further information or statutory declaration or the complaints were anonymous. 131 cases (28%) were dismissed by the PIC Chairman, the PIC Deputy Chairman in consultation with the Lay Member as being frivolous or groundless. 95 cases (21%) were referred to the PIC meeting. 225 cases (48%) are pending further information or statutory declaration. For cases referred to the PIC meeting, some of them have been carried

forward to the PIC meetings to be held in 2007. (See Table 9 Statistics on Disciplinary Cases Handled By the Medical Council )

The Hong Kong Medical Council has been ensuring the standard of doctors in Hong Kong and dealing with complaints from the public. Of the 397 complaints received in 2005, 38 cases (10%) were not taken action as the complainants failed to provide further information or statutory declaration, or the complainants were anonymous, etc. 151 cases (38%) were dismissed by the PIC Chairman, the PIC Deputy Chairman and the Lay Member as being frivolous or groundless. Sixty-seven cases (17%) were referred to the PIC meeting. One hundred and forty-one cases (35%) are pending further information or statutory declaration. The major categories of cases on disregard of professional responsibility to patients in 2005 include failure result of surgery (8%), failure to properly/timely diagnose illness or to give proper advice (16%) and conducting inappropriate treatment or inappropriate prescription of drugs (46%). (See Table 9: Statistics on Disciplinary Cases Handled by the Medical Council)

**Table 9 <sup>77</sup> STATISTICS ON DISCIPLINARY CASES HANDLED BY THE MEDICAL COUNCIL**

Year	Involving Negligence	Total Number	Considered by PIC	Referred for disciplinary hearing
2002	160	287	76	-
2003	166	350	108	1
2004	190	311	112	-
2005	237	397	123	-
2006	297*	465	118	-
PIC - Preliminary Investigation Committee				

## **2.2.4 Patient Advocacy in Hong Kong**

### **2.2.4.1 Alliance of Patients' Mutual Help Organizations**

In 1992, 16 self –help groups worked together in the public consultation of the “Green Paper on Rehabilitation Policies and Services”. By February 1993, these groups organized themselves into the Alliance of Patients’ Self Help Organizations.

In 2000, the group membership of the Alliance of Patients’ Mutual Help

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<sup>77</sup>‘Statistics on Disciplinary Cases Handled by The Medical Council’ (2007) April 3 *The Medical Council of Hong Kong* .

Organizations had grown to nearly 60 organisations about a total membership of 40,000 patients<sup>78</sup>. In collaboration with the Hong Kong Medical Association and the Rehabilitation Alliance, the Alliance of Patients' Mutual Help Organisations formed two Community Rehabilitation Network (CRN) in January 1994. The establishment of these two CRN provided a base for developing practice approaches and skills in rehabilitation and community care for patients. The information and educational materials were consolidated into publications and audio-visual materials for the training of professionals, patients and the general public.

#### **2.2.4.2 Patient's Right Association**

The Patient's Right Association was established in 1992. It is under the supervision of Society for Community Organization. The objective of the Association is to advocate patients' rights in Hong Kong. Their staff assists victims of medical incidents to launch complaints and claims for compensation individually. The nature of the relationship between patient and medical professional goes beyond that of a 'trader' and a 'consumer'. While patients' rights education has led to greater empowerment of consumers, it is also a threat to doctors' absolute authority. The Hong Kong Medical Association (HKMA) originally produced a seven-point list of patients' rights in 1990. However, its existence was not generally known to the public. The issue of patients' rights was debated in the Legislative Council on 8 July 1992, at which time the government felt that it was mainly the responsibility of

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<sup>78</sup>Chan, Ceilia L. W, 'People Who Suffer in Silence and in Pain' (2001)  
<<http://www.hku.hk/spcwprl/hksw/staff/html>> accessed 17 Sept 2008.



patients to exercise their own rights. Following this, the HKMA in conjunction with the Consumer Council produced a pamphlet on patients' rights which included a telephone number specifically dedicated to patients requesting further information or assistance.

It may be because of the Chinese culture that people in Hong Kong would be a bit passive when they receive medical treatment. People do not know what their rights as patients are nor do they know what their responsibilities are. However, it would be beneficial to both patients and health care providers if the patients know their rights and their responsibilities. In this way, the government has attempted to educate the community with regard to patient rights as an alternative or supplement to professional – regulation.<sup>79</sup>

#### **2.2.4.3. Patients' Resource Centre**

With the funding from the Hong Kong Cancer Fund, Patients' Resource Centres were set up in Queen Elizabeth Hospital, the Tuen Mun Hospital and the Lady Pamela Youde Nethersole Eastern Hospital. These hospitals pioneered the introduction of resource centres to serve patients in hospitals. By October 1998, there were more than 30 hospital based patients' resource centres in public hospitals. The experiment was very successful and the Hong Kong Government started

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<sup>79</sup> Mao Qun'an, 'Patients should be put first' *Jiangnan Metropolis News* (Hong Kong 15 August 2007)10.

funding the patients' groups in 2001.<sup>80</sup> In the same manner, the government is expected to provide a high standard of universal health care to its citizens. It has found that a better way to assist dissatisfied and aggrieved patients/relatives is to establish a 'resource centre' to support their needs. The resource centre can also act as a mediator between the aggrieved patients/relatives and the involved professionals. If the patients/relatives are still not satisfied and would like to pursue a case, the resource centre can offer assistance by pointing out other channels along which they can proceed, for example issuing an instruction to the Office of Ombudsman and guide them through the necessary procedures. In addition, the resource centre can play an important role in this by providing a unified force to deal with a particular provider/institution to identify areas of weaknesses and to suggest ways of improvement. The increased availability of medical information through the media and Internet has created a new generation of interactive patients who are more knowledgeable about their own condition and prepared to question a doctor's diagnosis or prescribed treatment.

#### **2.2.4.4 Office of the Ombudsman**

The hospital staff would understandably be under additional pressure when the number of complaints increases. Formidable practical problems confront the plaintiff patient. Council member Tse Hung-hing suggested that an independent panel should be set up to deal with complaints. Patients Rights Association

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<sup>80</sup>自助組織/互助小組資料表<<http://www.autosoft.com.hk/stroke.org/list.htm>> accessed 15 Sept 2008.

spokesman Tim Pang Hung-cheong said that the system should be independent of the medical profession. It is believed that the government should consider a Medical Ombudsman who has the power to investigate all and to conduct disciplinary hearings. In order to respect professional autonomy, the defendants would be referred back to the Medical Council which would pass sentence on the doctors. In addition to investigating complaints, the Office of the Ombudsman also provides alternate dispute resolution services including the Internal Handling Programme which affords departments and organisations an opportunity to handle relatively minor complaint.<sup>81</sup>

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<sup>81</sup> The Office of the Ombudsman is an independent authority established under the Ombudsman Ordinance (Cap 397) since February 1989. The Ombudsman is appointed by the HKSAR. The role of the Ombudsman includes redressing individual grievances against maladministration in the public sector, making bureaucracy more humane and lessening the gap between the government and the public. Two major amendments were made to the Ombudsman Ordinance in 1994 and 1996 to enable citizens to lodge directly with the Ombudsman in order to empower him to initiate direct investigations on his own volition and to extend his jurisdiction to include nearly all Government departments and 14 major statutory bodies.

## **CHAPTER 3 THE BASIS OF LIABILITY OF MEDICAL PRACTITIONERS**

### **Chapter Summary**

In the era of human right and freedom, people in Hong Kong are more conscious of their right and have great aspiration for autonomy. As people become more affluent, our society has become more aware of individual rights, autonomy and self-determination. This idea penetrates into their daily life and affects their relationship with medical personnel. Specifically, in our century, the advances in IT have taken an influential role in doctor-patient relationships. They may no longer be established through face-to-face encounters, but through the internet, for example, E-mail. Clearly, this modern diversion raises issues of particular sensitivity in the medical sphere. Once the patient-physician relationship (PPR) is established, the medical professionals are bound by a profession of fidelity to serve the patients' best interests at the expense of their own in both emergency and non-emergency circumstances, to be accountable to his patients and keep confidentiality. The duty of confidentiality is part of medical general duty of care to patient. These duties are found in the codes of ethics and the law. The ethical duty to maintain medical confidentiality allows patients to discuss their health with their doctors freely, safe in the knowledge that there is patient confidentiality. Patient can sue for damages for negligence if got unauthorised disclosure of confidential information about him that causes physical harm. This is a well-established tradition among healthcare

professionals and forms the cornerstone in medical practice. Therefore, it is important to establish a working relationship with patients in the form of verbal and written agreements. These often take the form of consent agreement which is one of the main issues in a medical negligence action.

Consent is a key issue in both clinical practice and clinical negligence claims. The explanation of risks and complications to a patient is worthy of a special mention. It is not safe for the doctor to rely solely on the fact that the patient has signed a consent form which says that the patient has been explained. A doctor should record the details of what he informed the patient. If a doctor's practice consists of performing the same procedure frequently, e.g. Lasik surgery for an ophthalmologist, a standardised form detailing the risks is to be signed by the patient. Before a decision is made to use an intervention, its benefits and harms must be weighed ideally by the clinician and the patient together. Central to the law of consent is the controversial issue of how much information should be given to patients to facilitate them to give free consent. The Court will in the first instance look to expert opinion. However, the Court is not bound to accept that a practice is accepted as proper by a responsible body of medical opinion simply because an expert tells the Court that it is so. If the Court finds that the practice is not justified, the Court may rule that it is not a practice accepted as proper by a responsible body of medical opinion. The Court will be slow to strike down a practice which has been followed in appropriate circumstances.

This is well demonstrated in the result of an interview in which 90% of medical profession thinks that adequate information and informed consent is given before medical treatment but only 10% of the public is satisfied with the extent of information given to them before implementing treatment. The discrepancy shows that expectations of patients is not fully met by medical professions and create a challenge to doctor – patient relationship. The situation adds further stress on doctors who already find it more and more difficult to satisfy the need of their clients. In the medical context, healthcare professionals should ensure that patients are clear on what message will be conveyed and who will be involved. Similarly the safest option to an unclear answer to a patient’s question is to find out the right answer and get back to them, instead of pretending to know or dismissing the question. The doctor should be capable of responding to any questions fully and answering them honestly. Even when time is precious and pressing, there is no excuse for not signing a good consent with clear explanation. Not explaining or inadequately explaining the risks of surgery or invasive procedure by the doctor to his patient is medical negligence under Hong Kong law.

### 3.1 Existence of Physician –Patient Relationship

#### 3.1.1 Patient-Physician Relationship -----Fiduciary Relationship

In the patient-physician relationship, medical professionals (MPs) are delegated mandatory power in dealing with matters of healthcare like prescribing medicine and exposing patients' bodies to physical examination. While treating patients, medical professionals often ask for very personal information that would otherwise be strictly private. Patient trust is based on the good faith to forgo their privacy in order to facilitate their health care. The scope of liability in negligence is considered below. This starts with the beginning of the doctor-patient relationship. A doctor owes a duty of good faith to his patient<sup>82</sup>. This fiduciary concept is not new to the medical community. The patient-physician relationship (PPR) has been recognised as a fiduciary relationship (FR) in the West by the American College of Legal Medicine.<sup>83</sup> Beauchamp and Childress unequivocally state that:

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<sup>82</sup> *Hunter v Mann* [1974]QB 767; *X v Y*[1988] 2 All ER 648; *W v Egdell* [1989] 2 WLR 689. The cases *Hunter v Mann* and *W v Egdell* were considered in *Venables v News Group Newspapers Ltd* [2001] EMLR 255, where the Family Division held that information about the claimants' medical,, psychological or therapeutic care was, in principle confidential. The obligation extended to any form of therapy and to all those taking part in group therapy,, not only the therapist. See also *Campbell v MGN Ltd* [2003] EMLR 39at 54, where Lord Phillips quoted what the judge said at first instance. "In my judgement it matters not whether therapy is obtained by means of professional medical input or by alternative means such as group counselling or as here organised meetings for discussion between sufferers." His Lordship, however did not consider that the information that Miss Campbell was receiving therapy from Narcotics Anonymous was to be equated with disclosure of clinical details of medical treatment: *ibid.*, at 54.

<sup>83</sup> American College of Legal Medicine Textbook Committee. *Legal Medicine* (5<sup>th</sup> ed. Missouri, SL ; Mosby Inc 1998)245.

“The patient-physician (PPR) relationship is a fiduciary relationship (FR) - that is founded on trust or confidence; and the physician is therefore necessarily a trustee for the patient’s medical welfare.”<sup>84</sup>

Without clearly mentioning the term ‘fiduciary’, the Council on Ethical and Judicial Affairs of the American Medical Association has stated: “The relationship between patient and physician is based on trust; patients’ dependence gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest.”<sup>85</sup> A fiduciary relationship is a very special legal relationship. It arises when a person (the beneficiary) entrusts another (the fiduciary) with a power which may affect the beneficiary’s interests and which is to be exclusively exercised for the beneficiary’s benefit.<sup>86</sup> This “fiduciary expectation” is justified and compatible with the Hippocratic tradition: “The actions of medical practitioners are supposed to promote the interests of patients above all others, including the physician.”<sup>87</sup> Pellegrino<sup>88</sup> aptly notes that “the knowledge the physician offers is not proprietary; ... [it] is not individually owned and ought not to be used primarily for

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<sup>84</sup> Beauchamp TL, Childress JF, *Principles of biomedical ethics* (Oxford University Press : New York 1994 )430.

<sup>85</sup> American Medical Association, Report of the Council on Ethical and Judicial Affairs, *CEJA Report* 2001: 3.

<sup>86</sup> See discussion in the leading works on fiduciaries: P. D. Finn, *Fiduciary Obligations* (1977) and J.C. Shepherd, *Law of Fiduciaries* (1981). See also, R. P. Meagher, W. M. C. Gummow and J.R.F. Lehane, *Equity: Doctrines and Remedies* (3<sup>rd</sup> ed 1992) ch 5 and Goff and Jones, *The Law of Restitution* (4<sup>th</sup> ed, 1993) chap 33.

<sup>87</sup> Capron AM. ‘Containing healthcare cost: ethical and legal implications of changes in the methods of paying physicians.’ (1986) 36 Case Western Reserve Law Review 708 759.

<sup>88</sup> Pellegrino ED. ‘Altruism, self-interest, and medical ethics.’(1987) 258 JAMA 1939 40.



personal gain, prestige, or power. Rather the profession holds this knowledge in trust for the good of the sick.” However, in daily practice pressure is often put on doctors to “serve” their “customers”. Some may argue that if a “customer” asks for a service and is willing to pay for it, the doctor should provide it without question. However, this is a dangerous argument as the doctor-patient relationship is much more than just a general “customer – service provider” relationship. In providing a service, doctors are mandated to exercise their own independent and professional judgement to act for the best interest of their patients. Hence, if the patient’s request is against the patient’s own best interest, the doctor should refuse to provide it.<sup>89</sup> In a case of negligence, it would not be a defence for a doctor to argue that “the patient asked for that treatment” if the treatment was not a reasonable or acceptable one. However, if the patient still insisted the treatment after explanation from the doctor, the doctor should not feel compelled to oblige but should advise that there was a breakdown of the doctor-patient relationship. Also, the patient may choose to break the relationship unilaterally. This view was affirmed in the recent UK case of *Re Wyatt*.<sup>90</sup> The National Health Trust (NHT) therefore sought a new court order to the effect that in the event of irreconcilable disagreement between the parents and

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<sup>89</sup>Johnson Stokes & Master. ‘The customer is always right’ vs. ‘Doctor knows best’? (2006) February *The Hong Kong Medical Association Journal* 32.

<sup>90</sup>*Re Wyatt*. a premature baby was suffering from multiple medical problems and was treated at a NHS trust hospital. The NHS trust had already applied for and granted declaration from Court permitting the trust to discontinue artificial ventilation if this was deemed not to the baby’s best interest, even if this was contrary to the parent’s wishes.

the doctors, the doctors have the last word.<sup>91</sup> This principle is of paramount importance in medical practice as rapport between a doctor and the patient governs the compliance to treatment and success of outcome. Meanwhile, doctors have an extra duty to transfer the care of the patient to an equal if not more qualified doctor before the relationship is ended.

### **3.1.2 An Overview of Accountability**

The concept of accountability is similar to the ideas of responsibility and control. To account is to perform one's conduct appropriately. A person cannot be accountable to anyone unless that person has been given the responsibility to do something. Healthcare professions are subject to many established and planned layers of accountability. It is useful to explore the terms and issues surrounding public and professional accountability in this discussion.<sup>92</sup> In analysing accountability, it must be clear who is accountable and to whom is the person accountable. A recent case in Hong Kong demonstrates this principle clearly. The case was in relation to the patient in Hong Kong who went to see the Defendant doctor for consultation on four occasions. On each occasion the defendant at the request of the patient split the consultation fee into two separate receipts, and one of

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<sup>91</sup>The Court held that: 'Where a clinician concluded intellectually that a requested treatment was inimical to the best interests of the patient and his professional conscience, intuition or hunch confirmed that view, he could refuse to act and could not be compelled to do so, although he ought not prevent another from so acting, should that clinician feel able to.'

<sup>92</sup> Hayllar, Mark, *The Impact of New Public Management Reforms on the Accountability of Hong Kong's Hospital Services : A Case Study of Staff Perception*. (City University of Hong Kong, HK 1991).

the receipts was dated with a date on which there was no consultation. The patient subsequently submitted the receipts to the insurance company in support of her insurance claim<sup>93</sup>. In relation of the facts alleged, he had been guilty of misconduct in a professional respect. All the facts of the case were admitted by the Defence. The Defence submitted that the Defendant was misled by the patient and there was no ulterior motive in splitting the fees, and that the Defendant readily admitted to the insurance company that there was consultation on only some of the dates of the receipts. It was not accepted that the Defendant was acting innocently when he issued the receipts at the patient's request. In his explanation to the Preliminary Investigation Committee, the Defendant said that the patient needed the separate receipts with separate dates in order to claim reimbursement from her employer, and the Defendant expressed concern about issuing split receipts. His concern must have stemmed from his view that this was a misleading act. Given that the patient actually told him the purpose of the split receipts, the Defendant must have known that the receipts were required in order to give the false impression that consultation took place on the dates of the receipts. Having regard to the gravity of the case and the mitigation advanced, it was ordered that the Defendant's name be removed from the General Register for a period of 3 months.<sup>94</sup>

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<sup>93</sup> Hayllar, M.R., 'The Importance and Attributes of Effective Accountability Relationships', Paper presented at the EROPA Hong Kong Conference 2000: Developing Asia's Public Services: Sharing Best Practices (October 2000).

<sup>94</sup> A disciplinary inquiry was held on 31 March 2006. The charges alleged against the Defendant doctor were: "That he, being a registered medical practitioner on or around 3 March 2004, issued a medical receipt dated 4 March 2004 in respect of his patient, which was untrue, misleading or otherwise improper in that there was no consultation by the patient on 4 March 2004."

From the above mentioned case, it can be seen that an untrue or misleading receipt may expose the issuing doctor to disciplinary proceedings by the Medical Council and the risk of criminal liability as well. In these instances, the doctor must take care to ensure that everything stated on the receipt is truthful and not misleading. Although a doctor may wish to help his patient as much as he could for the insurance claim, the doctor must realize that it is not his duty or obligation to do so. The doctor's primary duty is to treat the patient to the best of the patient's interest with truthful and non-misleading manner. It would be unwise for doctors to split his receipts. It should be pointed out that an untrue or misleading receipt may not only expose the issuing doctor to disciplinary proceedings by the Medical Council; it may also expose the doctor to the risk of criminal liability.<sup>95</sup> There, a doctor is not just accountable to the patient but also to the public who trust him as a professional.

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<sup>95</sup> Paragraph 3.1 of the Professional Code and Conduct states: "Medical practitioners are required to issue reports and certificates for a variety of purposes (e.g. insurance claim form, receipts, medical reports, international vaccination certificates, incapacity to work through illness or injuries certificates etc.) on the assumption that the truth of the certificates can be accepted without question ...Medical practitioners are expected to exercise care in issuing certificates and kindred documents and should not include in them statements which the medical practitioner has not taken appropriate step to verify. Any medical practitioner who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper render himself liable to disciplinary proceedings."

### 3.1.3 Medical Confidentiality <sup>96</sup>

Virtually every professional relationship involves a duty of confidentiality, whether or not it is expressly written into any contract.<sup>97</sup> The classical medical confidentiality between physician and patient and that between lawyer and client has its roots in nineteenth century decisions. Doctors are under a duty of confidentiality to their patients and cannot disclose the patients' information without the latter's consent.<sup>98</sup> As a general rule, a doctor owes a duty of confidence to his patient. For doctors it is contained in the Hippocratic Oath which dates from around 500 BC from the Greek philosopher/medico Hippocrates states: <sup>99</sup>

“All that may come to my knowledge in the exercise of my profession or not in connection with it, or in daily commerce with men which ought not to be spoken abroad. I will not divulge abroad and will never reveal. Reckoning that all such should be kept secret. ... Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not to be

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<sup>96</sup> The Common Law duty of confidentiality is the legal obligation not to disclose confidential information concerning a patient which a doctor learns in the course of his professional practice. The Personal Data (Privacy) Ordinance Cap 486 reinforces this duty by providing that personal data shall not, without the prescribed consent (express given voluntarily) of the data subject, be used for any purpose. (“PDO”).

<sup>97</sup> *Seager v Copydex* [1967] 1 WLR 923.

<sup>98</sup> Personal Data (Privacy) Ordinance Cap 486. : Personal data should not be used for any purpose other than for the purpose for which the data were collected, except with the written of the data subject or where a relevant exemption applies. (I'm guessing the original chunk of footnotes doesn't apply since it was repeated previously).

<sup>99</sup> Hippocrates, *The Medical Works of Hippocrates*, trans. Chadwick, J. and Mann W.N (Blackwell Scientific, London 1950).

spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.”

In the case of *Gillick v West Norfolk and Wisvech Area Health Authority and the DHSS*<sup>100</sup> (concerning contraceptive advice and treatment to minors) affirmed the duty of confidentiality.<sup>101</sup> The House of Lords recognised the duty of confidentiality imposed upon a medical practitioner not to disclose information about the patient without consent.<sup>102</sup> In the absence of the prescribed consent of the patient, the disclosing of the patient’s medical information to a third party might not be construed as a directly related purpose under Data Protection Principle 3 as medical treatment of patient is a personal matter.<sup>103</sup> Doctors, like lawyers and priests, must be able to keep secrets. The legal position is described in *Hunter v Mann* by Boreham J (with whom Lord Widgery CJ and May J. agreed):<sup>104</sup>

“...in common with other professional men ... the doctor is under a duty not to disclose [voluntarily] without the consent of his patient information which he, the doctor, has gained in his professional capacity, save... in very exceptional circumstances ...”

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<sup>100</sup> *Gillick v West Norfolk and Wisvech Area Health Authority and the DHSS* [1986] AC 112.

<sup>101</sup> Reference may be made to the Scottish cases of *A.B. v. C.D* 1851) 14 D 177, and *A.B. v. C.D.* (1904) 7 F 72.

<sup>102</sup> The Public Health (Control of Disease) Act 1984, AIDS Control Act 1987, the Abortion Act 1967, the Misuse of Drugs Act 1971, the Road Traffic Act 1972, and the Prevention of Terrorism Act 1984.

<sup>103</sup> Data Protection Principle 3, Schedule 1, Personal Data (Privacy) Ordinance, CAP 486.

<sup>104</sup> *Hunter v Mann* [1974] 1QB 767.

For medical care to be effective, patients have to trust in their doctors. They must have confidence that they can safely talk to their doctors. The International Code of Medical Ethics<sup>105</sup> also states that a doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him. If confidences are broken, the patient might not pass on vital information to the doctor and this might result in a misdiagnosis or the wrong treatment being given to the patient which could have potentially damaging, or even fatal results. This is described by Raanan Gillon:<sup>106</sup>

“Why should doctors from the time of Hippocrates to the present have promised to keep their patients’ secrets? If confidentiality is not a moral good in itself what moral good does it serve? The commonest justification for the duty of medical confidentiality is undoubtedly consequentialist: people’s better health, welfare, the general good, and overall happiness are more likely to be attained if doctors are fully informed by their patients, and this is more likely if doctors undertake not to disclose their patients’ secrets. Conversely, if patients did not believe that doctors would keep their secrets then either they would not divulge embarrassing but potentially medically important information, thus reducing their chances of getting

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<sup>105</sup>International Code of Medical Ethics of the World Medical Association (as amended at Venice, 1983). Adopted by the Third General Assembly of the World Medical Association at London (1949) October World Medical Association Bulletin 109, 111.

<sup>106</sup>Gillon, R, *Philosophical Medical Ethics* (Chichester: John Wiley, 1986)108.

the best medical care, or they would disclose such information and feel anxious and unhappy at the prospect of their secrets being made known.”

All in all, the duty of confidentiality is an important concept in the provision of healthcare by a health professional to individuals. Patients seek relief from ailments from their doctors, thus healthcare providers have the professional responsibility to care for them.<sup>107</sup> Healthcare professionals such as doctors and nurses are generally expected to preserve secrecy with regard to personal information of their patients. Medical care is effective if patients can trust their doctors not to divulge information about their condition. If confidentiality is assured, patients can freely talk to their doctors, thereby allowing for more accurate diagnosis and treatment.

### **3.2 Consent of Treatment**

Consent to medical treatment is widely regarded as the cornerstone of the doctor/patient relationship. The consent agreement can be the single most important document for protecting an organization and provider in a malpractice suit from a patient. As a general rule, patients cannot be required to accept treatment that they do not want no matter how painless, beneficial and risk-free the treatment may be and no matter how dire the consequences of a refusal of treatment. This proposition is recognised as both an ethical principle and a legal rule, and is founded, ultimately,

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<sup>107</sup> Young A, The legal dimension. In Tingle J and Cribb A (eds) *Nursing Law and Ethics* (Oxford, Blackwell Scientific, 1995)3-20.



on the principle of respect for the patient's –autonomy.<sup>108</sup> Legal standards for decision-making capacity for consent to treatment vary somewhat across jurisdictions, but generally they embody the abilities to communicate a choice to understand the relevant information to appreciate the medical consequences of the situation and to reason about treatment choices.<sup>109</sup>

Essentially, consent is a principal issue in both clinical practice and clinical negligence claims where a claim in civil and criminal law may be available. The doctor might be liable in negligence if he performed an act quite unconnected with the procedure to which the plaintiff did not consent<sup>110</sup>. Without consent from a patient, the act of a doctor may amount to a tort of battery, which may result in all direct damages recoverable. The defendant may be liable for all the damages which can factually be seen to flow from his wrongdoing. The patient may sue for damages for the battery which was committed if non-consensual treatment involving touching of any sort is carried out. The essence of the wrong of battery is the unpermitted contact. It used to be argued that it was for the defendant, the

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<sup>108</sup>At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults..... are generally at liberty to refuse medical treatment even at risk of death. The right to determine what shall be done with one's body is a fundamental right in our society. The concepts inherent in this right are bedrock upon which the principles of self – determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority," per Robins J.A. in *Malette v Shulman* (1990) 67 D.L.R. (4th) 321,336 (Ont.C.A.). See also *Flemming v Reid*(1991) 82 D.L.R.(4th) 298, 309-310( Ont.C.A.).

<sup>109</sup> Grisso T, Appelbaum PS, *Assessing competence to consent to treatment: a guide for physicians and other health professionals* (Oxford University Press, New York 1998).

<sup>110</sup> *Marshall v Curry* [1993] 3 D.L.R. 260 ; *Murray v McMurchy* [1949] 2 D.L.R. 442.

doctor, to prove that the patient agreed. However, the onus of proof lies on the patient to establish that he did not agree. <sup>111</sup>

The recent English case of *Chester v Afshar* alters the law on informed consent. In the case of *Chester v Afshar*,<sup>112</sup> Miss Chester sued surgeon claiming that he failed to warn her about cauda equina syndrome (CES) which was one of the 1% to 2% of patients left with an unavoidable complication of this surgery. As the surgeon lacked documentary evidence that he had warned the patient of CES risk, the court accepted the patient's allegation and liability for failure to warn was established. Lord Hoffman said: <sup>113</sup>

“It was about as logical as saying that if one had been told, on entering a casino, that the odds on No.7 coming up at roulette were only 1 in 37, one would have gone away and come back next week or gone to a different casino”

As a result of the surgeon's failure to warn the patient, the patient could not be said to have given informed consent to the surgery in the full legal sense. The court took the view that the negligence to inform of risk led to injury was satisfied on policy grounds. The policy being that the patient's autonomy and dignity should be respected by allowing her to make an informed decision. Careful and comprehensible warnings about all significant possible adverse outcomes must be

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<sup>111</sup> *Freeman v Home Office* [1984] 2 W. L. R. 130, QBD, [1984] 2 W.L.R. 802, CA.

<sup>112</sup> *Chester v Afshar* [2004 ] UKHL 41.

<sup>113</sup> <[http:// www. bailil.org/cgl-bin/markup.cgi ?doc=/uk/cases/UKHL/2004/41.htm](http://www.bailil.org/cgl-bin/markup.cgi?doc=/uk/cases/UKHL/2004/41.htm)> accessed 11 Aug 2008

given. Lord Steyn saw a causal link between the failure to warn of risk and the injury (nerve damage) because ‘but for the surgeon’s negligent failure to warn the patient of small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small.’<sup>114</sup> The implication of *Chester* makes it more important than ever to take extreme care in ensuring that patients are fully informed.

### **3.2.1 The Legal Justification: Is Consent Always Necessary**

Consent is an integral part of medical treatment. In the context of healthcare, this consent does not mean that when a patient signs a form or presents himself for treatment he agrees to take the risk of being treated negligently. In reality, Hong Kong hospitals adopt a fairly uniform standard consent form which they require the patient to sign before embarking on treatment. These forms declare that both the nature and effect of the treatment / operation has been explained to the patient; however they are silent as to the particulars specific to the treatment. Nevertheless, if the consent form has been signed but no explanation is given in reality, the consent is vitiated. The question of which action is appropriate - trespass to the person or negligence - was considered in *Chatterton v Gerson*<sup>115</sup> where Bristow J said :

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<sup>114</sup> *Chester v Afshar* (2005) Lloyds L.R. 109.

<sup>115</sup> *Chatterton v Gerson* [1981]QB 432, 443.

“...it would be very much against the interests of justice if actions which are really based upon a failure by the doctor to perform his duty adequately to inform were based upon a failure by the doctor to perform his duty adequately, was pleaded in trespass [battery]. .... Once the patient is informed in broad terms of the nature of the procedure which is intended and gives her, that is real and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass. Of course, if information is withheld in bad faith, the will be vitiated by fraud. ”

Misunderstanding between a doctor and his patient frequently arises from examination by the doctor of the patient and the treatment given to the patient. Moreover, certain actions taken by the doctor during the treatment may be misinterpreted by the patients as being improper. A patient may complain that had he known it might go wrong, he would not have agreed to receive the treatment.

After some initial uncertainty, it appears that [English] law is now firmly committed to respecting patient choice, even when it is made in advance of an illness arising or deteriorating, and even when it risks the life of the patient or a potential child, so long as the person making the choice is deemed legally competent to do so.<sup>116</sup> The question that arises in the case will be whether sufficient information was given to the patient and whether he or she could make an informed choice.

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<sup>116</sup> McLean and Mason, *Legal and Ethical Aspects of Healthcare* (4<sup>th</sup> ed, Butterworths London )68.

Lord Donaldson MR, in *Re W (a Minor) (Medical Treatment)* produced a detailed analysis of the more practical clinical and legal purposes of advice giving to medical treatment :<sup>117</sup>

“It has two purposes, one clinical, and the other legal. The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient’s faith or at least confidence in the efficacy of the treatment is a major factor contributing to the treatment’s success. Failure to obtain such will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment . . . . The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. It does not, however, provide them with any defence to a claim that they negligently advised a particular treatment or negligently carried it out.”

The case was in relation to the patient consulted the Defendant doctor for vaginal itch on 23 May 2005. The Defendant doctor examined the patient’s genitalia and made a diagnosis of genital warts. The Defendant performed electro-cautery on the patient’s labia major and labia minor. However, the bone of contention was whether the Defendant doctor had explained the procedure to the patient and obtained consent from the patient before she performed the procedure.<sup>118</sup> These facts were not disputed by the Defence. The Defendant doctor was argued that the patient by

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<sup>117</sup> *Re W (a Minor) (Medical Treatment)* [1992] 9 BMLR 22, 29.

<sup>118</sup> Medical Council Inquiry on 1 December 2006, 22 January and 2 February 2007.

not objecting was actually consenting to the procedure. However, a patient cannot give consent unless she knows what she is consenting to. How could the patient object if she did not even know what was going to be done? In this case, the Defendant as a doctor had the duty to explain the invasive procedure to the patient and she had completely failed that duty. It was satisfied that this constituted professional misconduct. The Defendant's conduct was found to have fallen significantly below the standard expected of registered medical practitioners.<sup>119</sup>

In a Canadian case, a woman who expressed her wish to be injected in her right arm was injected by the doctor in her left. She sued in battery and succeeded.<sup>120</sup> Of course, it shows that the doctor has been careless. Similarly, a doctor who discovered that his patient's womb was ruptured while performing minor gynaecological surgery was held liable to her for going ahead and sterilizing her there and then. She had not agreed to sterilization.<sup>121</sup> In view of the above cases, one can conclude that in usual daily practice, proper consent is essential to avoid unnecessary litigation and negligence claim.

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<sup>119</sup> The above order was published in the Gazette of the Hong Kong Special Administrative Region (G. N. 1638) on 9 March 2007. The order should be published in the Gazette in accordance with the provisions of the Medical Registration Ordinance.

<sup>120</sup> *Allan v New Mount Sinai Hospital* [1980] 109 D. L. R. (3d) 536 cf.

<sup>121</sup> *Devil v West Midlands A. H. A.* [1980] 7 C. L. 44.

### 3.2.2 Medical Staff Acting Without Consent

There is no English reported case on the right or duty of a doctor to carry out emergency treatment on a patient when consent cannot be obtained, but commentators generally agree that where such treatment is necessary to preserve the life or the health of the patient no action lies for assault. Another possible basis for this immunity, beside that of implied, is the duty of medical staff to take all reasonable steps to preserve life albeit a moral duty rather than legal one. In *Wilson v Pringle*<sup>122</sup> the Court of Appeal, speaking of the rule that allows a casualty surgeon to perform an urgent operation on an unconscious patient who is brought into hospital', said;

“The patient cannot [give consent], and there may be no next-of kin available. Hitherto it has been customary to say in such cases that are to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say that the surgeon’s action is acceptable in the ordinary conduct of everyday life, and not a battery. ”

It was on the basis of a similar procedure in England that the Court of Appeal ordered an operation to sever conjoined twins, in circumstances where the death of one of the twins would result from the operation: *Re A (Children)*<sup>123</sup>. Despite the

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<sup>122</sup> *Wilson v Pringle* [1987] QB 237.

<sup>123</sup> *Re A (Children)* [2001] Fam 147. In the court’s view, the operation was in the best interests of both children as that principle was explained in *F v West Berkshire Health Authority* [1989] 2 WLR 1025.

fact that it would kill one of the twins, because the death of both would otherwise occur within another six months anyway. The court thus overrode the wishes of the parents, to leave matters as they were and to let the children die naturally. In *Hospital Authority v C*,<sup>124</sup> the pregnant patient had suffered irreparable brain damage and fallen into a coma. The Hospital Authority accepted the husband's advice that the patient would have preferred that the baby be born. At 32 weeks, the Hospital Authority felt that a caesarean section was indicated in order to save the child, taking into account the patient's deteriorating condition. The husband objected on the basis of spiritual advice he obtained. The Hospital Authority thought that the delay might endanger the child and so sought a declaration from the court that the operation proceeds immediately. The court granted the declaration on that basis and ordered the caesarean section to proceed immediately.<sup>125</sup>

The issue of getting consent may at times arouse controversy especially in developing country like China. The tragedy of Li Liyun, a 22-year-old pregnant woman who died in a Beijing hospital after her husband (Xiao) refused to consent to a Caesarean operation has shocked the public because her husband wrongly believed that a Caesarean section would have negative impact on his wife if she tried to have a second child. Who should be held responsible for the deaths of the mother and the baby in her womb?<sup>126</sup> The case has sparked controversy over

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<sup>124</sup> *Hospital Authority v C* [2003] 1 HKLRD 507 .

<sup>125</sup> *Re MB* (1997) 38 BMLR 175. *Re T (Adult Refusal of Treatment)* (1992) 2 WLR 782.

<sup>126</sup> 'Women's Death Unavoidable' <<http://wwaper.sznews.com/szdaily/20071130/ca2841892.htm>>



whether the families of patients have too much power when it comes to making decisions about medical treatment. Nevertheless, no doctor would dare perform the surgery without a family member's signature. No hospital would dare do such an illegal rescue. Xiao accused by the public of ignorance. It seemed that the hospital had fulfilled its responsibility by informing the patient's family members about her condition and reporting the case to the supervisor for instructions. Management regulations at medical institutions state that a hospital should perform an operation on a patient after the treatment proposed has been either approved by people in charge of the medical institution when it cannot get consent from the patient or relative or in the case of an emergency.<sup>127</sup> The regulations also say that any measures to save a dying person in an emergency cannot be considered a medical accident. A recent online poll by [www.sina.com](http://www.sina.com) of about 50,000 people found that 70 percent of them thought the husband was to blame for the death of his wife. Twenty-three percent said it was the hospital's fault and the rest said it was hard to determine who was to blame. Although regulations effectively protect the rights and medical records of patients and their family members, they also limit doctors' rights to treat them. In this case, the family members had more decision-making power than the medical staff. Doctors do not dare to oppose the wishes of family members

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accessed 17 Sept 2008.

<sup>127</sup> The defence of necessity may obviate the need for consent where the patient's life is at risk. Necessity will not justify surgery done for the sake of convenience or even for the patient's general welfare. On this point, recall the views expressed the House of Lords about necessity in *F v West Berkshire Health Authority* is really an application of the necessity principle.

and perform the surgery because if the surgery is not successful, the doctors might land up in court.

A common misconception is that the next of kin of an incompetent patient has authority to give or withhold consent. This misconception was dispelled in *Hospital Authority v C*<sup>128</sup>. Although the incompetent patient's husband's views would be heard as to what the patient would happen to his wife or her unborn child, his opinion was not determinative. The sole consideration was the patient's best interests, determined by the court based on all of the available evidence.

### **3.2.2.1 Necessity as a Defence – Procedure Without Prior Consent**

Necessity will be an adequate defence to any proceedings for non-consensual treatment when an unconscious patient is involved and there is no known objection to treatment. In *Murray v Mc. Murchy*<sup>129</sup>, the Supreme Court of British Columbia imposed liability on a surgeon who, while performing a Caesarean section, discovered fibroid tumours on the uterus of the patient and concerned for the hazards of any future pregnancy tied her tubes. Here the action of the doctor, though undertaken from the best of motives was not a necessity at that particular

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<sup>128</sup> *Hospital Authority v C* [2003] 1 HKLRD 507.

<sup>129</sup> *Murray v Mc. Murchy* [1949] 2 DLR 442.

time.<sup>130</sup> Patients are, of course, able to refuse. Given that the patient is competent (that they have understood the information, retained and believed it, and come to a decision) they are entitled not to give their consent. The court in this case took the view that it would not have been unreasonable in the circumstances to postpone the sterilisation until after consent had been obtained in spite of the convenience of doing it on the spot. The principle that a doctor is justified by necessity in proceeding without the patient's consent if a condition is discovered in an unconscious patient for which treatment is necessary in the sense that it would be in the circumstances, unreasonable to postpone the operation to a later date. In any event, details of any discussions should be clearly recorded. Finally, patients can withdraw their consent at any time. So, for example, a cry of pain during a procedure i.e., colonoscopy, is not necessarily a withdrawal of consent, and the doctor's reassurance may be enough to allow him to continue. However, if patients do object, if possible the doctor should stop the procedure, find out what their concerns are and explain the consequences of not proceeding. Establishing the competence of patients during a procedure is clearly difficult – pain, shock and the medication they have already received will affect their capacity and the doctor's ability to assess it. However, if they are competent and decide to withdraw their

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<sup>130</sup> P. D. G. Skegg, 'A justification for medical procedure s performed without consent' (1974) 90 LQR 512.

consent, the doctor/healthcare provider must respect their wishes and stop the treatment.<sup>131</sup>

In short, prior consent from the patient or his relative is deemed necessary unless a life saving procedure is performed. Meanwhile, withdrawal of consent should be respected if the patient is aware of the risk involved.

### **3.2.2.2 Consent in Minor and Incapacitated Patients**

In 1997, Hong Kong introduced new provisions (Part IVC) into the Mental Health Ordinance (Cap 136) to regulate the obtaining of consent to medical and dental treatment of persons found to be mentally incapacitated for the purposes of that ordinance. The new provisions appear to reflect the views of the House of Lords in *F v West Berkshire Health Authority*.<sup>132</sup> According to Section 59 ZA, in the absence of an appointed guardian's consent, medical treatment can be undertaken only in the best interests of the patient to: save the life of the medically incapacitated person; prevent damage or deterioration to the physical or mental

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<sup>131</sup> Paragraph 2. 1 (a) of the Professional Code and Conduct provides that consent has to be informed and proper which means that patient should be properly informed about the general nature, effect and risk of medical procedure.

<sup>132</sup> *F v West Berkshire Health Authority* [1990] 2 AC 1 HL. A declaration was sought from the High Court by the mother of an adult woman whose mental age was assessed to be that of a small child. While in voluntary hospital confinement, she had formed a relationship with a male patient in the same institution. The mother felt that it would be in the interests of her daughter to be sterilized, no other form of contraception being likely to be efficacious. The House held that it was within jurisdiction for a judge to make a declaration that an action would not be an assault, if it was in the interests of the victim, where the victim was unable to consent by reason of incapacity.

health and well-being of that person; or bring about an improvement in the physical or mental health and well-being of that person. Moreover, by virtue of Section 59ZG of the Mental Health Ordinance, “special treatment”, including a sterilization operation, requires the court’s consent.

Nevertheless, some doubts has been cast by what was said in the House of Lords in *Re F*,<sup>133</sup> which involved the non-consensual sterilization of a 36-year-old mentally incompetent woman. This would seem to include the situation where the patient is already anaesthetised and the treatment is given in an emergency where the patient is mentally handicapped. There was no legal obligation on a doctor to seek permission from the court before sterilising a mentally handicapped adult. Lord Brandon said that a doctor was not justified in carrying out any treatment upon a person who could not give consent that was in his best interests. However, his best interests fell to be decided according to the classic Bolam test- if a responsible body of medical opinion, albeit a minority one would have approved of the treatment given, the doctor is not in breach of his duty to the patient. The doctor is justified and should not have criminal or civil liability imposed upon him if the value which he seeks to protect is of greater weight than the wrongful act he performs – that is, treating without consent. A common misconception is that the next of kin of an incompetent patient has authority to give or withhold consent. This misconception was dispelled

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<sup>133</sup> *Re F* [1989] 2 WLR 1025.

in *Hospital Authority v C*.<sup>134</sup> Although the incompetent patient's husband's views would be heard as to what the patient would have desired and what was in her best interests, his opinion was not determinative as to what would happen to his wife, or her unborn child. The sole consideration was the patient's best interests, determined by the court based on all of the available evidence.

Thus, when treatment of mentally incapacitated person is concerned, it is governed both by the Common Law and Mental Health Ordinance in Hong Kong. While it is lawful to treat the mentally incapacitated person at his best interest, proxy consent is validated by the Mental Health Ordinance in contrary to the Common Law principle. This specially applies to non-urgent treatment in which a valid consent can be sought from guardian of the mentally incapacitated person if the former is empowered by the Guardianship Board. For doctors working in Hospital Authority, they can check with the Legal Service Section of the Hospital Authority headquarters to sort out whether the patient has a guardian while for doctors in private practice, they can check with the Guardianship Board to see if a guardian is appointed and empowered to give proxy consent. For mentally incapacitated patient without guardian or with guardian who cannot make decision, a doctor may treat the mentally incapacitated patient without consent if it is at the best interest of the

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<sup>134</sup> *Hospital Authority v C* [2003] 1 HKLRD 507.

patient or in controversial issue, seek judicial approval from the court before treatment.<sup>135</sup>

### 3.2.2.3 Refusal of Treatment – Blood Transfusion

In the recent Canadian case of *Malette v Shulman*,<sup>136</sup> a card clearly declining any blood transfusion was found on an adult accident victim. At the hospital her daughter forbade a transfusion. Nevertheless the emergency doctor transfused her to save her life. He was ordered to pay for assault. Donnelly J. said: <sup>137</sup>

“A conscious rational patient is entitled to refuse any medical treatment and the doctor must comply, no matter how ill-advised he may believe that instruction to be.”

Similarly, in *Re T*<sup>138</sup>, a 20-year-old pregnant woman who was injured in a car accident when she was 34 weeks pregnant. She was admitted to hospital where following an emergency Caesarean, her baby was stillborn. Afterwards her

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<sup>135</sup> Liu A. ‘Consent to medical treatment by or for a mentally incapacitated adult: the HongKong common law and Part IVC of the Mental Health Ordinance’(2006)1 Asian Journal of Gerontology & Geriatrics 93-98.

<sup>136</sup> *Malette v Shulman* [1991] 2 Med LR 162.

<sup>137</sup> In June 1990 the High Court in England made a two-year old Cypriot child who was suffering from leukaemia a ward of court as an emergency after her Jehovah’s Witnesses parents had taken her from the Great Ormond Street Hospital to avoid a blood transfusion. And in New York a Christian Scientist couple were convicted of manslaughter of their son in July 1990 for failing to seek medical treatment for him when he was taken ill. There was a report in The Times for 21 March 1991 of a Jehovah’s Witness mother who had died in childbirth after refusing a transfusion.

<sup>138</sup> *T, Re* [1992] 4 All ER 649.

condition deteriorated (she developed an abscess on her lungs) but as she had refused a blood transfusion on religious grounds a court order was sought overriding her refusal. The central issue before the court was whether T's refusal had been freely given, i.e., was it truly voluntary and genuine? Whether it was based on her own wishes, bearing in mind that she was an ex Jehovah's Witness who retained some beliefs – although these were described as neither “so deep – seated or so fundamental as to constitute an immutable decision by her as to her way of life –or her way of death”? The Court of Appeal decided that her refusal did not represent her own independent decision because “her will had been overborne” by the undue influence exerted by her mother (who was described as a “fervent, deeply committed” Jehovah's Witness) in the time she had spent alone with her shortly after she was admitted to the hospital. Furthermore, as a result of the various drugs she had taken (including sedatives), she was in any event in no fit state to make a decision. This meant that the hospital could lawfully administer blood to her if it was in her best interests. In *Re T*<sup>139</sup>(see above) the Court of Appeal said that doctors should give ‘very careful and detailed consideration to the patient 's capacity at the time of the decision’.

Assuming the patient is competent, the patient's wishes must be respected, whether or not this is due to him being a Jehovah Witness or belonging to some other system of belief or religion. A doctor cannot give a patient a blood transfusion without the

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<sup>139</sup> *Re T (Adult: Refusal of Treatment)* [1992] 9 BMLR 46, 50.



patient's consent. The doctor should record in his notes the fact that the doctor has informed the patient of the full risks and implications of not giving him a blood transfusion and also, the fact of the patient's express refusal to receive the blood transfusion, notwithstanding what he has been told. If, however, the doctor suspects for any good reason that the patient is incompetent to decide whether he should receive treatment or not ( e.g. the patient is delirious or under the influence of some psychosis- for instance, he believes that he is a superhero and his magical healing powers), then the doctor has to act in the patient's best interests. This may include giving the patient a blood transfusion if that is warranted.

### **3.2.3 The Standard of Care in Consent**

According to a 15-year study,<sup>140</sup> doctors who ignore their importance of good communication with their patients are more likely to be sued. The likelihood of litigation is associated with feelings that the doctor has covered up facts and deliberately misled the patient. The essentials in *Sidaway v Bethlem Royal Hospital Governors*<sup>141</sup> were applied in *Ho Yee Sup v Dr May Chan Yuk & Others*.<sup>142</sup> In *Ho*, the plaintiffs were failed in their claims against the defendants. This is a claim by a relatively young couple for damages for an unwanted birth after sterilization. In medico-legal terms, it was a "wrongful birth". The wife plaintiff following the

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<sup>140</sup>Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. 'Patient complaints and malpractice risk' (2002 )287 *JAMA* 2951-7.

<sup>141</sup>*Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643, 160.

<sup>142</sup>*Ho Yee Sup v Dr May Chan Yuk & Other* [1991] 1 HKC 499.

birth of her third son, she underwent a sterilization operation. Sterilization may be attempted after birth (post partum sterilization - "PPS") following a Caesarean section operation. It may be carried out immediately or at an interval after a normal or induced birth (puerperium) or abortion. Obviously, it can be performed at any time. However, there is a natural tendency to recanalize in sterilization operations, including one by the modified Pomeroy technique. Nevertheless, late recanalization occurs in about four to five cases in a thousand (0.4% - 0.5%). In other words, the sterilization operation undergone immediately following the delivery of the third son by Caesarean section carried a small risk of failure rate of 1%, i.e., one in a hundred. The plaintiffs' complaint is that they were not advised on this small risk of 1% failure rate in advance. However, medical science has never ceased to surprise: there are 27 reported cases of conception even after hysterectomy! The wife plaintiff claimed that she had never been counselled. The wife plaintiff maintained that if she had been advised of the failure rate, she would have taken contraceptive pills or other measures after her sterilization. However, there was a responsible body of obstetricians and gynaecologists practising in Hong Kong who would not have counselled the wife plaintiff about such failure risk. In conclusion, there was no duty of care owed to the plaintiffs so to warn in 1980, as indeed there was then a responsible body of obstetricians and gynaecologists in Hong Kong who would not have counselled about such failure rate. But one must not lose sight of the central issue, i.e., whether in 1980 in Hong Kong, there was a responsible body of obstetricians and gynaecologists who would not counsel on the risk of

recanalisation and unwanted pregnancy. Nonetheless, the principle was applied in *Wong Shui King v Dr Wu HinTing & Others*<sup>143</sup> where the defendant doctor had failed to inform the plaintiff of the potential side effects of the steroids that he had prescribed. Deputy Judge To ruled that “at no time had the defendant explained to the plaintiff the reason for the dexamethasone treatment its nature and side effect, so that she may make an informed choice as to whether the risk was worth taking”. The defendant doctor was found liable in negligence.

Another recent Hong Kong case was in relation to a doctor, former legislator; Lam Kui-chun has been accused of professional misconduct by the Medical Council of Hong Kong on a 67-year-old patient with a liver tumour died following therapy using radio waves. In RFA, a needle electrode is inserted in the tumour and a radio frequency current is passed through the electrode to heat tissue near the needle tip. The Hong Kong Medical Council said Defendant doctor, Lam had failed to use a guide probe, an essential piece of equipment for the treatment. As a result other organs were damaged by the heat. The panel was told in July that RFA can be dangerous if used near other organs. According to charges being considered by the Medical Council of Hong Kong, Medical Council found Lam guilty of performing radio frequency ablation procedure without proper training and inducing the patient, Lo Tai, into believing he had the expertise to carry it out. Dr Lam failed to advise his patient, 68-year-old Lo Tai, of his lack of experience with radio frequency

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<sup>143</sup>*Wong Shui King v Dr Wu HinTing & Others* [2000] HCPI 440 of 1997.

ablation treatment, or RFA, and of the risks it involved. Lo Tai died in Queen Mary Hospital after his second round of RFA treatment in November 2001. Dr Lam told a disciplinary panel he had controlled the current to the needle electrode used for radio frequency ablation (RFA) while his partner Dr Chan controlled the needle electrode. Dr Lam said he could not see clearly from ultrasound images what was going on during the operation. If [Dr Chan] had visualisation difficulty he should have said so, but he did not. Dr Lam was also accused of failing to inform the patient he had limited experience in such treatment, and inducing the patient into believing the procedure was the best form of treatment and that he had expertise in performing the procedure. The hearing also revealed that Lam had only received training from conferences and workshops and experiments on pig livers. While he had performed RFA only three times, he had the necessary background and Lo's family knew of his lack of experience. As a matter of fact, Lo's family known Lam had no prior experience with the technique; they would have reconsidered and may not have proceeded with it. The Defendant Doctor did warn the patient's family about the procedural risks of organ damage and had, in fact, shown them how the instrument worked. However, Lo's family members claimed they could not recall Lam suggesting any alternative treatment. Representing Lam at the hearing, barrister Douglas Jones said in his final submission the case against his client was "ambiguously prejudicial and fundamentally unfair." Jones said that in 2001, Lam did not know if there were other experts in the procedure in Hong Kong. "Lam knows as much as anybody in Hong Kong about ablative procedures. I don't think

there're any experienced doctors around. He felt Hong Kong was lagging behind the rest of the world, not having the radio frequency ablation procedure to treat terminal patients like Mr Lo. After a careful examination, the Medical Council found Dr Lam guilty on two charges of professional misconduct. The Council has suspended the licence of former legislator, Doctor Lam Kui-chun, for six months over the death of a 68-year-old patient following therapy for liver cancer. It placed him on a two year good behaviour bond and ordered him not to repeat the procedure.<sup>144</sup> The doctor should provide information to the patient about the nature of the treatment – that is what is going to be done and how the treatment is likely to progress - about alternative treatments regarding the risks and side-effects that might be expected. The patient needs to be fully informed about the treatment to be undertaken in order to decide to take the treatment or not. Most providers and patients realize that health care services are potentially hazardous and that errors sometimes occur despite the best efforts of people and institutions.<sup>145</sup> Patients expect to be informed promptly when they are injured by care, especially care that has gone wrong.<sup>146</sup> However, a divide between these expectations and actual clinical practice is increasingly evident.<sup>147</sup> Until recently, virtually no guidance was available to health care professionals regarding how or when to disclose errors; professional societies

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<sup>144</sup> Una So, 'Lam guilty in patient death case'. *The Standard China's Business Newspaper* (Hong Kong 29 January 2007).

<sup>145</sup> Blendon RJ, DesRoches CM, Brodie M, et al. 'Views of practicing physicians and the public on medical errors'. (2002) 347 *New England Journal* 1933-40.

<sup>146</sup> Mazor KM, Simon SR, Yood RA, et al. 'Health plan members' views about disclosure of medical errors'. (2004) 140 *Ann Intern Med* 409-18.

<sup>147</sup> Blendon RJ, DesRoches CM, Brodie M, et al. 'Views of practising physicians and the public on medical errors' (2002) 347 *New England Journal* 1933-40.

merely identified disclosure as an ethical obligation. To our knowledge, a key barrier to disclosure is the uncertainty of healthcare professionals regarding how much information to share with patients after adverse events.

### **3.3 Advance Directives in Relation to Medical Treatment**

The discussion of consent for medical treatment is incomplete without mentioning the recent recommendation of advance directive in relation to medical treatment by the Law Reform Commission.<sup>148</sup> Under the existing common law, one may give directions to his future health care while capable before he reach the state of inability to make such decision. These instructions are valid as long as they are clear and not under influence by others.<sup>149</sup> The Commission has proposed a model format for those who want to make advance directive and two witnesses without interest in the estate of the person making directive is needed, including a medical practitioner. These instructions may be changed orally or in writing by the person making the directive according to his will. An individual can then make sure his wishes are carried out and the medical profession involved may also be confident in giving treatment according to the patients' prior wishes. A clear instruction from the

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<sup>148</sup> The Law Reform Commission of Hong Kong has recently considered the issue of medical consent for persons, like the patient in *Airedale NHS Trust v Bland* (above) in a vegetative state, and the related issue of advance directives, whereby persons can express preference for treatment in advance of falling into a state of incapacity.

<sup>149</sup> The Commission recommended the promotion of the use of advance directives, as well as amendment of the definition of mentally incapacitated persons in the Mental Health Ordinance (Cap 136) *2006 Report on Substitute Decision-making and Advance Directives in Relation to Medical Treatment*

patient given in advance avoid among health care providers, the patient and the relatives involved.<sup>150</sup>

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<sup>150</sup> A report on two aspects of decision-making in relation to medical treatment of persons who are comatose or in a vegetative state, namely substitute decision-making and advance directives was released by *August 16 200 the Law Reform Commission Report*.

## **CHAPTER 4 THE DUTY OF CARE IN THE MEDICAL CONTEXT**

### **Chapter Summary**

This chapter highlights the importance of duty of care in the medical context. It discusses the duty owed to patients of all ages as well as the duty owed by doctors and Hospitals, with comments on foreseeable future challenges. The duty of care is an important concept in the provision of healthcare by one person to another. A duty of care is owed to anyone placing themselves in the hands of a medical practitioner who accepts that person as a patient. Any treatment, or lack of it, will clearly affect the patient. Like the biblical Pharisee, a doctor has no duty of care to the victim of a traffic accident whom he drives past. They were not obliged to render assistance to an accident victim. Under medical ethics, a doctor should come forward to help the passenger. Legally, a doctor is under no duty to come to the rescue of a passer-by. Under such circumstances, a doctor is not liable as he is treating the person with limited resources outside a hospital setting. However, should a doctor be found to be wantonly negligent, he can be sued for negligence. Once someone is accepted as a patient, a duty of care arises in consequence. It is necessary to show that doctors have a duty to exercise their skill to their patients but not to strangers, otherwise the liability may be extended to a third party. It extends to anyone attending an Accident & Emergency or Casualty Department in a hospital. Additionally, doctors



have an extra duty to transfer the care of the patient to an equally or more qualified colleagues before the relationship ends.<sup>151</sup> Nonetheless, duty of care at common law permits legal action brought by a child in respect of pre-birth injuries. Although an unborn child lacks the status to be the subject of a legal duty, a newly born child enjoys that status. It is apparent that the duty of care is owed to the patient (of all ages) with whom the physician has entered into a relationship of professional trust governed both by ethics and legal rules<sup>152</sup> while the hospital and its staff owe a duty to patients admitted for treatment or accepted as out-patients. The hospital can be sued for either vicarious liability for the actions of its nurse, or it can also be sued directly if there is no system or protocol for nurses to follow in such a situation, or the failure of such a system. This means that hospitals have a vicarious duty to ensure that the hospital staff, facilities, and other supplementary requirements provided can supply safe and satisfactory medical services for patients. This is true irrespective of whether the patient pays for the service or gets the service through charity. In the healthcare context, a patient claiming against his doctor or a hospital usually has no difficulty in establishing that the defendant owes him a duty of care. For any claim to be substantiated, the plaintiff (patient) has to prove that the doctor has not discharged his duty by exercising all reasonable skill and care that the law requires of him. In other words, the hospital is obliged to follow the Bolam test. If application of the test shows that the hospital should not have turned the patient

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<sup>151</sup> *Donoghue v Stevenson* [1932] AC 562.

<sup>152</sup> Dr T Thirumorthy, 'Understanding the Basis of Medical Negligence' (2006) *June Medical Grapevine* 30.

away, then the hospital can be sued for negligence. Our interview showed that physicians were more likely than the public to hold the hospitals responsible for the error whereas the majority of the public (90%) believed that physicians should hold individual responsible for medical errors. A minority of interviewees in both groups think that both the health professionals and hospital system should bear responsibility to the consequence of medical errors. It reviews the fact that general population has poor knowledge of vicarious liability held by the hospital.

In the United Kingdom the Department of Health has a statutory duty to provide medical services while in Hong Kong the Hospital Authority has no equivalent statutory duty. Thus if there is limitation of service due to financial restraint, it will be a matter of policy which the court rarely adjudicate. Plaintiff can only claim for individual negligence while Hospital Authority may be held vicariously liable. General practitioner work under National Health Service in England and owe a duty of care to patient over his practice area. This is different from private practitioner in Hong Kong who owes a duty of care only after he establishes a contractual relationship with the patient.<sup>153</sup>

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<sup>153</sup> Professor DK Srivastava and Neville Sarony. *Tort Law and Practice in Hong Kong* (Sweet & Maxwell Asia 2005).

#### 4.1 The Duty Owed to Patients

The concept of duty of care comes from a well-known British case *Donoghue v Stevenson*<sup>154</sup> in which it was pointed out that everyone should take reasonable care to avoid acts or omissions that are likely to injure their neighbors. The word ‘neighbor’ in this sense does not simply refer to the person living next door, but includes any persons who are likely to be affected by your activities. The case laid down the general principles of liability for unintended harm. In simple medical language and situations, doctors are responsible for their action (or inaction) which may directly (or indirectly) cause harm to their patients. In this regard, the practitioner will also owe a duty of care to all those persons who come within the so-called “neighbour principle” espoused in the famous dictum of Lord Atkin in *Donoghue v Stevenson*:

“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 law is my neighbour? The answer seems to be—persons who are so closely and directly affected by my acts that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions that are called in question”<sup>155</sup>

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<sup>154</sup> *Donoghue v Stevenson* [1932] AC 562.

<sup>155</sup> *Donoghue v Stevenson* [1932] AC 562.

This principle makes a medical practitioner responsible for the consequences of any action (or inaction) in the course of exercising his profession. As Lord Hewart CJ said in *R v Bateman*<sup>156</sup>:

“If a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to that patient to use due caution in undertaking the treatment of that patient. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.”

Furthermore, he is also legally responsible for causing harm to third parties because of his inaction. For example, a medical practitioner would be responsible for the immune-deficient household members contracting serious infection via a child who received a dose of oral polio vaccine if the parents are not told to dispose of the child’s excrement carefully. This general statement of principle clearly covers the position of a doctor or nurse in relation to a patient, who by definition must be ‘someone who is so closely and directly affected’ by their acts that he or she ought to ‘have them in contemplation’.<sup>157</sup> Generally, most of the healthcare professionals

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<sup>156</sup> *R v Bateman* [1925] 94 LJ KB 791, CCA.

<sup>157</sup> *Donoghue v Stevenson* [1932] AC 562.

undoubtedly owe a duty of care to patients in healthcare settings.<sup>158</sup> Once having established the contractual relationship with the patient, the doctor is duty bound to exercise the necessary care. In the healthcare setting, the claimant's first task is to establish that he or she was owed a duty of care by the defendant.<sup>159</sup> As Michael Jones comments:

“Normally, there will be no difficulty in finding a duty of care owed by the doctor to his patient, at least where the claim is in respect of personal injuries, and this is true even where there is a contractual relationship. The practitioner may also owe a duty to the patient in respect of pure financial loss. In addition, there are a number of circumstances where a doctor may also owe a duty to a third party arising out of the treatment given to the patient, but the incident and extent of such duties is more problematic.”<sup>160</sup>

On the other hand, there is no duty owed by a doctor to a patient on whom he or she carries out a pre-employment medical examination at the request of a third party (the employer). In *Kapfunde v Abbey National plc and others*,<sup>161</sup> the Court of Appeal held that a doctor engaged to assess the medical questionnaires of applicants for posts did not owe a duty to an applicant who had completed a pre-employment

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<sup>158</sup> Young A. ‘The legal dimension’ in Tingle J and Cribb A (eds) *Nursing Law and Ethics*. (Oxford, Blackwell Scientific, 1995)3-20.

<sup>159</sup> Brazier, M. *Medicine. Patients and the Law* (2<sup>nd</sup> edn Penguin, 1992)117-118.

<sup>160</sup> Jones, M. *Medical Negligence* (Sweet & Maxwell, London 1996)29.

<sup>161</sup> *Kapfunde v Abbey National plc and Others* [1998] 46 British Medical Law Review 176.

questionnaire. The claimant had completed a medical questionnaire and the report was sent to Dr Daniel, Abbey National's occupational health adviser. Dr Daniel advised that her medical history suggested that she was likely to have a higher-than-average absence level from work and she was not accepted for the post. However, there was no special relationship between Ms Kapfunde and Dr Daniels. There may well be a contract between the commissioning body and the doctor who produces the report, but contractual duties do not extend to third parties in cases like this. It is clear that the doctor owes a duty of care to anyone he/she accepts as a patient. As observed by Margaret Brazier<sup>162</sup>:

“[a] patient claiming against his doctor ... usually has no difficulty in establishing that the defendant owes him a duty of care”.

#### **4.1.1 The Limits of the Duty Owed to Patients – Good Samaritans**

There is no duty in U.K. law at present to act as a Good Samaritan,<sup>163</sup> for example, at the scene of an accident. As we saw earlier, a physician is not legally obliged to assist at a car crash. There is no duty to act where the plaintiff is not a patient, or required to be accepted as a patient -- as there is at a casualty department.<sup>164</sup> If he chooses to, as in most cases he would, he must exercise all proper skill. If he is a General Practitioner and the injured party happens to be his patient, he might be

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<sup>162</sup> Brazier, M. *Medicine, Patients and the Law* (2 ed n Penguin, 1992)117-118.

<sup>163</sup> *The Ogopogo* [1971] 2 Lloyds Rep 410.

<sup>164</sup> *Thompson v Schmidt* [1891] 8 TLR 120.

held to be under a legal duty to act. The duty is owed to anyone placing themselves in the hands of a medical practitioner who accepts that person as a patient. If a doctor, nurse or first-aider does decide to assist an injured person at the scene of an accident or a heart attack victim in a hotel, a duty arises as soon as the doctor assumes responsibility for the care of the injured person. Not only does this course engage in a duty to start all necessary treatment for the health of the patient, but also a duty to take some appropriate steps in the course of the treatment once commenced<sup>165</sup> meaning that he or she could be liable for damages. The principle was further explained by Willes J in *Skelton v London North Western Railway*<sup>166</sup> where he said: ‘if a person undertakes to perform a voluntary act, he is liable if he performs it improperly.’ Thus, if he bungles the job, he may be liable for causing or aggravating the stranger’s injuries.<sup>167</sup> A voluntary doctor is legally bound by the same laws even if he gives free medical treatment; he is still liable for negligence in the same way as a regular doctor who charges medical consultation fees.<sup>168</sup> Generally speaking, a medical practitioner is not under a duty to act without cause and accordingly is not required by law to come to the aid of an injured person who is not his patient or who is not presented to a hospital. The law of negligence does not oblige anyone to be a Good Samaritan. For example, if a man has a coronary attack on an Inter-City express, and a doctor fails to respond to the guard’s call ‘Is there a doctor on the train?’ the doctor incurs no liability to the victim who dies for

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<sup>165</sup> *Pippin v Sheppard* [1822] 11 Price 400.

<sup>166</sup> *Skelton v London North Western Railway* [1867] LR 2 CP 636.

<sup>167</sup> *Harrison v British Railways Bd* [1981] 3 All E.R.679.

<sup>168</sup> *Shiells v Blackburne* [1789] 126 ER 94.

lack of medical treatment. Indeed, the law mostly discourages the Good Samaritan. If the doctor comes to the sick man's aid, he undertakes a duty to him and will be liable if his skill fails him. Medical Protection Society protects doctors who act as Samaritans whatever jurisdiction they are in, is to adopt accepted practice and act within your competence and make a clinical record afterwards.<sup>169</sup>

#### **4.2 The Duty of Care Owed to Psychiatrists and other Medical Practitioners**

Sometimes, a doctor is liable for someone other than his or her immediate patient especially in the field of psychiatry. In such a circumstance, another person, often referred to as a 'third party', may sue the doctor. This is illustrated in a best known case *Tarasoff v Regents of University of California*,<sup>170</sup> where a patient of a psychologist confided that he intended to kill a girl. The Supreme Court of California pronounced that psychiatrists owe a duty to protect third parties who are "foreseeably" at risk of violence or injury. The psychiatrist informed the campus police who briefly detained the man, releasing him on the basis that he appeared to be rational. Consequently, the man killed his girlfriend. Her parents sued the University for failing to warn them that their daughter was in danger. By a majority, the California Supreme Court upheld their claim. Supreme Court of California pronounced that psychiatrists owe a duty of care to protect third parties who are "foreseeably" at risk of violence or injury where a duty was recognised by a

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<sup>169</sup> Bible Luke, chapter 10, verses 25-37.

<sup>170</sup> *Tarasoff v Regents of the University of California* [1976]551 P (2d) 334.



psychiatrist to warn the intended victim if his patient uttered death threats in session.

Tobriner J:

“We shall explain that defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger to notify the police or to take whatever other steps are reasonably necessary under the circumstances .... In each instance the adequacy of the therapist’s conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances... In sum, the therapist owes a legal duty not only to his patient, but also to his patient’s would be victim and is subject in both respects to scrutiny by judge and jury. Some of the alternatives open to the therapist, such as warning the victim, will not result in the drastic consequences of depriving the patient of his liberty. Weighting the uncertain and conjectural character of the alleged damage done to the patient by such a warning against the peril to the victim’s life, we conclude that professional inaccuracy in predicting violence cannot negate the therapist’s duty to protect the threatened victim...”<sup>171</sup>

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<sup>171</sup> *Tarasoff v Regents of the University of California* [1976] 551 P (2d) 334.

Tarasoff has been affirmed in many states of America, rendering psychiatrists potentially liable to third parties who are the reasonably foreseeable victims of a psychiatric patient's violent disposition.<sup>172</sup> Consequently, a doctor should be aware of this potential liability not only to his patient but also for the psychiatric illness suffered by a relative of the patient as a result of the negligence. In fact, it is now generally accepted, following the decision of the House of Lords in the case of the Hillsborough disaster,<sup>173</sup> that even though the risk of psychiatric illness would have been reasonably foreseeable by the defendant, the law will be slow to award damages to such a plaintiff. In *Cullin and Others v London Fire Civil Defence Authority*<sup>174</sup> that the issue as to whether the claimants were primary or secondary victims was a question of mixed fact and law. Claims by secondary victims are frequently ruled out by the courts on the basis that there is insufficient proximity<sup>175</sup> between the victim and the person who caused the injury. The law has little difficulty in recognising the existence of primary victims who are directly involved in traumatic events; the position of secondary victims is more tenuous. The first hurdle in deciding whether a claimant is a primary or secondary victim is to establish that he or she is suffering from a recognisable psychiatric condition as outlined not simply from grief, distress or transient medical condition.<sup>176</sup> The

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<sup>172</sup> *Osman v Ferguson* [1993] 4 All E.R.344

<sup>173</sup> *Alcock & others v Chief Constable of S Yorks* [1992] 1 AC 310.

<sup>174</sup> *Cullin and Others v London Fire Civil Defence Authority* unreported 1999.

<sup>175</sup> *Caparo Industries plc v Dickman* [1989] 2 WLR 316, 322, 13.

<sup>176</sup> *Alcock v Chief Constable of South Yorkshire* [1991] 3 WLR 1057, 29.

criteria for determining whether a duty is owed to the secondary victim of psychiatric injury are set out in the case of *Alcock v Chief Constable of South Yorkshire*<sup>177</sup> Staughton LJ restated the rationale for the *Alcock* principle in these terms in *Sion v Hampstead Health Authority*<sup>178</sup>

‘It is ... recognised almost universally that the Common Law ought to impose some limit on the circumstances in which a person can recover damages for the negligence of another. The Common Law has to choose a frontier between those whose claims succeed and those who fail. Even the resources of insurance companies are finite.’

The effect of the *Alcock* case has been to limit the number of successful claims for psychiatric injury. It is clear that pure psychiatric injury may be compensatable in medical negligence cases, insofar as the limiting criteria imposed by the law of negligence are satisfied. A further illustration of the principle occurs in *Allin v City and Hackney HA*<sup>179</sup>, a woman recovered damages for post-traumatic stress disorder caused by being told falsely that her baby was dead. On the contrary, recovery was not allowed in *Sion v Hampstead Health Authority*<sup>180</sup>, where the cause of the psychiatric injury was watching someone die over a long period of time. *Sion* suggests that for a claimant to succeed there must usually be a single sudden shock

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<sup>177</sup> *Alcock v Chief Constable of South Yorkshire* [1991] 4 All ER 907.

<sup>178</sup> *Sion v Hampstead Health Authority* The Times 17 March 2000.

<sup>179</sup> *Allin v City and Hackney HA* [1996] 7 Med LR 167.

<sup>180</sup> *Allin v City and Hackney HA* [1996] 7 Med LR 167.

rather than a steady accumulation of events culminating in psychiatric injury. If the psychiatric illness is not caused by nervous shock, but develops as a result of the cumulative effects of small assaults of grief on the mind, this condition is not satisfied. Peter Gibson LJ said<sup>181</sup>:

“A psychiatric illness caused not by a sudden shock but by an accumulation of more gradual assaults on the nervous system over a period of time is not enough”

Furthermore, a claim failed in *Taylor v Somerset Health Authority*<sup>182</sup> on the basis that the plaintiff had not witnessed her husband’s death at the time nor incurred her shock in the immediate aftermath of the death. While it succeeded in *Tredget v Bexley Health Authority*<sup>183</sup> where the plaintiffs had observed the death of their new-born baby caused by the defendants’ negligence in delivery. The court was influenced by the fact that there was proximity of relationship between the parties (parents and child) -- the shock was reasonably foreseeable since neo-natal death is known to give rise to psychiatric disturbance. The injury suffered by the parents was more than grief or distress, but was a recognised form of psychiatric injury.

It has long been recognised that doctors should be aware that their patient’s relatives could suffer from the patient’s injury as a result of the doctor’s medical

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<sup>181</sup> *Sion v Hampstead Health Authority* The Times 17 March 2000.

<sup>182</sup> *Taylor v Somerset Health Authority* [1993] 4 Med. L.R. 34.

<sup>183</sup> *Tredget v Bexley Health Authority* [1994] 5 Med. L. R. 178.

negligence. The members of a patient's family and relatives also play an important role in the patient's health condition. When a person sees that his loved one is suffering, he/she may undergo the normal human emotions. These temporary emotions may have an effect on the life and work of the person and may persist for a period of time. The limited circumstances in which compensation to a secondary victim (such as a patient's spouse or parent) would normally be awarded, are where that plaintiff can show that as a result of the defendant's negligence he is suffering from a recognised psychiatric illness which was caused by a sudden shock to the nervous system. If the strict ingredients of the nervous shock action are proved, a third party may recover damages for psychiatric injury caused by witnessing the effect of the defendant's medical negligence on a close family member or friend.

#### **4.3 Duty of Care and the Unborn**

A duty of care is owed by the doctor to patients of all ages.<sup>184</sup> Traditionally, if injury is done to an unborn child, no duty is broken.<sup>185</sup> However, it is now clear, by virtue of the provisions in Part IVA of the Law Amendment Reform (Consolidation) Ordinance (Cap 23) (LARCO),<sup>186</sup> an unborn child lacks the status to be the subject

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<sup>184</sup>By virtue of the provisions in Part IVA of the Law Amendment Reform (Consolidation) Ordinance (Cap 23) (LARCO), that such a child is owed a duty and has the right to sue, a right independent of his/her mother commenced on 14 April 1978.

<sup>185</sup>*Re F (In Utero) Fam 837*; see also Hartman J in *Re C (Emergency Medical Treatment)* [2003] HKC 245.

<sup>186</sup>It is clear that by virtue of the provisions in Part IVA of Law Amendment Reform (Consolidation) Ordinance (Cap 23) (LARCO) are similar to those found in the Congenital Disabilities (Civil Liability) Act 1976. The provisions in Part IVA of LARCO are remedial and were intended to cure a longstanding defect in the common law.

of a legal duty, but a newly born child enjoys that status. In *Cherry v Borsman*<sup>187</sup>, the doctor was negligent in performing an abortion with the result that the pregnancy was not terminated and the child was subsequently born with injuries inflicted during the attempted abortion. The defendant argued that he should not be liable to the injured child because he owed a clear duty of care to the mother to carry out the abortion and this duty was in sharp conflict with any alleged duty of care owed to the child. The British Columbia Court of Appeal rejected this contention. The surgeon owed a duty of care to the mother to perform the abortion properly but at the same time owed a duty of care to the foetus not to harm it if he should fail to meet the duty of care owed to the mother. The cause of action arose on the live birth of the foetus.<sup>188</sup> The position taken in *Burton v Islington Health Authority*<sup>189</sup> is similar to the position recognized earlier by legislation in England and Hong Kong. In England, the relevant legislation was enacted in 1976 under the title Congenital Disabilities (Civil Liability) Act 1976 and in Hong Kong Part IVA<sup>190</sup> of the Law Amendment and Reform (Consolidation) Ordinance, Cap 23

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<sup>187</sup>*Cherry v Borsman* (1992) 94 D.L.R. (4th) 487 (B.C.C.A.).

<sup>188</sup>Section 1 of the Congenital Disabilities (Civil Liability) Act 1976 which came into force on 22 July 1976 establishes the right of a disabled child to claim compensation from a person responsible for his disabilities which were caused via a tortious act perpetrated on the child's parent or parents.

<sup>189</sup>*Burton v Islington Health Authority* [1993] QB 204 the plaintiff born with numerous abnormalities brought an action against the health authority alleging that her condition had been caused by the medical negligence of the medical staff in carrying out the operation without first ascertaining whether the plaintiff's mother was pregnant. It was held that the plaintiff had a cause of action in respect of the injury caused to her by the medical staff's negligence before she was born.

<sup>190</sup> Part IV A LARCO commenced on 14 April 1978.

(LARCO) was enacted in 1978<sup>191</sup> to clarify the position with regard to tort actions in respect of injury suffered by a person while en ventre sa mere. <sup>192</sup> Under s 22 A of LARCO, a person born with a congenital disability caused by a pre-natal injury in turn caused by the negligence of the defendant can sue on the basis of civil liability in tort. In *W (an infant) v Hong*

*Kong Adventist Hospital & Another*,<sup>193</sup> a child who is born alive and disabled will have a right of action in respect of the disability if the disability is caused by an occurrence which affected either parent's ability to have a normal healthy child or affected the mother during pregnancy or labor causing.<sup>194</sup> The court made a declaration that doctors could force feed a woman who was 12-weeks pregnant to prevent any injury to the fetus According to s 22B of LARCO, a child has no action against his mother for injuries caused while it was in her womb.<sup>195</sup> However, in certain circumstances the law may prevent a pregnant mother from doing something which is likely to cause harm or injury to the child.

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<sup>191</sup> The Hong Kong provisions on congenital disability under the LARCO are more or less similar to the provisions of the UK Congenital Disabilities (Civil Liability) Act 1976.

<sup>192</sup> It should be noted that in *Burton v Islington Health Authority* [1992] All ER 833, the two plaintiffs who made claims against the Health Authority were born before the UK Congenital Disabilities (Civil Liability) Act 1976 came into force.

<sup>193</sup> *Wendy Fang Wen Qing (unrep...) v Hong Kong Adventist Hospital & Another* [1999] 3 HKLRD 420. An infant's negligence action under section 22B (1) of the Law Amendment and Reform (Consolidation) Ordinance (Cap 23) concerning congenital disabilities) also extends liability for acts of negligence occurring before conception where negligently manufactured contraceptive pills taken by the mother had an adverse effect on the child and he is born with a disability.

<sup>194</sup> Subsequent to the enactment of the above provisions in the United Kingdom and Hong Kong, it was held that a does exist at common law and permitting an action by a child in respect of pre-birth injuries.

<sup>195</sup> Law Amendment and Reform (Consolidation) Ordinance (Cap23).

## 4.4 Duty of Care in Relation to Hospitals

### 4.4.1 Vicarious Liability

Vicarious liability is a legal responsibility imposed on a person for the torts of others, regardless of any fault on the part of the non-tortfeasor.<sup>196</sup> The courts take the view that the duty of care to the patient was owed by the doctor and the hospital. Hospitals are thus liable for the negligence of medical officers, nurses, radiographers, consultants, anaesthetists, and other staff. Whatever confusion remained was removed in *Cassidy v Ministry of Health*<sup>197</sup> where the hospital was held liable for the negligence of a house surgeon employed as part of the permanent staff. Since *Cassidy v Ministry of Health*<sup>198</sup>, Lord Denning explained:

“The hospital authorities, cannot, of course, do it by themselves. They have no ears to listen through the stethoscope, and no hands to hold the knife. They must do it by the staff they employ, and, if the staff is negligent in giving treatment, they are just as liable for their negligence as is anyone else who employs others to do his duties.”

The judgement of Denning LJ in *Cassidy* laid the foundations for the application of vicarious liability of hospitals for the negligence of clinical staff employed by them. Thus the hospital authority is liable for the negligence of clinical staff employed in hospitals and clinics under their control. In a famous English case, *Hiller v St*

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<sup>196</sup> Fleming, *The Law of Torts* (9th edn, 1998) 409-410.

<sup>197</sup> *Cassidy v Ministry of Health* [1951] 1 All ER 574.

<sup>198</sup> *Cassidy v Ministry of Health* [1951] 1 All ER 574



Bartholomew's Hospital,<sup>199</sup> the English Court of Appeal concluded that a hospital undertook certain duties toward a patient:

“The governors of a public hospital, by their admission of the patient to enjoy in the hospital the gratuitous benefit of its care, do, I think, undertake that the patient whilst there shall be treated only by experts, whether surgeons, physicians or nurses of whose professional competence the governors have taken reasonable care to assure themselves; and, further, that those experts shall have at their disposal, for the care and treatment of the patient, fit and proper apparatus and appliances.<sup>200</sup> A hospital's responsibilities were to ensure that the persons giving medical care were competent and qualified. However, the scope of the direct duty was expanded: It included the instruction and supervision of personnel employed by the hospital and then to the provision of the systems and organisation to co-ordinate these activities so that the patient received reasonable care.<sup>201</sup> Since a patient is treated in a physical plant with equipment and medical tools, it is not surprising that hospitals were also given a direct duty to provide and maintain proper facilities and equipment.

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<sup>199</sup>*Hillyers v Governors of St Bartholomew's Hospital* [1909] 2 KB 820, CA.

<sup>200</sup>*Hillyers v Governors of St Bartholomew's Hospital* [1909] 2 KB 829, CA.

<sup>201</sup>The duty to provide organisation could be expanded to include the provision of medical treatment by doctors who are not employees.

The decision in *Wong Wai Ming v The Hospital Authority*<sup>202</sup>, the Hospital Authority was found to be liable in negligence for the injuries of a receptionist nurse injured by a mentally unbalanced intruder. Its own negligence in not providing a safe workplace especially as there was no screen barrier to protect the staff from attacks by visitors or patients nor was there any emergency button in the reception area to call for help; and vicarious liability for the negligence of a senior nurse in mishandling the mentally unbalanced intruder. As employers, hospitals have vicarious liability towards any patient for negligent or intentional wrongdoing by their staff. Despite the absence of fault or errors on their part, and even if they lack control over the employees' quality of performance, the liability of hospitals remained. The principle was well explained in the obiter statement of Browne-Wilkinson V-C in *Wilsher v Essex Health Authority*:<sup>203</sup> "A health authority which so conducts its hospitals that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient."

The courts have acted on the assumption that Health Authorities and trust hospitals are vicariously liable for the tortious acts of all staff employed by them, (including consultant medical staff) and this assumption has gone unchallenged. Thus, this has

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<sup>202</sup> *Wong Wai Ming v The Hospital Authority* [2001] 3 HKLRD 209.

<sup>203</sup> *Wilsher v Essex Health Authority* [1988] 2 WLR 557.

been accepted against health authorities and hospitals (including private hospitals) in respect of alleged acts of negligence by nursing staff<sup>204</sup> and radiographers.<sup>205</sup>

Another medical mishap occurred in 2007 in Hong Kong. A woman who became paraplegic after jumping from the third-floor podium of Union Hospital is suing the hospital for more than HK\$25 million for failing to stop her harming herself. As a consequence of that failure, it is alleged that no adequate precautions were put in place either to supervise her or stop her trying to take her own life.<sup>206</sup> This clearly demonstrates the vicarious liability held by hospital in delivery of health care service. The trial is still going on but both patients are intending for an out of court settlement for about 12 million which is shared between the hospital and the Medical Protection Society involved.

In Hong Kong, the Hospital Authority managing public hospitals is also liable for any injury or damage caused by their hospital employees in the course of their employment.<sup>207</sup> In the light of the decision in *Ming An Insurance Co (HK) Ltd v*

*Ritz-Carlton Hotel Ltd*<sup>208</sup>, it is more probable than not that the for the duration of the consultant's relationship with the Hospital, the Authority will be held

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<sup>204</sup> *Fussell v Beddard* [1942] 2 BMJ 411.

<sup>205</sup> *Gold v Essex County Council* [1942] 16 KIR 329.

<sup>206</sup> Nick, 'Hospital sued over serious injuries in suicide attempt.' *South China Morning Post* (Hong Kong 8 January 2008).

<sup>207</sup> Chapter 1-2 of the Hospital Authority Ordinance (Cap 113).

vicariously liable for the consultant's tortious acts or omissions. As a counsel of prudence, plaintiffs will be well advised to bring proceedings against both the individual consultant as well as the Hospital Authority. The worst recorded medical blunder in Hong Kong on August 20, 1998 further illustrated the vicarious liability of hospital. Three kidney patients at the private Hong Kong sanatorium and hospital died because the haemodialysis machine to which they were connected was contaminated with disinfectant. Although the Coroner's Court later returned a verdict of accidental death on three kidney patients, however, the incident has raised public concern over the supervision of private hospitals. The public at the time was very critical of private hospitals. A number of private hospitals contract with doctors for the provision of services at the hospital but expressly deny that it is a contract of employment. Each case will be fact sensitive, but, again in the light of the *Ming An Insurance Co (HK) Ltd*<sup>209</sup> decision, it is highly probable that all medical staff having a contractual relationship with a private hospital for the provision of clinical services will bind the hospital vicariously. All in all, a hospital cannot avoid liability by demonstrating that it has delegated the task to someone else. It is therefore irrelevant whether a medical health practitioner is under a contract of service (employee)<sup>210</sup> or under a contract for services (independent

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<sup>208</sup> *Ming An Insurance Co (HK) Ltd v Ritz-Carlton Hotel Ltd* [2002] 5 HKCFAR 569, [2002] 3 HKLRD 844.

<sup>209</sup> *Ming An Insurance Co (HK) Ltd v Ritz-Carlton Hotel Ltd* [2002] 5 HKCFAR 569, [2002] 3 HKLRD 844.

<sup>210</sup> By section 2(2A) of the Employment Ordinance (Cap 57), a 'contract of employment' means any agreement, whether in writing or oral, express or implied, whereby one person agrees to employ another and that other agrees to serve his employer as an employee and also a contract of

contractor).<sup>211</sup> By the same token, both public and private hospitals can be vicariously liable for injury or damage caused to their patients by their employees. The liability of hospitals is strict in that they are liable without any fault on their part, and even if they have no control over the employees' mode of performance of his or her work. In the healthcare context, this means that hospitals are under a duty to employ suitably qualified and competent workers<sup>212</sup> to ensure that staff and work are adequately directed and supervised, to provide the equipment and back-up support appropriately to the relevant skill in order to provide a competent and safe system of work.<sup>213</sup> The extent of the obligations undertaken by a hospital toward patients must be inferred from the circumstances of the individual case. For example, the risk of AIDS in blood transfusion was unknown until 1983 but to transfuse blood without taking precautions today would be negligent. Similarly, it will be negligence on a hospital's part now to put SARS or Avian Flu patients together with other patients.<sup>214</sup>

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apprenticeship. Whether a person works under a contract of service, that is, as an employee, or under a contract for services, that is, as an independent contractor, is decided by tests laid down by judicial decisions.

<sup>211</sup> The common law position as stated by the House of Lords in *Thomson v Cremin* was that an occupier's duty of care was personal and that its delegation to an independent contractor could not absolve the occupier from liability.

<sup>212</sup> *Yepremian v Scarborough General Hospital*, *supra*, n. 7.

<sup>213</sup> *Osburn v Mohindra and St John Hospital* (1980) 66 A.P.R. 340; *Ogden v Airedale Health Authority* (1996) 7 Med. L. R. 153. In some U.S. states, this has been extended to reviewing the treatment provided by doctors to hospital patients, and to ensuring that doctors personally examine patients and review their medical errors prior to their discharge. See respectively: *Darling v Charleston Community Memorial Hospital* 11 N. E. 2d 253, 383 U.S. 946 (1966); and *Polischeck v United States* 535 F. Supp. 1261 (1982).

<sup>214</sup> DK Srivastava and R Cullen, 'SARS in the HKSAR: Some Important legal issues' (2003) July Hong Kong Lawyer 79-90.

#### 4.4.2 Duty of Care in Relation to Other Health Care Providers in the

##### Community

A duty of care is owed by any health carer, including paramedics and alternative medical practitioners, who take responsibility for treating a patient. An elderly patient slips and falls on a highly polished floor. Who is held responsible? The relevant negligence may be that a nurse failed to supervise the patient or it may be that cleaners were careless. Within hospitals, nurses, paramedical staff and other health carers may find themselves liable for negligence if they fail to take careful note of instructions given to them or if they fail to provide adequate nursing care or attention. Take an example where nurses and doctors work together in the operating theatre, liability for an accident may be shared. The theatre nurse should check all swabs are removed, but so should the surgeon. They are jointly liable. However, a swab marker was still in an elderly lady after exploratory surgery, the patient developed complications. An X-ray was taken, but the consultant radiologist missed the swab marker on the X-ray. The lady was admitted to hospital with an intestinal obstruction after fifteen months, and then the fault was discovered. A settlement has since been reached. Liability was shared equally between the surgeon, the radiologist and the hospital on behalf of the theatre nurse.<sup>215</sup> This is a question of fact for the court to decide in each case and the answer depends upon the point at which the particular consultant assumed responsibility for the patient.<sup>216</sup>

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<sup>215</sup>Annual Report of the Medical Defence Union 1982 at 64.

<sup>216</sup>*Lord v Nathan in Medical Negligence* (1957), cited in Kennedy and Grubb in *Medical Law*, Butterworths 2000 at 280.

A duty of care is also owed in other specialist areas of healthcare, for example, physiotherapists and speech therapists, all of whom have professional relationships with their patients. They will be assessed on the same basis as is applied to medical practitioners. There is the potential for a claim if inadequate care is not carried out properly in medical/healthcare procedures. Those of the allied professions will be judged against the same basic principle that they are expected to meet the standard of a reasonably careful and skilled practitioner in their chosen field. An interesting illustration of the broad ambit of professional liability is to be found in the decision of Curtis J in *O' Loughlin v Greig*,<sup>217</sup> which concerned a claim in professional negligence against a chiropractor. The decision is significant because the learned Judge applied all the principles established in *Bolam*, *Maynard v West Midlands Regional Health Authority*<sup>218</sup> and *Bolitho*<sup>219</sup> thereby bringing the ancillary art of the chiropractor within the curtilage of professional duty.

#### **4.5 Duty of Care in Alternative Medicine Provider– Traditional Chinese**

##### **Medicine**

In Hong Kong, 'alternative medicine' is increasingly popular. There is no international consensus on the definition of 'alternative medicine' and similar name such as 'complementary and alternative treatment' is applied. An exhausting listing

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<sup>217</sup> *O' loughlin v Greig*. Lexis report of decision dated 5 Nov 1999.

<sup>218</sup> *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, [1984] 1 WLR 634.

<sup>219</sup> *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, [1984] 1 WLR 634.

of alternative medicine practices is impossible; however, some examples include tea therapy, massage therapy, magnet therapy, spiritual healing, chiropractic, osteopathy, aromatherapy, reflexology, acupressure, hydrotherapy, hypnotherapy, music therapy and qigong. The World Health Organisation regards Chinese herbal medicine, acupuncture and bone-setting as alternative medicine.<sup>220</sup> Most practices of alternative medicine are not governed by specific regulation. However, chiropractic is regulated by the Chiropractors Registration Ordinance (Chapter 428) and only registered chiropractors are allowed to practise chiropractic in Hong Kong. Traditional Chinese medicine (TCM) has been widely used in the community for a long time; we need in Hong Kong a specific control mechanism to assess and ensure the standards of Traditional Chinese Medicine and to regulate the use, manufacture and sale of TCM. At present, for the protection of public health, controls over the use of TCM are exercised through a number of health and trade-related ordinances. For example, according to the Public Health and Municipal Services Ordinance (Cap 132), action can be taken against Chinese medicines found to be unfit for human consumption or falsely labelled. Chinese medicines are also subject to import licensing control under the Import and Export Ordinance (Cap 60). Suppliers of counterfeit Chinese medicines may also be prosecuted under the Trade Descriptions Ordinance (Cap 362). The practice of Chinese medicine is likewise subject to legal regulation and is under the Chinese

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<sup>220</sup> Robin Gauld & Derek Gould. *The Hong Kong Health Sector Development and Change*. (The Chinese University Press: 2002).



Medicine Ordinance (Chapter 549).<sup>221</sup> Only registered Chinese Medicine practitioners and listed Chinese medicine practitioners are allowed to practise Chinese medicine and they are required to comply with professional codes of practice.<sup>222</sup> Although practices considered ‘alternative medicine’ other than chiropractor and traditional Chinese medicine are not regulated by law, a registered doctor practising alternative medicine is subject to the code of professional conduct laid down by the Medical Council of Hong Kong. In the case of *Leung Sik Chiu v Medical Council of Hong Kong*,<sup>223</sup> the Medical Council ordered that the offending physician be removed from the General Register for 18 months after he had been found guilty of two counts of professional misconduct. First, the doctor had instituted a treatment inappropriate to a patient’s medical condition, namely hydrogen peroxide oxytherapy. Second, the doctor had failed to arrange prompt emergency treatment for respiratory failure whilst the patient underwent oxytherapy in his clinic. The doctor appealed unsuccessfully against the decision. The Medical Council emphasised “the standard required of registered medical practitioners, whose fundamental duty is to preserve the life of the patient.”

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<sup>221</sup>The Chinese Medicine Ordinance was enacted on 14 July 1999. A draft of this was released in mid 2000 and incorporated a code of ethics and standards to guide practitioners. The standards included a need to keep patient records and write clearly and legibly on issued prescriptions and to label dispensed medicines.

<sup>222</sup>J. Tse, ‘Doctors practising alternative medicine – the legal considerations’ (2006) April Hong Kong Medical Journal No 2. Paragraph 22 of the Professional Code of the Medical Council of Hong Kong.

<sup>223</sup>*Leung Sik Chiu v Medical Council of Hong Kong* [2004] 3 HKLRD L18.

It is arguable whether the ‘Bolam test’ should be applied to any physician practising alternative medicine. In the management of a patient, the doctor owes a duty of care to the patient and the ‘Bolam test’ is a test of the standard of that care. On the other hand, it is reasonable to conclude that the ‘Bolam test’ should apply<sup>224</sup>. On the other hand, when a court comes to decide whether a doctor has been negligent in practising alternative medicine, a lot of weight will be given to Paragraph 22 of the Professional Code and Conduct<sup>225</sup> of the Medical Council of Hong Kong. Following that, if the ‘Bolam test’ applies and it refers to a responsible body of medical opinion, surely the views of the Medical Council of Hong Kong in its Professional Code and Conduct constitute a responsible body of medical opinion. In February 2001, the Hong Kong Medical Council revised its code of medical practice to allow doctors to administer ‘alternative medicine’ to patients<sup>226</sup>. Physicians who may wish to practise alternative medicine should be certain that they have the necessary expertise and skill, the modality is safe and does not contradict orthodox medicine.

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<sup>224</sup>A plaintiff may succeed in an action against a traditional medical practitioner “either by calling an expert in the speciality in question to assert and prove that the defendant has failed to exercise the skill and care appropriate to the art”.

<sup>225</sup>Paragraph 22 of the Professional Code and Conduct of the Medical Council of Hong Kong. <[http : // www. hkam.org.hk/publications/hkmj/articles\\_pdfs/ hkmo604p164.pdf](http://www.hkam.org.hk/publications/hkmj/articles_pdfs/hkmo604p164.pdf)> accessed 10 August 2008.

<sup>226</sup>Mary Ann Benitez, ‘Revised code allows doctors alternative approach’. *South China Morning Post*(Hong Kong 18 January 2001).

Cases of negligence in the context of alternative medicine are very rare in the legal record. In a case in England, *Shakoor v Situ*,<sup>227</sup> the defendant was not a medical doctor but an experienced practitioner of Chinese herbal medicine. The patient received from the defendant a course of nine doses of herbal remedy for multiple benign lipomata and died of acute liver failure produced by an extremely rare reaction to the remedy. The defendant was sued for negligence in prescribing the remedy and in failing to warn the patient of the potential risks. The defendant received support from a fellow practitioner and the claim failed. Counsel for the plaintiff argued that the test in *Bolam* should apply. However, this test was rejected by the court in favour of a modified version of the *Bolam* test.<sup>228</sup> A plaintiff may succeed in an action against a traditional medical practitioner “either by calling an expert in the speciality in question to assert and prove that the defendant has failed to exercise the skill and care appropriate to the art”. The defendant was found to have satisfied this test as the literature from the western journals was somewhat inconclusive and at any rate the risk identified was very low. In *Tai Kut Sing v Choi Chum Kwan*,<sup>229</sup> the plaintiff suffered injury after being treated for his haemorrhoids by the defendant practitioner of traditional Chinese medicine. No case law was cited and no explanation provided to support the standard of care that was adopted in finding the defendant in breach: “the reasonable standard of an

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<sup>227</sup>*Shakoor v Situ* [2000] 4 All ER 181.

<sup>228</sup>The *Bolam* test as applied to Traditional Chinese Medicine ; or “ by proving that prevailing standard of skill and care ‘in that art’ is deficient in this country having regard to risks which were not and should have been taken into account.”

<sup>229</sup>*Tai Kut Sing v Choi Chum Kwan* [2002] 1 HKLRD B14.

herbalist who specialised in curing haemorrhoids”. No reference was made to the need to refer to western medical literature as expressed in *Shakoor v Situ*<sup>230</sup> While TCM has been widely used in the community and has made significant contributions to the health care services in Hong Kong, the establishment of a sound regulatory system will lay a solid foundation for the future development of TCM within our health care system. The recent full time degree courses in the Universities in Hong Kong and the setting up of licensing body guarantee the standard of practice for Chinese Medical Practitioner and the promotion of scientific research helps with the long term development of TCM and enhance public’s confidence. All those efforts shall be supported. It is expected that the duty of care and standard of care of TCM providers will be better defined and the equivalent of Bolam’s test shall be applied in the future.

#### **4.6 Future Challenges**

As a medical profession practicing in Hong Kong, one has to adapt to the rapidly changing environment. Areas of concern from the medical legal perspective include development of telemedicine, recent swine flu epidemic and future practice in mainland China through the introduction of CEPA.

Telemedicine became a major part of the health care equation long before we realized what it was and how significant it will be in the future. Telephone

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<sup>230</sup>*Shakoor v Situ* [2000] 4 All ER 181

discussions and consultations between health care providers has been part of medical practice in the past. Propelled by the information explosion and the width of emerging computer and communication technologies, telemedicine will alter the face of medicine and ways of interaction between doctor and patient. Telemedicine is in a way reconfiguring the doctor patient relationship. In the traditional medical negligence case, the plaintiff must establish the existence of a physician-patient relationship. The alleged negligence usually happened within the temporal boundaries of an episode of care by the doctor. Moreover, any further specialist consultation occurred in a sequential pattern, with each one occupying a distinct period of the patient and the provider time. Nevertheless, in telemedicine interaction, the temporal boundaries become blurred. The intervention may involve a number of doctors at the same time, or associated with stored images and data that the service providers review at an undefined time. Thence, with telemedicine, the court has to redefine doctor-patient relationship and the duties that arise from it in a more flexible way. In a negligence suit, once a relationship between the provider and the patient sufficient to give rise to a duty is established, a plaintiff must prove that the doctor breached the standard of care. Traditionally, courts have applied the “locality” rule in determining the standard of care. Under this principle, the doctor and other health provider must follow the standard of care in the local geographic zone. However, modern communications, information conduits and transportation improved access to current medical and scientific knowledge, the standard of care should reflect the accessibility to updated knowledge. Diversity of services

available for patients in different areas should further vanish leading to the emergence of a single standard of care. A more practical issue faced by doctors in Hong Kong is the increased use of e-mail by physicians, patients and other health care providers. Doctors have to alert that e-mail is similar to other technology, can be redirected, printed, intercepted, rerouted, and read by unintended recipients. Furthermore, e-mail material can be stored indefinitely even after its user deletes the message. Encryption software may help to ensure message's integrity and authenticity although it is imperfect and politically charged because of government proposals to retain the deciphering codes. Nevertheless, all physicians and health care providers should take precautions to avoid inadvertent forwarding, copying, and printing of e-mail that would otherwise further expose patient confidence. Patients on the other hand should be informed of the potential risks and benefits of using e-mail as a means of medical consultation and communication. While telephone conversation are not routinely recorded and often only documented through a few key words, e-mail provides direct evidence of doctor patient consultation and should be stored in the computer or printed out as hard copy and kept in the patient record. From a legal point of view, it is necessary to ask doctor to accurately record the communication and patient to retain the material as evidence in case there is a law suit. Electronic communication should not compromise a physician's judgment concerning the necessary information essential to give valid medical advice. Thus, physicians who are not prepared to respond to e-mail regularly and bear the responsibility may decide not to offer it to their clients.

Another issue of concern is the recent epidemic of swine flu. Whenever a new disease emerges, doctors will have difficulty in prescribing the best treatment because of inadequate knowledge. This happened in the past when SARS struck Hong Kong in 2003. The law of negligence penetrates all kinds of human activity and has gain increasing significance in regulating actions that influence others, endanger lives or disrupt safety. Treatment of newly emerging disease with the use of new medications and modality, will lead to new opportunities for mischief and legal liability. The use of high dose of steroid was complicated by serious side effect including avascular necrosis of hip and other residue damage in some of the victims. Claims for damages against medical profession and hospitals are still proceeding. The same ordeal may occur with swine flu as treatment with tamiflu is neither perfect nor without side effect. Further, one may predict problems to occur with mass vaccination of the public as side effect and complication is inevitable. Health care provider must be vigilant and thorough discussion with patients is needed before any unorthodox and new treatment is implemented.

With the development of CEPA, doctors with specialist qualification may be registered in mainland China and apply for medical practice. It is a trend for more and more doctors to set up clinics in China and private hospitals to establish subsidiary in the area. As the legal system in China is different from that of Hong Kong, problem may arise when there is claim for medical negligence against

medical profession while they practice in China. Further, doctors must ensure that their liability is fully covered by the Medical Protection Society before they can practice in China with peace in mind. For the time being, the Medical Protection Society has no established guideline for doctor who is going to practice in China. Protection of indemnity is offered in individual basis depending on the time, place and nature of practice. As the rule governing medical malpractice is not well established, medical professionals and administrators are advised to make sure their practice is legal and insured before they start.

## **CHAPTER 5 BREACH OF DUTY: THE STANDARD OF CARE**

### **Chapter Summary**

The main principles in English law which establish medical negligence are essentially the same principles as the general principles which operate under the English tort of negligence. In this chapter, we consider the second element in a negligence action, that of whether the duty of care was breached. Once it has been



established that a duty of care is owed, the next question would be “how much care is required?” The surgeon, like the inn keeper or common carrier, exercised a “common calling” which gave rise to a duty to exercise proper care and skill. A professional is required to exercise the ordinary skill of a competent practitioner in his field. Moreover, in holding himself out as possessing the special skills of his profession, the doctor is under a duty to conform to the ordinary standards of that profession. An echo of this is to be found in *R v Bateman*<sup>231</sup> where it was said:

“If a person holds himself out as possessing special skill and knowledge, by and on behalf of a patient he owes a duty to the patient to use diligence, care knowledge, skill and due caution in undertaking the treatment. No contractual relation is necessary nor is it necessary that the service be rendered for reward...The law requires a fair and reasonable standard of care and competence.”

If he is following approved practice, the physician cannot be held to be negligent. This statement was approved by the House of Lords in *Whiteford v Hunter*<sup>232</sup>. A court cannot choose between two approved practices, i.e., between two schools of thought. In the *Maynard*<sup>233</sup> case Lord Scarman said :

“A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent, clearly presents certain

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<sup>231</sup> *R v Bateman* [1925] 94 LJKB 791 at 794.

<sup>232</sup> *Whiteford v Hunter* [1950] WN 553.

<sup>233</sup> *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634.

difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision if there also exists a body of professional opinion equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.”

In *Hunter v Hanley* Lord President Clyde stated:<sup>234</sup>

“ In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men....The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty if acting with ordinary care....”

In most negligence cases other than medical malpractice, defendants are judged on a “reasonableness” standard (what a reasonable person would have done in similar circumstances). In contrast, however, physicians have been allowed to set their own standard, which is based on “customary” practice (what physicians would customarily or typically do in similar circumstances). As an adjunct to the

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<sup>234</sup> *Hunter v Hanley* [1955] S.L.T. 213, 217.

customary care standard, many states recognize the “second school of thought” doctrine (also known as the “respectable minority” doctrine) in which there may be more than one acceptable method of delivering care in a given situation. The Bolam test <sup>235</sup> basically judge the standard of a doctor by referring to the standard of his peer at the time of occurrence of the event, while the exception occurred in case of Bolitho and Sidaway when the risk to patient is so great that the judge could not conclude the action of the defendant as reasonable even though he is supported by his peer and expert advice. Although the application of Bolam test make life simple, it may be unfair as medical profession tend to protect their colleagues. However, the overturn of Bolam may result in the judge deciding on unfamiliar medical issues which is difficult to understand and arouse anxiety for doctors who may practice defensive medicine in order to protect himself. In addition, the substitution of court’s view for those of the expert may not be appropriate in some circumstance.

Breach of duty is established if a doctor’s standard of care does not conform to current practice as advocated by a body of learned opinions. Deviation from “normal” practice can be justified with the support of opinion of another responsible body of professionals skilled in the faculty. However the courts may at times apply what is called the Bolitho’s<sup>236</sup> test in law. In this case the Court would not just accept the standard as articulated by respected professionals but in addition it would exercise its own critical analysis to see if the standard articulated stands the

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<sup>235</sup> *Bolam Friern Hospital Management Committee* [1957] 2 All ER 118.

<sup>236</sup> *Bolitho (Deceased) v City and Hackney Health Authority* [1998] AC 232, HL.

test of logic and reason. A defending doctor's approach to diagnosis, advice and treatment should stand up to logical analysis and should be reasonable in the light of the state of medical knowledge at the time. After considering all of the evidence, including explanations of relevant medical reports, it is ultimately for the Court, rather than medical experts, to determine whether the defendant is liable for medical negligence.

The standard of care in Hong Kong should be as good as in other developed countries and overseas experts are frequently asked to give expert opinion. Specialist in Hong Kong commonly has solo practice and has no employment contract with private hospital. Thence plaintiff usually claims for individual responsibility when medical blunders occur and private hospital has no vicarious liability for visiting specialist. The situation is different when medical negligence involves staff from Hospital Authority.

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In order to establish medical negligence, the plaintiff (patient) has to prove that the doctor has not discharged his duty by exercising all reasonable skill and care that the law requires of him. There is no breach of duty unless the defendant has failed to meet the standard required by law in the context of the duty that exists to take all reasonable care. The question that arises here is 'by what standard is a doctor or other health professional to be judged'. Any claimant in negligence has to prove that the defendant was careless. The onus of proof is on the plaintiff. He must show

that the defendant fell below the required standard. The basic standard is that of the reasonable man in the circumstances of the defendant. In defence the doctor must convince the jury that he has taken all precaution in the process. The best argument in favour of the doctor would be either he can provide a convincing alternative explanation for the worsening of the patient's condition or he can convince the judge that he has taken all reasonable care by applying the accepted current techniques with meticulously recorded entries of the procedure.

Lastly, the patient must prove that the doctor's mismanagement caused damage, one that is recognised by law as meriting compensation. The plaintiff must have actually suffered some degree of harm from the physician's carelessness. The claimant has the legal burden of proving each of the above elements on a balance of probabilities and the entire claim will fail unless the claimant succeeds at every point. The burden of proving fault lies with the plaintiff except in a case of *res ipsa loquitur*, which literally means "the thing speaks for itself" can help patient where he cannot specify what exactly caused his injury. If doctor cannot give satisfactory explanation, then he is liable for damage. In medical procedure things may go wrong with no explanation of what actually happened.

The following cases are just a few examples from Hong Kong and other jurisdictions which make a particular point and serve as a useful reminder of the essentials of good practice. It does not attempt to cover all available cases but

instead seeks to highlight notable cases in medical malpractice. Pointing out legal cases that occurred in various medical fields could provide an overview about the situation and trends in litigation. These could be used as an invaluable risk management tool to warn medical health professionals about the hazards that are posed to them and which may have caught their colleagues unaware. Some of the common cases include error in diagnosis or treatment, failure to give proper advice, failure to x-ray fractures, oversight of foreign bodies, tight plaster casts and transfusion of incompatible blood.

### **5.1 Accepted Practice and the Medical Profession - The Bolam Test** <sup>237</sup>

How is accepted practice applied to the medical profession? The standard of care is an objective one. It does not take account of the relative experience or inexperience of the individual practitioner. The standard by which doctors will be judged at least in the context of a negligence claim is well known and was set out in such leading UK cases as Bolam and Bolitho. The Bolam case also established the following test for negligence:

“A doctor 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, even though there is a body of such opinion that takes a contrary view.” Putting it the other way round a doctor is not negligent, if he is acting in accordance with

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<sup>237</sup> ‘Interpretation of the Bolam Test in the Standard of Medical Care. Impact of the Gunapathy Case and Beyond,’ (2003)19 Tolley’s Journal of Professional Negligence No.2.

such a practice merely because there is a body of opinion that takes a contrary view. It remains that a doctor should not be held negligent if he has acted in a way that would be regarded as appropriate by a responsible (and logical) body of relevant medical practitioners. In English law the Bolam standard had been approved by the House of Lords on at least three occasions in respect of actions for clinical negligence : in *Whitehouse v Jordan*<sup>238</sup> (concerning treatment ); in *Maynard v West Midlands Regional Health Authority*<sup>239</sup> (concerning diagnosis) and in *Sidaway v Bethlem Royal Hospital Governors*<sup>240</sup> (concerning the disclosure of risks of treatment to a patient ). The test holds that where a doctor is acting in accordance with a practice accepted as proper by a responsible body of medical opinion he will not be regarded as negligent simply.... “ because there is a reputable body of opinion which would take a contrary view.” It might be thought that all a doctor has to do is adduce evidence from other practitioners in his field who assert that the impugned conduct is within the bounds of accepted practice.”

In *Bolam* itself, the plaintiff claimed that the broken pelvis he sustained during electro-convulsive treatment could have been avoided had he been given relaxant drugs and been properly restrained. He also complained that he was not warned of the risk of treatment. Mr Bolam lost his claim as at the time there was evidence that different doctors used different techniques and methods- some used relaxant drugs,

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<sup>238</sup> *Whitehouse v Jordan* [1981] 1 All ER 267.

<sup>239</sup> *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634.

<sup>240</sup> *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871.

others did not. Since both approaches were equally acceptable the doctor was not negligent in choosing one method rather than the other. The Bolam test was applied to disclosure of risks as well as diagnosis and treatment. The doctor was not negligent in not telling the patient about the risk of fracture in electro-convulsive therapy because this practice was supported by a responsible body of opinion. This was confirmed in *Sidaway* that the doctor was not negligent in not telling the patient of the small risk of nerve injury associated with spinal surgery because this could pass the Bolam test.

### **5.1.1 Application of Bolam Principle**

With regard to the applicability of the Bolam test in advising patients. The Bolam principle is accepted in Hong Kong and was applied in *Ho Yee Sup v Dr Chan Yuk May & Others*<sup>241</sup> in Hong Kong. The plaintiff had decided on sterilisation following the birth of her third child in 1980. However, the procedure proved ineffective as the plaintiff gave birth to another child in 1985. The plaintiff sued the defendant doctor alleging breach of duty to warn of the continuing risk of pregnancy. However on the basis of expert testimony the court was satisfied that the failure to warn would not constitute a breach of duty. The court applied the Bolam principle and was satisfied that there was in 1980 a substantial body of medical opinion in Hong Kong that would not have recommended a warning. In *Defreitas v O'Brien*<sup>242</sup> the English Court of Appeal held that it need not be substantial. In this

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<sup>241</sup>*Ho Yee Sup v Dr Chan Yuk May & Others* [1991] 1 HKC 499.

<sup>242</sup>*Defreitas v O'Brien* [1995] 6 Med LR 105.



case, 11 practitioners supported the defendant's position while 1200 doctors were opposed to that view. Although the group supporting the defendant was small, they were nonetheless a responsible body, and so the defendant was not found to be negligent. Whilst still upholding the Bolam test, the Court decided that it could examine whether the body of medical opinion which accepted a practice as proper was indeed a "responsible body of medical opinion". The Court said that such body of opinion must be able to stand up to scrutiny and reasoning in order to be a "responsible" body of opinion. The result of proving that the defendant doctor acted in accordance with a practice accepted as proper by a body of medical opinion, does not necessarily exonerate the doctor from liability.

What is the position where there is evidence of conflicting practices used by the profession? The principle further enunciated in *Maynard v West Midlands Regional Health Authority*<sup>243</sup> in which the plaintiff had a chest complaint. Two consultants thought it was tuberculosis but also considered the possibility of Hodgkin's disease. Before obtaining the result of a tuberculosis test, they decided to perform an exploratory operation to determine whether it was Hodgkin's disease. The operation showed tuberculosis and not Hodgkin's disease. Consequently the operation resulted in damage to a nerve affecting the plaintiff's vocal cords, such damage being an inherent risk of the operation. The plaintiff sued the consultants claiming that they had been negligent in deciding to carry out the operation before obtaining

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<sup>243</sup>*Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635.

the result of the tuberculosis test. The Court found that there were two practices each accepted as proper by a responsible body of medical opinion and the consultants had followed one accepted practice even though there was another body of opinion that took a contrary view. As seen above, the Bolam test relies on what the reasonable standard of the profession was and what the accepted practices were at the material time.

The Bolam principle was further applied in the medical context of *Atzori v Dr Chan King Pan*<sup>244</sup>. In that case, the plaintiff who suffered pain in his left hip consulted the defendant doctor who decided to operate. After surgery, the plaintiff suffered from weakness in his left knee, ankle and foot, and atrophy of muscles. The defendant doctor was held to have fallen below the Bolam standard which reasonably to be expected of a competent surgeon in his field in that he resorted to surgery when there was no need for it. As seen above, if there were at the relevant time two or more schools of thought or opinion among doctors about a particular procedure, diagnosis, treatment or other matter, a doctor would be justified in following one of them, provided it could be regarded as acceptable to a 'responsible body of medical opinion'. Thus the Bolam principle has proved a strong defence to doctors in these medical negligence cases.

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<sup>244</sup>*Atzori v Dr Chan King Pan* [1999] 3 HKLRD 77.

Following the landmark decision in *Bolam*, McNair J set out the test for determining the standard of care in clinical negligence cases. He explained in his direction to the jury as follows:

“.....where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus because he has not got that special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest 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. A doctor 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 ... a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion which takes a contrary view.”

This test had been criticised for placing too much power in the hands of doctors, Lord Scarman had commented in *Sidaway*<sup>245</sup> that the *Bolam* test ‘leaves the determination of a legal duty to the judgement of doctors’ Whether or not the standard has been met or breached is determined by the *Bolam* test. The reason behind the *Bolam* test was that medicine was an imprecise science and the courts were not the appropriate forum to decide which the better practice was.

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<sup>245</sup>*Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871.

### 5.1.2 The Limitation of Bolam Test

However, following an accepted practice is not necessarily a complete defence. The limits imposed on medical negligence liability by the Bolam case have been put to test in a series of decisions in several other common law jurisdictions such as Australia, Canada and the United States and even in the United Kingdom itself. Although Bolam remains the leading authority in medical negligence cases, in at least three areas the authority has been considerably weakened in recent years. In *Rogers v Whitaker*,<sup>246</sup> Whitaker who was almost totally blind in the right eye consulted Rogers, an ophthalmic surgeon. The surgeon advised Whitaker that an operation on her right eye would not only improve its appearance but would probably restore significant sight to it. Whitaker agreed to the surgery which developed inflammation to her left eye and this led to the loss of sight of that good left eye. The Supreme Court of New South Wales held that Rogers was liable as he failed to warn Whitaker that as a result of the surgery she might develop a condition known as sympathetic ophthalmia in her left eye. The Australian High Court while affirming a decision of the New South Wales Supreme Court laid down that a medical practitioner has a duty to warn the patient of a material risk inherent in proposed treatment. A risk is material if in the circumstances of the particular case a reasonable person in the patient's position if warned of the risk, would be likely to attach significance to it. The aforesaid duty towards the patient of answering all his questions about treatment and risk truthfully had never been addressed in the Bolam

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<sup>246</sup>*Rogers v Whitaker* [1993] 4 Med LR 79.

approach. Thus in the field of non disclosure of risk and the provisions of advice and information the decision in Rogers has virtually discarded Bolam. Yet another Australian High Court decision *Rosenbreg v Percival*<sup>247</sup> has extended the decision in Rogers in respect of a medical practitioner's duty to inform the patient of the inherent risks associated with the proposed treatment. The court in this case endorsed a subjective test in assessing whether the patient would have avoided the risk if it had been disclosed.

The Bolam test is thus supplemented by the *Bolitho v City and Hackney Health Authority*. *Bolitho* is an important case because their Lordships discuss many of the legal principles constituting negligence, including causation. In the case of *Bolitho v City and Hackney Health Authority*<sup>248</sup>, Lord Browne Wilkinson's following ruling is notable in this respect:

“The court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The use of these adjectives- responsible reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such

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<sup>247</sup>*Rosenbreg v Percival* [2001] 178 All 577.

<sup>248</sup>*Bolitho v City Hackney Health Authorities* [1997] 4 All ER 771.

opinion has a logical basis. In particular in cases involving as they so often do the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible position on the matter.”

Lord Browne –Wilkinson in *Bolitho* emphasized that the court was not bound to find for a defendant doctor simply because a body of experts testified in his favour. In *Bolitho*, the House of Lord held that a doctor could be liable for negligence with respect to diagnosis and treatment, despite a body of professional opinion sanctioning the doctor’s conduct, where it had not been demonstrated to the judge’s satisfaction that the body of opinion relied on was reasonable or responsible” ( per Lord Browne- Wilkinson). However such cases will be rare. In *Michael Charles Leonard v Julian Wei Chang* <sup>249</sup>, an action brought by a professional football player against his physician for failing to adopt a more aggressive form of treatment for his knee injuries, the court considered the conflicting expert evidence in light of the *Bolitho* dictum but nonetheless the *Bolam* principle applied in finding that there was no breach of that duty.

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<sup>249</sup>*Michael Charles Leonard v Julian Wei Chang* [2006] HCPI 959 of 2003.

Overall this aspect of the Bolam test is a difficult one for plaintiffs to overcome. The accepted practice must be able to stand up to scrutiny. He has to establish that no reputable body of practitioners would have behaved as the defendant did. It is clear that no doctor (or other health professional) could as judge in the Bolam case said, “obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: ‘I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century’. That clearly would be wrong. However, Hong Kong’s medical community is a small one. One can understand the reluctance to stand up in court to criticize colleagues with whom you might be sharing the same golf course. Thus, it is difficult to prove negligence of a doctor if he clearly follows the ‘norm’ of his colleagues. Bolitho case gives a chance for the judge to veto a defence for negligence, however, it is rare to substantiate as judge has only limited medical knowledge to comment on a case and relies heavily on an expert opinion.

## **5.2 Standard of Proof in Hong Kong**

In law, there are two standards of proof. One is "proof beyond reasonable doubt" which is applied to criminal proceedings and the other is "proof on balance of probability" which is applied to civil and non-criminal proceedings. A higher

standard of proof is applied to criminal proceedings as the punishment attached to conviction is serious and it is important to avoid punishing innocent. On the other hand, the standard of proof is lower for civil claim in which punishment is often made in terms of monetary compensation. In disciplinary proceedings, problem arises as there was no clear guideline in the past. A compromise solution was adopted by the Hong Kong Medical Council with a which meant the standard of proof is between and "beyond reasonable doubt", with higher standard of proof applied to more serious and criminal-like allegations. Nevertheless, the recent case where a solicitor was convicted of practice promotion and posing nude for two magazines, the court of Final Appeal made the decision that the standard of proof in disciplinary proceedings in Hong Kong is "proof on ". Mr Justice Bokhary stated that:- "the more serious the act or omission alleged, the more inherently improbably must it be regarded. And the more inherently improbably it is regarded, the more compelling will be the evidence needed to prove it on a preponderance of probability." The Court of Final Appeal judgement gives the Medical Council a clearer guideline and logical thought process which avoid the artificial model of a "" standard of proof.<sup>250</sup>

Despite the change of sovereignty, the court still strictly follows the tort law principle and Bolam test is still the legal standard. In Bolam's case, it is clearly stated that a doctor is not negligent as long as he is acting in accordance with a

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<sup>250</sup> On appeal from the order of the solicitors disciplinary tribunal dated 15 March 2005 against a solicitor.CACV107/2005. CIVIL APPEAL NO.107 of 2005.



responsible body of medical opinion despite there is another opinion opposing him. I view Bolitho case as an extension to Bolam rather than exception. Bolitho further extend the statement in clarifying that the assessment lies on the judge weighting the risk and benefit of the treatment on the patient. It is also well demonstrated by the case of *Elijah v Raffle Medical Group*<sup>251</sup> which emphasis the importance of expert and the necessity of including standard of care in the expert opinion. On the contrary, the recent UK case of *Manning v King's College Hospital NHS Trust*,<sup>252</sup> the court refuted Bolam's principle and take the privilege of preferring the expert opinion from the plaintiff over the defense despite the fact that many complex medical issue was involved in the case. This rarely happen in Hong Kong as even with appeal cases, the High Court Judges tend to ignore disputes concerning medical facts but concentrate on legal issues of irregularity such as role of legal adviser of the Medical Council.<sup>253</sup>

Hearing by Medical Council should be by standard of criminal procedure as the verdict affects the professional life of the doctor and may lead to serious accusation including manslaughter. Furthermore, it should be noted that doctors concern have to re-apply for registration after license suspension and the application may be refused by the Council. Thus, suspension of registration may be equivalent to life sentence to the doctor and proclaiming an end to his career.

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<sup>251</sup> *Elijah v Raffle Medical Group* (unrep., CACV 109/2008, [2009]HKEC 559.

<sup>252</sup> *Manning v King's College Hospital NHS Trust*(QB) 29/0908.

<sup>253</sup> *Dr Helen Chan v The Medical Council of Hong Kong* . In the Court of Final Appeal of the HKSAR. Final Appeal No 13 of 2009 (Civil) FACV No 13 of 2009.

### 5.3 Error in Diagnosis

Errors in diagnosis can arise from various causes, including inadequate-history taking, errors in conducting an examination, failing to perform appropriate tests or failure to refer the patient for specialist consultation. An example of an unsuccessful claim of this sort is provided by *Whiteford v Hunter*<sup>254</sup> the defendant in this case had diagnosed carcinoma of the bladder diagnosis which was subsequently found to be incorrect. The court held that there was no negligence in the mis-diagnosis as the defendant had used methods which were in common use at the time. Good practice may require that the patient be referred to a specialist for further consideration.

Lord Edmund Davies declared :

“To say that a surgeon committed an error of clinical judgement is wholly ambiguous for some whole errors may be completely consistent with the due exercise of professional skill other acts or omissions in the course of exercising ‘clinical judgment’ may be so glaringly below proper standards as to make a finding of negligence inevitable....[doctors and surgeons fall into no special category ].... If a surgeon fails to measure up to that standard in any respect he has been negligent and should be so adjudged. ”

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<sup>254</sup>*Whiteford v Hunter* [1950] 94 Sol Jo 758, HL.

Malignancy of the cervix and breast carcinoma is among the most common sources of misdiagnosis in medical practice. Included in the most frequent illnesses to be misdiagnosed is declaring a breast lump as benign which would later turn out to be malignant. Therefore the doctor could not definitely pinpoint the illness unless the person is examined properly. On the other hand, there have been numerous cases in which negligence in diagnosis has been established. In *Langley Campbell and Tuffil v East Surrey Area Health Authority*<sup>255</sup> instances are provided of successful actions against doctors on the basis of failure to diagnosis correctly the nature of the patient's complaint. A typical example is a case of *Langley Campbell*,<sup>256</sup> the patient had returned from East Africa shortly before the development of symptoms. The general practitioner failed to diagnose malaria and medical negligence was found. The judge had accepted the evidence from the relatives who said that the family had suggested such a diagnosis to the doctor. In another case *Tuffil*,<sup>257</sup> the patient had spent many years in a tropical climate; however the doctor failed to diagnose amoebic dysentery which proved fatal. This failure was held to be negligence on the doctor's part. A patient alleging that a mis-diagnosis was negligent, must establish that the doctor failed to carry out an investigative procedure or examination which the patient's symptoms called for. Ordinary laboratory tests must be used if symptoms suggest their use.

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<sup>255</sup>*Tuffil v East Surrey Area Health Authority* [1978] *Times*, 15 March.

<sup>256</sup>*Langley v Campbell* [1975] *Times*, 6 November.

<sup>257</sup>*Tuffil v East Surrey Area Health Authority* [1978] *Times*, 15 March.

In accordance with the principle discussed above, a doctor is expected by the law to use the same degree of care in making a diagnosis that is required of him in all his dealings with his patients. In the doctor patient relationship it will always be a duty upon the doctor to caution what he speaks, as it is part and parcel of their relationship. It must be noted that telephone diagnosis is dangerous especially when the patient tries to describe the conditions that create some doubts in the mind of the doctor. Diagnosis by telephone has become a significantly litigated area. In the seminal case of *Hunter v Hanley*<sup>258</sup> , a Scottish judge has said :

“In the realm of diagnosis and treatment there is ample scope for a genuine difference of opinion and one man is clearly not negligently because his differs from that of other professional men ...”

Finally, it may be said that it is not negligent for a doctors to miss a diagnosis where they have acted appropriately and in line with what is reasonable for their specialty and experience.

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<sup>258</sup>*Hunter v Hanley* [1955] S.L.T. 213.

## **5.4 Negligence in Treatment**

Every treatment is attended by its risks. No treatment can be guaranteed to succeed. When something goes wrong the patient first asks whether the doctor has been negligent in his treatment.

### **5.4.1 Extreme Care to be Taken by Doctors -- Drug Labelling**

Doctors have been given the privilege to dispense medicine. Going hand in hand with this privilege is the corresponding responsibility to properly label the medicine so that the information is readily available to any other doctor who may have to treat the same patient. There are numerous mishaps which may, and do, occur in the course of administering drugs. A patient must prove some specific negligence against the medical man before he can succeed in an action. Recently in May 2005, 152 people with stomach ailments were given a mislabelled drug for diabetes by a Wong Tai Sin Doctor Ronald Li Sai lai and four later died. Again there were 3 charges alleged against the Defendant in regard to the defendant doctor's failure to label properly the drugs dispensed. The facts were that<sup>259</sup> "On 23 September 2004, a registered medical practitioner, disregard his professional responsibility to treat or care for his patient or otherwise neglected his professional duty in that he failed to properly label the syrup dispensed to his patient by only putting the name of a drug

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<sup>259</sup>Benjamin Wong and Martin Wong, 'Patients die after drug blunder'. *South China Morning Post* (Hong Kong 31 May 2005).

“Gastrogel suspension” on the medicine bottle, but in fact he had mixed the drug Gastrogel suspension with drugs Stemetil and Diamotil, which names had also to be put on the bottle, failed to separately label the medicines dispensed to his patient by dispensing multiple drugs in a medicine bag to her. Moreover, the defendant did not put a name properly identifying the patient and the date of dispensing on the medicine bag to the patient.”<sup>260</sup> In relation to the facts alleged, he was found guilty of misconduct in a professional respect. In such circumstances, it would not be a defence that the mistake was committed by the clinic nurse. Moreover, it was also not acceptable for multiple drugs to be dispensed in the same medicine bag. It is clear that this was a practice which Hong Kong Medical Council has repeatedly emphasized to be unacceptable. The Defendant’s conduct in respect of each fell below the standard expected of registered practitioners amounted to misconduct in a professional respect. The Defendant was found guilty of each of the 3 charges.<sup>261</sup> It has long been recognised that a General Practitioner prescribing drugs must check what other medication the patient is on. In an action for negligence, it was admitted that there are instances of over-prescribing and for prescribing unnecessary short courses of treatment. The over-prescription of drugs may compromise quality of care.

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<sup>260</sup>Ella Lee, ‘Doctor may be charged over medicine mixing blunder’. *South China Morning Post* (Hong Kong 12 Sept 2006).

<sup>261</sup> The above order was published in the Government of the Hong Kong Special Administration Region Gazette No. 3246 on 26 May 2006.

Here, the case arose in Hong Kong where a three-year old girl who was taken to a Tuen Mun doctor and given cough medicine that burned her throat. A Health Department investigation is being carried out into how the mix-up occurred. The investigation revealed that the cough medicine contained 69% concentration of disinfectant Isopropyl alcohol which can cause death if swallowed in large quantities. Medical Authorities claimed the incident to be an isolated one and that we should not be anxious. However, it would be fine were it not for the incident being the latest in a string of similar ones in recent years. At least 31 children were given an antihistamine wrongly diluted with the same alcohol and one child, a six-year old boy, ended up in hospital. These incidents clearly highlight the fact that the present system, in which private doctors maintain their own drug supplies and have staff dispense them, is flawed. The complaint pointed out that the standard expected for doctors is clearly described in Section C (10.1) of the Professional Code and Conduct. The standard emphasized that “the duty to ensure proper dispensing of medicine is the personal duty of the prescribing doctor which cannot be delegated”<sup>262</sup> The requirement to label all dispensed medications properly and separately has been in force for more than ten years. The information which was required to be written down on the label has been clearly set out in paragraph 10.1 of the Professional Code and Conduct. The responsibility is on the doctor himself to

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<sup>262</sup>This was particularly accentuated when Paragraph 10.1 of the Professional Code and Conduct was amended in August 2005 to set out the requirement in writing. It was also clearly stated in the Good Dispensing Practice Manual that “medications be double-checked by doctors before dispensing”. ‘Short of double checking the medicine personally, the doctor cannot be considered as having properly fulfilled that response’.

ensure compliance with the requirement. It would not be a defence that the mistake was committed by the clinic nurse. It is also not acceptable for multiple drugs to be dispensed in the same medicine bag. In fact this was a practice which this Council has repeatedly emphasized to be unacceptable. However, the proposals by the Practising Pharmacist Association of Hong Kong that legislation should be implemented to separate drug prescriptions and dispensing being carried out at the same clinic have received cool response by the Health Chief and lawmakers. Nevertheless, Hong Kong Medical Association President Choi Kin told a radio programme that ‘human error is unavoidable and had sent guidelines to private doctors in order to remind them not to allow inexperienced staff to dilute syrup without proper investigation’.

#### **5.4.2 Failure to Enter Dangerous Drugs Records**

Under the Dangerous Drugs Ordinance, registered medical practitioners are authorized to process and use dangerous drugs. This important and onerous duty falls under Section 23(4) of the Dangerous Drugs Ordinance, which requires that they be stored in a locked receptacle.<sup>263</sup> A further point is brought out by the case in relation to the Defendant Chung’s conviction of ten counts of failing to keep proper records and one count of storing dangerous drugs other than in a locked

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<sup>263</sup>Section 23(4) of the Dangerous Drugs Ordinance requires that registered medical practitioners are authorized to process and use dangerous drugs. The Ordinance requires that they be stored in a locked receptacle will not fall into the wrong hands. It is also necessary for the proper control of dangerous drugs to facilitate their ready and efficient inspection by the authorities. The purpose of the requirement to keep proper records of dangerous drugs is to ensure that all dangerous drugs are traceable.



receptacle. The amount of dangerous drugs involved, being over 4000 tablets, was large. By failing in that duty, the Defendant's conduct fell below the standard expected of registered medical practitioners. The court was satisfied that the negligence amounted to professional misconduct, and the offence of failing to keep proper records of dangerous drugs -- punishable with 3 years of imprisonment. <sup>264</sup>

This was in entire agreement with the following observation of Mr. Justice Ching J.A. in *Lai Chung Lim Peter v The Medical Council of Hong Kong*<sup>265</sup>:

“It is generally neither a mitigating factor nor a defence to say that all of the information as to drugs received can be found from the supplier's invoices or that all of the information as to drugs dispensed can be discovered from the patients' records. Given the many thousands of patients which a medical practitioner may have, it would take the authorities an enormous amount of time to check through records such as those. That should not be a task which they have to perform. The task is put squarely on the medical practitioner conducting his practice in the proper manner.”

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<sup>264</sup>Disciplinary Inquiry and Order' (2005 )November Hong Kong Medical Association.

<sup>265</sup>*Lai Chung Lim Peter v The Medical Council of Hong Kong*[1996] 2 HKLRD 249.CACV10/1996. The decision was published in The Government of the Hong Kong Special Administrative Region Gazette on 21-10-2005 (G.N. 5377).

In other words, failure to keep proper Dangerous Drugs records is a criminal offence. What is now sought to be emphasised is that the doctor would risk criminal prosecution if his Dangerous Drugs records in any way deviated from the format specified in the Dangerous Drugs Regulations. Therefore, it is the responsibility of the doctor, as the person who is authorised to prescribe Dangerous Drugs, to ensure that there are proper Dangerous Drugs records and it is not a defence to say that he has delegated the responsibility to his nurse or someone else.

#### **5.4.3 Registered Pharmaceutical Product - Use of Unregistered Flu Vaccines**

With the increase competition among Health Maintenance Organisation (HMOs), doctors are squeezed to the detriments of patients. Due to the supply of influenza vaccine being so tight and because the increased demand, renowned Health Maintenance Organisations (HMOs) imported some unauthorized vaccines to supplement this deficit and generate profit. Hence, some medical practitioners were offered influenza vaccines which were of an unknown source and were not authorized for import. <sup>266</sup>The Medical Professionals regretted that the incident of unregistered influenza vaccines saga provoked government action.

There is no professional licensing body for HMOs. In order to ensure the safety of our citizens, Authority should regulate these HMOs under the same level of

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<sup>266</sup>The Hong Kong Medical Association Condemns Unauthorized Influenza Vaccines' (2005)  
December Hong Kong Medical Association News.

regulation as medical practitioners.<sup>267</sup> It is recommended that doctors or other healthcare professionals be particularly careful when purchasing drugs from a new supplier, when informed that the product ordered has a different name, when it is imported from another country, or when it's produced by another manufacturer. The doctor would be well advised to check with the supplier that the product is a duly registered pharmaceutical product with the name of the manufacturer as well as the product name having been approved for use in Hong Kong.<sup>268</sup>

Furthermore, such verbal verifications by the supplier should be documented. The doctor cannot be criticized if he has carried out the necessary checks and thus has a reasonable belief that the product is safe and legal. Failure to carry out the necessary checks may also result in disciplinary proceedings and civil proceedings if the product is unregistered.

#### **5.4.4 Failure to Keep Proper Records**

The responsible keeping of medical records is essential both for the treatment of patients and in the defence of claims on clinical negligence. The Medical Protection Society has always emphasized the importance of adequate medical records, which includes adequate accounts of the patient's history, physical findings, results of

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<sup>267</sup> A press conference was held on December 2005 to condemn sales of unauthorized influenza vaccine.

<sup>268</sup> 'The Chief Pharmacist warned against the use of pharmaceutical products of unknown source' (2005) December Hong Kong Medical Association News .

investigations (if any), possible complications of medical and surgical treatments explained beforehand, signed forms and accounts of inpatient and outpatient visits. With regard to prescriptions, one has to record details of allergies, inform the patient about possible adverse reactions to the drugs and a reminder to follow the manufacturer's instructions. Here again, it has been seen that more and more Medical Council Disciplinary actions. In the case concerning Dr. WU Hin Ting, Peter Brendan, being a registered medical practitioner, disregarded his professional responsibility to treat or care for his patient Madam W. In the period between August 1992 and November 1992, he prescribed the patient with medication that contained steroids and he failed to inform and to explain to the patient the reason for such medication, its nature and side-effects. Moreover, he failed to keep proper medical records on all the patient's consultations and the prescription of medication that contained steroids. The Council was satisfied that in relation to the facts alleged, he was guilty of misconduct in a professional respect. In accordance with section 21(1) (ii) of the said Ordinance, the Council ordered on 15 January 2003 that Dr. WU Hin Ting, Peter Brendan be removed from the General Register for a period of 12 months In accordance with section 26 of the Medical Registration Ordinance, Dr. WU Hin Ting, Peter Brendan subsequently filed an appeal to the Court of Appeal against said Order, but it was dismissed.<sup>269</sup>

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<sup>269</sup> The decision was published in The Government of the Hong Kong Special Administrative Region Gazette on 4-11-2005 (G.N. 5706).

With respect to the facts alleged, the defendant's conduct fell way below the expected standard. The court was satisfied that such conduct was a clear case of professional misconduct. The importance of keeping good records has been stressed repeatedly by the Medical Protection Society (MPS). The experts consulted by the MPS took the view that the claims could not be defended because "The notes are particularly poor and even if it had done more than is evident, the paucity of notes makes a defence of liability impossible."<sup>270</sup>

It is widely accepted that good communication between doctor and patient is of paramount importance. However, communication among doctors may also affect the health of the patient. As depicted by the Harvard Report, referring doctors rarely communicate directly with the referred doctors -- the most common form of communication being through a referral letter. Moreover, the Patient Studies Summary Report revealed that only 55% of the referral letters reviewed contained the patients' symptoms, and many lacked vital information such as the symptoms, diagnosis, and even the name of the referring doctor.<sup>271</sup> The Harvard Report found that patients with chronic illnesses expressed concern about the lack of continuity of care across the public and private sectors, noting that there is limited communication among providers so that patients themselves must assume a role in relating their histories, diagnoses and treatments. The Harvard Report cited patients who, returning to the private sector, rarely have their records from public hospital

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<sup>270</sup> 'A case of delayed diagnosis of chest infection' *Casebook* No.16 ,18.

<sup>271</sup> Special Report #4: Hong Kong Private Practice Survey; also see *Harvard Report* 80.

stays transferred to private general practitioners or specialists. According to the Harvard Report, more than half of the sampled private doctors who have referred patients to the public sector received reports for less than 7-10% of those referrals.

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A patient was prescribed thirty injections of streptomycin for boils. The sister failed to note on the treatment sheet when the prescribed course was completed. An additional four injections were given before the error was discovered. Damage to a cranial nerve resulted. The sister was found to be negligent.<sup>273</sup> This illustrates that the more independent the nurse's function, the greater the risk of a finding of liability. Once the nurse is in the front line with some responsibility for diagnosis and choice of treatment, their responsibility equates with the doctor. Failure to make or record tests correctly can result in liability resting on the nurse. All in all, good record keeping is a basic requirement of good medical practice, particularly in a multidisciplinary environment. It also provides the evidence required to defend a negligence claim.

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<sup>272</sup> Special Report #5: Hong Kong Patient Studies Summary Report; also see *Harvard Report* 81.

<sup>273</sup> *Smith v Brighton and Lewes H. M. C.*, *The Times*, 21 June 1955.

#### 5.4.5 Failure to Write Prescriptions Clearly

The poorly written prescription can have serious, even fatal consequences. *Prendergast v Sam and Dee Ltd*<sup>274</sup> demonstrates that a failure on the part of a doctor to write sufficiently clearly for his notes/prescriptions/orders to be readily and correctly interpreted will find a claim in negligence. The case is also authority for a principle that, where a prescription is of sufficient clarity that the pharmacist should suspect that it may be wrong and the pharmacist fails to spot that error, there could be a breach of the duty of vigilance on the part of that pharmacist.<sup>275</sup>

Some of the drug names have very similar spellings, and some medical staff might misunderstand doctor's scribbles of prescriptions and dosages. A 21-year-old leukaemia patient died after vincristine was mistakenly injected into her spine in June at the Prince of Wales Hospital. Both vinblastine and vincristine are drugs for parenteral [injection] chemotherapy. But their allowable dosages are much different. Medical practitioners and patients should be more alert when giving out the medications which have similar spellings. Medical staff should check the dosages carefully when giving out the drugs. They should tell patients what drugs they are taking, and patients are encouraged to check the medicines before taking them. Where the doctor dispenses the drugs in his own clinic in Hong Kong, the doctor will be liable for the accuracy of filing the prescription and for the instructions to

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<sup>274</sup> *Prendergast v Sam and Dee Ltd* [1988] March 24 The Times

<sup>275</sup> J. Finch, 'A Costly Oversight' (1982) 132 NLJ 176.

the patient. When a doctor's bad handwriting led the pharmacist to dispense the wrong drug, the doctor was also held responsible. Nevertheless, it is important for the pharmacist to check with the prescribing doctor where dangerous drugs or dosages are prescribed. The patients should be more alert to ask why if the medicine doesn't look like what they usually take.

### **5.5 Medical Negligence in Different Specialities**

What if the doctor is a specialist? When a doctor holds himself out as being a specialist, the standard of care expected by the law was set out by Lord Scarman in *Maynard v West Midlands Regional Health Authority*:<sup>276</sup>

“I would only add that a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality.”

The defendant doctor will be expected to achieve the standard of a reasonably competent specialist in that field. In an action of damages against a doctor in *Hunter v Hanley*<sup>277</sup>, the pursuer who had suffered injury as a result of the breaking of a hypodermic needle while she was receiving an injection. The plaintiff alleged that the accident had been caused by the fault and negligence of the defender in failing to exercise the standard of care and competence which it was his duty to display in giving the injection. At the trial the presiding Judge directed the jury in the course

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<sup>276</sup> *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 at 638.

<sup>277</sup> *Hunter v Hanley* [1955] S.L.T. 213



of his charge that the test to be applied was whether there had been such a departure from the normal and usual practice of general practitioners as could reasonably be described as gross negligence. Lord Bridge makes it clear that a specialist will be judged by the standard of the specialist of ordinary skill. This is also indicated in Sidaway's case (per Lord Bridge) that the standard of the competent consultant in that specialty. As Lord Scarman said:

“... a doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty’. So a patient who attends his general practitioner complaining of an eye disorder cannot require him to have the skill of a consultant ophthalmologist. But he can complain if the G.P. fails to refer him on to a consultant when his condition should have alerted the reasonable G.P. to the need for further advice or treatment.’ No allowance is made for inexperience.”

Lord Scarman in a 1984 case added this important caveat to the Bolam test: “A judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence.”

This does not mean the medical profession is the sole judge of its own court when it comes to medical negligence. In the House of Lords decided in 1997, Lord Browne-Wilkinson warned that the court must be satisfied that:

“the exponents of the body of the opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge, before accepting a body of opinion as being responsible, reasonable and respectable, will need be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible position on the matter.”

### **5.5.1 Anaesthetics Accidents**

Anaesthetists are faced with specialised medical problems that can easily lead to litigation. In *Delaney v Southmead Health Authority*<sup>278</sup> the claimant had undergone a successful operation under routine general anaesthesia. However, three or four days later she noticed that she had a pain in her left hand and fingers and it transpired that she had suffered a lesion of the brachial plexus. The claimant alleged that this lesion was caused by the anaesthetist’s negligent failure to take consideration of an earlier injury which had left her susceptible. Alternatively, she contended that the lesion was caused by the incorrect positioning of the arm during surgery. Her action failed. The trial judge had decided on the evidence presented to him that the anaesthetist had followed the correct procedure and the Court of Appeal refused to interfere with that finding. Similarly, with regard to an anaesthetic, a recent case in *Taylor v Worcester and District Health Authority*<sup>279</sup> where the plaintiff’s claim for damages for awareness during a Caesarean section

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<sup>278</sup> *Delaney v Southmead Health Authority* [1995] 6 Med LR 355.

<sup>279</sup> *Taylor v Worcester and District Health Authority* [1991] 2 Med KR 215.

failed because the judge concluded that the anaesthetist had followed a procedure that was acceptable at the time of the operation (1985). An extension of this principle is found in *Allen v New Mount Sinai Hospital*<sup>280</sup>. An anaesthetist who acted without negligence was held liable in battery for unforeseeable injury suffered by the patient as he administered the injection that led to the injury into the patient's left arm. The patient had expressly told him not to inject into that limb. The defendant acted in accordance with normal medical procedure, but he had ignored the plaintiff's instructions. The doctor was accordingly liable for trespass to the person and for all the damage that flowed directly from that trespass.

In a number of cases allegations of negligence have been made in connection with the administration of anaesthetics and other drugs. While using a drug without knowing its properties and proper manner of administration can have fatal consequences. The allegation that an anaesthetist Dr. CHOW Po-wah, being a registered medical practitioner in Hong Kong was found guilty of a charge of using an anaesthetic agent remifentanyl without proper training and proper monitoring of the patient.<sup>281</sup> The Defence argued that there was no recognized training for the use of the drug. This was disputed. Training included the doctor properly acquainting

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<sup>280</sup> *Allen v New Mount Sinai Hospital* [1980] 109 DLR (3d) 364.

<sup>280</sup> *Freeman v Home Office (No. 2)* [1984] QB 524.

<sup>281</sup> It is hereby notified that after due inquiry held on 25 September 2003 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the laws of Hong Kong,

himself with the properties, administration and the indications of the drug. Evidence called during the criminal trial showed that the drug is a fast acting anaesthetic agent, with the significant side effect of respiratory depression.<sup>282</sup> The instructions for use of the drug, which had the trade name Utliva, contained the following passage:-“Utliva” should be administered only in a setting equipped for the monitoring and support of respiratory and cardiovascular function and by persons specifically trained in the use of anaesthetic drugs and the recognition and management of the expected adverse effects of potent opioids, including respiratory and cardiac resuscitation. Such training must include the establishment and maintenance of a patient airway and assisted ventilation. Bolus injections are not recommended.” The same instructions were repeated under the heading “Special Warnings and Special Precautions for Use”. It was accepted that the instructions were in small print which would be difficult to read at a quick glance. However, every doctor must properly acquaint himself with the use of a drug before using it on a patient, and it was no excuse that particular efforts had to be made to read the instructions. This was all the more important in respect of anaesthetic agents, given

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<sup>282</sup> The case was in relation to a registered medical practitioner in Hong Kong who was convicted in the High Court on 16 October 2003 regarding that the defendant doctor unlawfully used an instrument with intent to procure the miscarriage of a woman in the defendant doctor’s clinic in the Central. And on the same date and at the same place he unlawfully killed the said patient by an unlawful act, and was sentenced in respect of offence (a) to imprisonment for 12 months and in respect of offence (b) to imprisonment for 2 years, both to be served concurrently. In relation to the facts of the said offences on his said patient in violation of the law. He used an anaesthetic agent namely Remifentanyl on the said patient without having received proper training regarding its use and without properly monitoring the patient’s condition. He was guilty of misconduct in a professional respect.”

their potential for suppressing respiration and for slowing the heart beat. The Court was satisfied that the Defendant's conduct in the use of the drug fell short of the standard expected, and such conduct amounted to professional misconduct. She was found guilty of the charge.<sup>283</sup>

Nonetheless, anaesthetics is an area which gives rise to many claims for clinical negligence and was identified in 1990 as one of the areas for special concern by the Medical Protection Society. In some instances, the consequences of a mistake by an anaesthetist may be devastating for the patient. An extreme example of negligence in anaesthesia is *R v Adomako*<sup>284</sup> criminal case in which gross negligence by an anaesthetist was found to constitute manslaughter. The Court found that it is the duty of an anaesthetist at all times to watch and monitor the patient. The defendant who had failed to recognise disconnection from the ventilator for a period of six minutes was criminally negligent and was found guilty of manslaughter after the patient died following a cardiac arrest. It is mandatory to carry out a proper check of the anaesthetic machine, equipment and monitoring equipment prior to their use. A record of the check should be kept. Moreover, a local policy should be in place to ensure that anaesthetists are well acquainted with the anaesthetic equipment they are using and the checking procedure. Nevertheless, there is no breach of duty

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<sup>283</sup> Gazette Notice (G.N. 8267) Gazette Notice (G.N. 8451) published in the Hong Kong SAR Government Gazette No. 48/2003 dated 28 November 2003 A disciplinary inquiry was held on 8 March, 23 March and 19 April 2006.

<sup>284</sup> *R v Adomako* [1993] 15 BMLR 13.

unless the defendant has failed to meet the standard of care required by the law in the context of the duty that exists to take all reasonable care.

### **5.5.2 Obstetrics and Gynecology**

Obstetricians carry many risks that could lead to litigation and very large awards being paid to claimants. An obstetrics claim may involve one or more of three potential claimants: the mother, the baby and more rarely the father of the child. However recent changes in the ways in which damages are calculated have resulted in greatly increased awards since 1998.<sup>285</sup> In one case, *Clark v MacLennan*<sup>286</sup> proves an effective example of the operation of the rules laid down in *Hunter v Hanley*.<sup>287</sup> The plaintiff was admitted to the hospital for the delivery of her child. After the child was born it was discovered that the mother was suffering from a not uncommon post-natal condition referred to as stress incontinence. The plaintiff's condition had been described as acute. The condition persisted after the conventional treatment had been undertaken so the defendant gynaecologist decided to perform what is known as an anterior colporrhaphy operation. Practice at that time indicated that such an operation should not be performed until three months after birth because of the risk of a haemorrhage. Peter Pain J considered the nature of the plaintiff's submissions and found that the operation was designed to prevent

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<sup>285</sup> *Page v Sheemess Steel, Wells v Wells, Thomas v Brighton Health Authority* (1998) 43 BMLR 99.  
*Barry v Aberlex*, The Times, 22 March 2000.

<sup>286</sup> *Clark v MacLennan* [ 1983 ] 1 All ER 416.

<sup>287</sup> *Hunter v Hanley* (1955 ) SC 200.

or alleviate future occurrences. Nevertheless a doctor who departs from orthodox views is thus not automatically branded as negligent. It is for him to justify his course of action either by indicating features of the individual case which call for a different mode of treatment or by showing his novel method to be superior or at least equal to the general practice. In the important Scottish case of *Hunter*, there was a clear endorsement of the custom test in Lord Clyde's dictum:

“To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.”

Liability was proved in *Whitehouse v Jordan*<sup>288</sup>. In this case negligence was alleged on the part of an obstetrician who had pulled too hard in a trial of forceps delivery and had thereby caused the baby's head to become wedged with consequent asphyxia and brain damage. The trial judge held that although the decision to perform a trial of forceps was a reasonable one, the defendant had in fact pulled too hard and was therefore negligent. This initial finding of negligence was reversed in

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<sup>288</sup> *Whitehouse v Jordan* [1981] 1 All ER 267, [1981] 1 WLR 246, HL.

the Court of Appeal and in a strongly worded judgment, Lord Denning emphasized that an error of judgment was not negligence. In the event, the House of Lords held that there had not in any case been sufficient evidence to justify the trial judge's finding of negligence on the part of the defendant in question. As Lord Fraser pointed out:

The true position is that an error of judgment may or may not be negligent; it depends on the nature of the error. It is not that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having and acting with ordinary care, then it is negligence. If on the other hand it is an error that such a man acting with ordinary care, might have made then it is not negligent.

The following case was in relation to the Defendant's unlawfully using an instrument with intent to procure the miscarriage of a woman and unlawfully killing the same woman by an unlawful act. The Defendant practised as a doctor of medicine from a surgery in Melbourne Plaza in the field of gynaecology and obstetrics. The treatment administered to one of his patients was alleged to have brought about her death. This led to his conviction, on 16 October 2003, following a trial before Jackson J and a jury, on two counts. The first alleged that on 8 January 2001, he unlawfully used an instrument at Room 1108, Melbourne Plaza, 33 Queen's Road Central, with intent to procure the miscarriage of Zenaida Chu (Mrs



Chu), contrary to section 46 of the Offences against the Person Ordinance, Cap. 212. The second count alleged manslaughter on the same day and place. He was sentenced on 30 October 2003 to concurrent terms of twelve months and two years' imprisonment on counts 1 and 2 respectively.<sup>289</sup> The bone of contention was whether the Defendant knew or believed that the woman was pregnant at the time he performed the dilatation and curettage operation. The Defendant's contention was that he had no reason to believe that the woman was pregnant and he thought that she was suffering from dysfunctional uterine bleeding. There was authority for the proposition that it is an abuse of process for a person to mount a collateral attack on a criminal conviction which was arrived at on the proof beyond reasonable doubt by civil proceedings which will be decided on a lower standard of proof. However, there must be regard to the provision of Section 62(2) of the Evidence Ordinance that "in any civil proceedings in which a person is proved to have been convicted of an offence he shall be taken to have committed that offence unless the contrary is proved". If the convicted person was entitled to prove the contrary he must be entitled to adduce evidence to that effect.

The majority of actions for clinical negligence by healthcare professionals have been dealt under the tort of negligence within the civil courts. Nevertheless, there has been an increasing trend towards the criminalisation of fatal medical errors

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<sup>289</sup> *HKSAR v Harry Sudirman* (Sim Hok Gwan). In the High Court of the Hong Kong Special Administrative Region, Court of Appeal. Criminal Appeal No. 486 of 2003. CACC 486/2003.

recently, even resulting in homicide charges. Our modern day intolerance of mishaps as innocent events turns medical mistakes resulting in death into tragedies calling for criminal investigation and prosecution. The unlawful killing of a human being without malice or premeditation, express or implied, is manslaughter whereas in murder there is malicious intent or aforethought. The usual charge for death as a result of medical treatment would be manslaughter as there is no mens rea (guilty mind). Rarely, doctors can be charged for murder if there is malice aforethought, as seen in the case of Dr Harold Shipman.<sup>290</sup> In order to charge a doctor for manslaughter, there has to be gross negligence with an extreme or reckless action. To establish criminal liability, there must be proved that the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others as to amount to a crime against the state and deserving punishment.

The prerequisites for manslaughter to be proved are the existence of the duty causing death, a breach of the duty causing death and gross negligence, which, the court considers, justifies a criminal conviction. Thus gross negligence must be found to criminally convict the defendant. Proof of any of the following states of mind in the defendant would lead the courts to make a finding of gross negligence, including

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<sup>290</sup> Harold Shipman is a GP, who has been convicted for murdering his patient. It has been estimated that up to 200 patients have been killed by him for the past 10-20 years. The high mortality rate has brought to the attention of colleagues before. But the GMC found no evidence of mis-behaviour and acquitted him. He was finally brought to trial and found guilty of murder.

indifferent and wholly irresponsible disregard to an obvious risk to the patient that the defendant is aware of but making himself wilfully blind, the actual foresight of the risk coupled with the determination nevertheless to run it, an appreciation of the risk coupled with an intention to avoid it, but with such high degree of negligence in the attempted avoidance that the court considers justifying conviction, inattention or failure to alert to a serious risk which went beyond “mere adventure” in respect of an obvious and important matter which the defendant’s duty demanded he should have addressed. The judge has to decide whether, taking into account the risk of death involved, the doctor’s conduct was so bad that it must have been criminal.

Litigation is an ever present fear for obstetricians and gynaecologists and it has been claimed that most specialists in these fields of medicine retire early because of the stress of their practice.<sup>291</sup> Most Hong Kong private doctors are insured for professional negligence by the Medical Protection Society (MPS). But Obstetrics is regarded as one of the riskiest fields, and specialists in obstetrics and gynaecology have to pay more than HK\$200,000 in annual premium for professional insurance.

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<sup>291</sup> NICE is working to improve standards in Obstetrics and has approved guidelines on Induction of Labour.

### 5.5.3 Surgery and Post Operative Care : Retained Surgical Products

#### 5.5.3.1 Surgery

Surgery itself must be performed with the utmost care. Where surgery is called for the risk of injury is increased. One judge has suggested that the more skilled the surgeon the higher the risks. And the surgeon must not rely on nursing staff and accept his own responsibility.<sup>292</sup>In *Waters v West Sussex Health Authority*<sup>293</sup> per Buxton J involved an allegation that a neurosurgeon has been negligent in undertaking a unique form of back operation. In finding against negligence, the Court found that there was no material or body of professional opinion existing which could confirm the operation had been performed negligently. The medical practitioner is not an insurer and so cannot be blamed every time something goes wrong. Indeed, this has also been reflected in judicial statements of the law:

“A surgeon does not become an actual insurer; he is only bound to display sufficient skill and knowledge of his profession. If from some accident or some variation in the frame of a particular individual an injury happens it is not a fault in the medical man.” Lord Bridge makes it clear that a specialist will be judged by the ‘standard of the specialist of ordinary skill.’”

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<sup>292</sup> *Urry v Biere*, *The Times*, 19 July 1955.

<sup>293</sup> *Waters v West Sussex Health Authority* [1995] 6 Med LR 362.

Surgery carries many risks that could lead to litigation and to very large awards being paid to claimants. Leaving swabs and equipment inside the patient is a good example. Some errors advertise their negligence. Here, the case was in relation to a 54-year-old patient, Mr Lee, suffering from lower pharyngeal cancer, had surgery on July 5 to remove and reconstruct his pharynx and the larynx by using part of his small intestine. However, doctors were unaware of the gauze still in the patient's abdomen until X-rays were taken. Mr Lee was called back to the hospital and the swab was removed in a two- hour operation. The patient's family members had been informed of the mistake and the hospital staff had offered their apologies. It has long been recognised by the medical profession that the danger of swabs and instruments being overlooked at the end of operation is a very real and grave one. In *Mahon v Osborne*<sup>294</sup> where the surgeon was sued when a swab was left inside the patient the court held that the patient could know nothing about swab procedures in the operating theatre and it was therefore for the surgeon to show that he exercised due care to ensure that the swabs were not left behind The Court of Appeal was of the view that the principle did not apply in the case of a complex operation where a number of medical staff took part, but it is clear that the correct view was that taken by Goddard L. J. when he said:

“There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient’ body .... If therefore a swab is left in the patient’s

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<sup>294</sup> *Mahon v Osborne* [1939] 1 All E. R. 535; [1939] 2 K. B. 14.

body it seems clear that the surgeon is called upon to show, not necessarily why he missed it but that he exercised due care to prevent its being left there.”

Leaving swabs and equipments inside the patient is a common example. And the surgeon must accept responsibility for such matters and not rely on nursing staff.

In *Ashton v Alexander and Trent Regional Health Authority*<sup>295</sup> the plaintiff sustained a displaced fracture of the lower left jaw when under general anesthetic, an unerupted molar tooth was removed by hammer and chisel. The surgeon accepted that the most likely cause was either excessive force on the chisel or insufficient removal of bone from the jaw. And that would mean that he had fallen below his usual standard. On that the Recorder found negligence. However, the Court of Appeal ordered a new trial, saying that an error of judgement might or might not be negligent. The admission of a mistake does not equate with an admission of negligence and the Recorder should have gone on to ask whether the error was one that would not have been made by a reasonably competent professional person professing to have the standard and type of skill that the defendant held himself out as having and acting with ordinary care.<sup>296</sup>

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<sup>295</sup> *Ashton. v Alexander and Trent Regional Health Authority* [1988] N-J & B 154.

<sup>296</sup> *Ashcroft v Mersey A H.A.* [1983] 2 All E.R. 245, 247.

Surgery itself must be performed with the utmost care. There are many cases in which negligence is alleged when the result of surgery is not what was expected. Doctors and surgeons fall into no special category, the true doctrine was enunciated in *Bolam v Friern Hospital Management Committee* applied in *Chin Keow v Government of Malaysia*<sup>297</sup>. If a surgeon fails to measure up to that standard viz the standard of the ordinary skilled man exercising and professing to have a special skill in any respect ('clinical judgment' or otherwise), he has been negligent and should be so adjudged. There are of course some circumstances where even while exercising due care the surgeon can damage the patient. One example is the risk of damaging the spinal cord or the adjoining nerves when performing a laminectomy. This is a dangerous operation; the instruments can go too far even though the surgeon is using all possible care. Provided he was told the patient of the risks in accordance with the prevailing practice at the time he is not legally liable for his damaging act. In *Hucks v Cole*<sup>298</sup>, Lord Denning M.R. said:

With the best will in the world things sometimes go amiss in surgical operations or medical treatment. A doctor is not to be held negligent simply because something has gone wrong. He is not liable for mischance or misadventure; or for an error of judgement. He is not liable for taking one choice out of two or favouring one school rather than another. He is only liable when he falls below the standard of a reasonably competent practitioner in his field so much that his conduct may be deserving of censure or be inexcusable.

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<sup>297</sup> *Chin Keow v. Government of Malaysia* [1967] 1 WLLR 813.

<sup>298</sup> *Hucks v Cole* [1968] 118 NLJ 469

### 5.5.3.2 Post Operative Care

There are many cases in which negligence is alleged when the result of surgery is not what was anticipated. Nor does the surgeon's responsibility end with the careful completion of surgery. He must give his patient proper post-operative care and advice. In *Corder v Banks* a surgeon performed a cosmetic operation just below the eye. The doctor told the patient to inform him if bleeding occurred within 48 hours. It did and the patient tried to telephone the surgeon and got no reply. The surgeon was held to be negligent.<sup>299</sup>

The claimant in *Lavelle v Hammersmith and Queen Charlotte's Special Health Authority*<sup>300</sup> was a child who had been suffering from a serious congenital heart condition. Had the condition remained uncorrected he would have suffered brain damage or death through cyanosis, and a balloon atrial septostomy was performed in an attempt to alleviate the condition. The surgeon, who was alleged to have carried out the procedure negligently, had since died. The claimant had suffered brain damage as a result of the rupture of two of the three sheaths of the right middle lobe pulmonary vein. This had caused blood to leak into the chest cavity. The injury was severe. He was left doubly incontinent almost blind and unable to speak. He required constant care and physiotherapy. At first instance it had been

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<sup>299</sup> *Corder v Banks*, *The Times*, 9 April 1960

<sup>300</sup> *Lavelle v Hammersmith and Queen Charlotte's Special Health Authority* QBD 27 November 2000.



contended for the claimant that the surgeon although very experienced had been working under great pressure and speed when the operation was performed. However the judge had ruled at first instance after hearing the expert evidence, that negligence had not been proved. The Court of Appeal ruled that there were two equally speculative explanations of what might have happened in this case and that the trial judge had been entitled to conclude that the surgeon had relied on frontal screening when positioning the catheter so that there had been no mistaken insertion of catheter in the right middle lobe pulmonary vein. The claimant had therefore failed on the evidence to establish liability and the judge had been correct to conclude that negligence had not been established in this case. The appeal was dismissed. The defendants were found not to be liable because they had followed accepted practice in going ahead with the operation.

In *Attorney General v Madam Ho Hing –mui*<sup>301</sup> the plaintiff underwent an operation in the course of which the surgeon negligently left a surgical swab in her uterus. The plaintiff experienced great discomfort and consulted other private doctor who performed a hysterectomy for the patient. The court following *Knightley v Johns*<sup>302</sup> discussed above held the original doctor liable for the subsequent damage to the plaintiff. The court took the view that the hysterectomy was something which the defendant could reasonably have foreseen as likely

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<sup>301</sup> *Attorney General v Madam Ho Hing –mui* [1982] HKC 424.

<sup>302</sup> *Knightley v Johns*[1982] 1 All ER 851.

consequence of his own act. Thus, it can be seen that the liability of a surgeon does not end with a successful operative procedure, it also extend to a good post-operative care until the patient gain complete recovery.

#### **5.5.4 Accident and Emergency Services**

In some circumstances, it may be difficult to pin-point the exact time that the doctor assumed responsibility for the patient. It is difficult to establish when the relationship between doctor and patient begins.<sup>303</sup> To establish a duty of care as a matter of general law of negligence, there needs to be the foreseeability of harm to the plaintiff and a proximate relationship with the defendant. The duty is owed to anyone placing themselves in the hands of a medical practitioner who accepts that person as a patient. Like the biblical Pharisee, a doctor has no duty to the victim of a traffic accident whom he drives past. But if he should stop and attend to the victim, the duty would most probably arise. Once someone is admitted as a patient, a duty arises in consequence. This extends to anyone attending an Accident & Emergency Casualty Department in a Hospital.<sup>304</sup>

The existence of a duty of care in the hospital context is more likely to arise as an issue in cases where the patient presented himself to the casualty department of a

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<sup>303</sup> One view is that it will arise somewhere along the continuum which begins with the patient being at home and ends with the doctor embarking on the first 'laying on of hands'. Kennedy and Grubb *Medical Law* (Butterworths 2000)280.

<sup>304</sup> *Barnett v Chelsa & N Kensington Hospital Management Committee* [1969] 1 QB 428.

hospital for urgent treatment and was left untreated. The well-known case to consider on the requirement of proving medical negligence action is *Barnett v Chelsea and Kensington Hospital Management Committee*.<sup>305</sup> The question arose as to whether a duty had been owed to three men who had entered the Casualty Department of their local hospital on New Year's Eve, complaining of vomiting. At around 8am, the three watchmen entered the defendant's hospital without hindrance and walked into the casualty department -- which was open at that time. They made themselves and their condition known to the nurse who received them. One of the three (the deceased) appeared ill at that time and lay on some chairs in the casualty department. One of the other men told the nurse on duty at reception of their common symptoms. The nurse telephoned the casualty doctor and relayed these symptoms. The casualty doctor, himself unwell, told the nurse by telephone that they should all go home and consult their own general practitioners. One of the men subsequently died of arsenic poisoning.

There is authority for the proposition that an open Accident and Emergency Department has a duty to treat or at least assess the patient. Nield J. held that a hospital owed a duty to act vis-à-vis to a person who presented himself at the casualty department, notwithstanding that he had not yet been received by hospital in any way. The failure to act when he so presented himself was negligent. In discussing whether a duty was owed to the men, although they had not actually

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<sup>305</sup> *Barnett v Chelsea & N Kensington Hospital Management Committee* [1969] 1 QB 428.

been seen by the doctor it was said “This is not a case of a casualty department which closes its doors and says that no patients can be received”.

It would appear that the duty arises at the point when patients make their presence on the premises known to the appropriate hospital staff. It is his duty to take all reasonable actions in this particular case. A casualty officer was negligent in permitting a patient to go back home without a proper examination and investigation. In Nield J’s judgement: <sup>306</sup>

“There was here such a close and direct relationship between the hospital and the watchmen that there was imposed on the hospital a duty which they owed to the watchmen. Thus, I have no doubt that Nurse Corbett and Dr Banerjee was under a duty to the deceased to exercise that skill and care which is to be expected of persons in such positions acting reasonably.”

Medical ethics clearly requires doctors to provide medical assistance where it is needed. This reflects the vocational dimension of healthcare traditionally emphasised in successive codes of ethics and inherited concepts of beneficence.<sup>307</sup>

A patient who arrives at an Accident and Emergency Department of a hospital is probably owed a duty on being accepted for treatment. In *McCormack v*

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<sup>306</sup>*McCormack v Redpath*, *The Times*, 24 March 1961.

<sup>307</sup>Louis Waller, ‘Secrets Revealed: The Limits of Medical Confidence’, *Journal of Contemporary Health Law and Policy*. 9, 183-210.

Redpath,<sup>308</sup> a casualty officer was negligent in permitting a patient to go home without a proper examination.

## 5.6 Proving Negligence and Res Ipsa Loquitur

It may be difficult for the plaintiff to establish negligence on the part of the defendant in many personal injury cases; plaintiffs occasionally have recourse to the doctrine of res ipsa loquitur. This doctrine does not shift the onus of proof on to the defendant as is sometimes suggested. What it achieves is to raise an inference of negligence on the defendant's part.<sup>309</sup> If the defendant cannot then rebut this inference of negligence, the plaintiff will have established the case. Res Ipsa Loquitur can be applied in medical negligence cases. With this maxim, 'the thing speaks for itself' the patient can circumvent the difficulty of proving negligence and puts the burden of proof back to the doctor- 'prove your innocence if you can'. In *Ratcliffe v Plymouth and Torbay Health Authority*,<sup>310</sup> the effect of the maxim res ipsa loquitur was explained in depth after it had been examined by the Court of Appeal Hobhouse LJ said:<sup>311</sup>

"Res ipsa loquitur is not a principle of law; it does not relate to or raise any presumption. It is merely a guide to help identify when a prima facie case is being

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<sup>308</sup> *McCormack v Redpath*, *The Times*, 24 March 1961.

<sup>309</sup> *Ng Chun Pui v Lee Chuen Tat* [1988] RTR 298, PC. For discussion, J Fleming *The law of Torts* (8<sup>th</sup> edn 1992) 322.

<sup>310</sup> *Ratcliffe v Plymouth and Torbay Health Authority* [1998] PIQR P 170.

<sup>311</sup> *Strangeways – Lesmere v Clayton* [1936] 2 KB 11, [1936] 1 All ER 484;  
*Collins v Hertfordshire County Council* [1947] KB 598, [1947] 1 All ER 633.  
*Gray v Midherts Hospital Management Committee* [1974] 118 Sol Jo 501.

made out. When expert or factual evidence has been called on both sides at a trial, its usefulness will normally have long since been exhausted.”

Whether or not the standard of care has been met is a key element in deciding whether the standard of care has been violated. The media and the patients always want to see blood and no doctors dare to make their mistakes public. The Department of Health’s (DH) investigation into a suspected case of syrup medicine containing Isopropyl alcohol involving a private doctor in Tuen Mun has so far revealed that the doctor concerned had dispensed a transparent syrup (Terbutaline) for shortness of breath to six patients since March 21 this year. The DH had successfully contacted the six patients. Of these patients, only the three-year-old girl who sought medical consultation at the Accident and Emergency Department of Tuen Mun Hospital on April 20 reported to have symptoms of throat irritation after taking the syrup.<sup>312</sup> The symptoms subsided once the girl discontinued taking the syrup. The DH has provided health advice to all of the patients given the syrup, and has seized 17 bottles of the syrup which were claimed or labelled as “Terbutaline” from the clinic concerned. The syrup was subsequently tested by the Government Laboratory and samples were found to contain significant amounts of Isopropyl alcohol.

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<sup>312</sup> Fion Li, ‘Alarm as tainted syrup cases’, *South China Morning Post* ( Hong Kong 20 June 2007).

The requirement to label all dispensed medications properly and separately has been introduced for more than 10 years. The information which was required to be written down in the label has been clearly set out in paragraph 10.1 of the Professional Code and Conduct. The responsibility was on the doctor himself to ensure compliance with the requirement. Prescribing an overdose will readily be found to be negligent. If the wrong drug or the wrong dosage or a contaminated drug is used the patient's claim will generally be made. All doctors involved must act on adequate information and supply each other with adequate information. Gross medical mistakes will usually result in a finding of negligence. Use of the wrong drug or often with more serious consequences, will lead to the imposition of liability and in some of these situations the *res ipsa loquitur* principle may be applied.

An unsuccessful case to raise the doctrine of *res ipsa loquitur* was made in *Ludlow v Swindon Health Authority*<sup>313</sup> in which it was stressed that the plaintiff had to establish facts which would give rise to an inference of negligence. In this case the plaintiff claimed to have regained consciousness during a caesarean section operation and to have experienced intense pain. The plaintiff failed however to establish that the pain arose at a stage during which halothane should have been administered; there was accordingly no inference of negligence in the administration of an anaesthetic. In general there is a marked reluctance on the part

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<sup>313</sup> *Ludlow v Swindon Health Authority* [1989] 1 Med LR 104.

of the courts to apply the *res ipsa loquitur* principle, and this is certainly evident in medical negligence cases. As Megaw LJ said: <sup>314</sup>

“If one were to accept the view that negligence was inevitably proved if something went wrong and it was unexplained, few dentists doctors and surgeons however competent, conscientious and careful they might be would avoid the totally unjustified and unfair stigma of professional negligence probably several times in the course of their careers.”

In a case of neurological damage following difficult aortography the plea of *res ipsa loquitur* was rejected on the grounds that the injury sustained was of a kind recognized as an inherent risk of the procedure. The Canadian case of *MacDonald v York County Hospital Corpn*<sup>315</sup> provides a further example. In this case the plaintiff was admitted to a hospital for treatment of a fractured ankle and left with an amputated leg. All the requirements of *res ipsa loquitur* were present: a leg is not usually lost in such circumstances unless there is negligence; the plaintiff was not able to explain what had happened nor was the defendant; and the plaintiff had identified the doctor whose negligence must have been responsible for the injury. It applies only where the plaintiff is unable to identify the precise nature of the negligence which caused his injury and where no explanation of the way in which the injury came to be inflicted has been offered by the defendant. *MacDonald*

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<sup>314</sup>*Fletcher v Bench* [1973] unreported CA cited in [1973] 4 BMJ 117.

<sup>315</sup>*MacDonald v York County Hospital Corpn* [ 1972 ] 28 DLR (3d) 521.



followed the pattern of the early English case of *Cassidy v Ministry of Health*<sup>316</sup> in which the plaintiff went into hospital for an operation to remedy Dupuytren's contracture and came out with four stiff fingers. Denning LJ expressed the view that the plaintiff was quite entitled to say: <sup>317</sup>I went into hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. That should not have happened if due care had been used. Explain if you can.

Although the burden of proving negligence rests with the plaintiff however there are circumstances that the courts are prepared to infer from the facts that the defendant has been negligent. Erle, CJ said in the leading case of *Scott v London and St Katherine Docks Co*: <sup>318</sup>

“There must be reasonable evidence of negligence. But where a 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.”

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<sup>316</sup>*Cassidy v Ministry of Health* [1951] 2 KB 343, [1951] 1 All ER 574, CA.

<sup>317</sup>[1951] 2 KB 343 at 365, [1951] All ER 574 at 588. Other medical cases in which *res ipsa loquitur* has applied include: *Saunders v Leeds Western Health Authority* [1984] 129 Sol Jo 225  
*Cavan v Wilcox* [1973] 44 DLR (3d) 42 and *Homles v Board of Hospital Trustees of the City of London* [1977] 81 DLR (3d) 67.

<sup>318</sup>*Scott v London and St Katherine Docks Co* [1865] 3 H & C 601.

Nevertheless, the value of *Ratcliffe v Plymouth and Torbay Health Authority*<sup>319</sup> in a medical negligence claim must not be exalted. Expert evidence is needed to establish that what happened does not ordinarily occur if proper care is taken. *Res ipsa loquitur* is usually invoked in cases involving failure to remove instruments or swabs after surgery. Two relatively early medical negligence cases in which the principle was invoked are *Roe v Minister of Health*<sup>320</sup> and *Cassidy v Ministry of Health*<sup>321</sup>. In *Roe* the plaintiffs were paralysed during the course of surgery due to the contamination of their anaesthetic by phenol: the latter had seeped through invisible fissures in the glass storage vessels in which the anaesthetic was stored. Once again Lord Denning offers some hope to the patient who can show that there has been negligence but cannot identify the negligent actor. Lord Denning LJ has said this:

“ .... I do not think that the hospital authorities and the doctor can both avoid giving an explanation by the simple expedient of throwing responsibility on to the other. If an injured person shows that one or other or both of two persons injured him, but cannot say which of them it was, then he is not defeated altogether. He can call on each of them for an explanation.”

Although *res ipsa* will not be applied automatically there are cases where the injuries sustained by the patient are of such a nature that there is an inescapable

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<sup>319</sup> *Ratcliffe v Plymouth and Torbay Health Authority* [1998] PIQR P170.

<sup>320</sup> *Roe v Minister of Health* [1954] 2 Q.B. 66.

<sup>321</sup> *Cassidy v Ministry of Health* [1951] 2 KB 343, [1951] 1 All ER 574, CA.

inference of negligence. In *Mahon v Osborne*<sup>322</sup> where the surgeon was sued when a swab was left inside the patient the court held that the patient could know nothing about swab procedures in the operating theatre and it was therefore for the surgeon to show that he exercised due care to ensure that the swabs were not left behind. The Court of Appeal was of the view that the principle did not apply in the case of a complex operation where a number of medical staff took part, but it is clear that the correct view was that taken by Goddard L. J. when he said:

“There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient’ body .... If therefore a swab is left in the patient’s body it seems clear that the surgeon is called upon to show, not necessarily why he missed it but that he exercised due care to prevent its being left there.”

Here are a number of possible events. For instance, a patient suffers post-operative convulsion after an appendectomy. Was the convulsion due to mis-management? Whether a patient’s eardrum ruptures due to mishandling of ear syringing? Whether the sciatic nerve is damaged due to a poor technique of gluteal injection? In an action for negligence, it was admitted that it must be proved that the doctor was in breach of the appropriate level of skill and competency imposed by the law.

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<sup>322</sup> *Mahon v Osborne* [1939] 2 KB 14, [ 1939] 1 All ER 535, CA.

## **CHAPTER 6 BREACH OF DUTY WHICH LEADS TO THE PHYSICAL OR PSYCHOLOGICAL INJURIES (CAUSATION)**

### **Chapter Summary**

The third element in a negligence action is causation which must be proved. Moreover there must be some actual loss or injury which has resulted from the careless act or omission. Causation in the context of medical negligence cases would seem to be especially complex and problematic. Plaintiffs in a medical negligence claim are not like a motor vehicle accident victim who was 'normal' before and now because a negligent driver ran a red light, finds him or herself in a wheelchair. People consulting doctors or hospitals already have an injury or a disease. This is because the etiology of medical conditions is often unclear and the situation will often be complicated by the presence of an underlying illness or other pre-existing vulnerabilities. This chapter discuss the "But For" test which form the foundation of causation and the practical consideration needed when applying the principle of causation.

Causation is tremendously important in medical cases and always needs careful consideration. In determining causation, the law employs two tests. The first test is the "but for" test.<sup>323</sup> In order to ascertain causal relation, the patient should have suffered the damage but for the negligence of the doctor. The courts would often use the 'but for' test, where the question asked is "Would the claimant have

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<sup>323</sup> *Barnett v Chelsea & Kensington HMC* [1969] 1 QB 428.

suffered the injury but for the negligent act of the defendant?” This is best exemplified by Nourse LJ in *Fitzgerald v Lane*<sup>324</sup> when he said: ‘a benevolent principle smiles on these factual uncertainties and melts them all away.’ The second test is the test of the balance of probabilities. The law requires that there be a more than a 50% chance that the patient has suffered the damage because of the negligence of the doctor. The burden of proof lies with the plaintiff who must prove the case on the balance of probabilities (51% or more).<sup>325</sup> If the chance of cure would have been more than 50%, but because of the missed diagnosis, the chance has been reduced to a percentage below 50%, the patient can claim compensation. If, however, the chance of cure was already below 50% even before the missed diagnosis, the patient cannot claim compensation although the chance of cure has been reduced from 35% to 10% as a result of the missed diagnosis. In order to establish medical negligence, the patients must also prove that she/he was owed a legal duty of care by the defendant (health care provider). The plaintiff in a negligence action has to prove on the balance of probabilities that the acts or omissions complained of were a breach of the legal standard of care owed to him, he must also establish on the balance of probabilities that the resulting damage was occasioned by the breach. The breach of duty caused or materially contributed to the damage suffered and the damage was not ‘too remote’ in legal terms. The claimant has the legal burden of proving each of the above elements on a balance of probabilities and the entire claim will fail unless the claimant succeeds at every

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<sup>324</sup> *Fitzgerald v Lane* [1989] AC 328.

<sup>325</sup> *Hotson v. East Berkshire Health Authority* [1987] AC 750, CA.

point.<sup>326</sup>

Causation remains a thoroughly complex issue. What can the doctor do to defend himself? We need to understand the three basic principles by which the doctor is judged whether he is guilty of malpractice or not: (1) Lost Opportunity Causation, (2) Unrelated Factor and (3) Material Contribution Causation. If the medical condition is such that the outcome is uncertain even with good treatment, the doctor does not have a case to answer.

### **6.1 The “But For” Test**

The usual starting point for establishing causation is to apply the ‘but for’ test. The patients must prove that but for (without) the negligence, they would not have suffered the injury for which they are claiming. In *Barnett v Chelsea & Kensington HMC*<sup>327</sup>, a man accidentally drank arsenic and some hours later, he was sent to the Accident and Emergency Department. He was discharged home and died. In the judgment of this case, “...the ingestion of the arsenic had been a sufficiently long time beforehand to have meant that a stomach washout, or any other treatment for that matter, would have been to no avail. The patient would have died in any case.” The widow’s case failed on causation. As it was proved that the plaintiff would

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<sup>326</sup>Alan Merry and Alexander McCall Smith *Errors, Medicine and the Law*.( New York :Cambridge University Press, 2001).

<sup>327</sup>*Barnett v Chelsea & Kensington HMC* [1969] 1 QB 428.

have died whatever course of action the defendant had pursued (there was no chance of a cyanide antidote being administered in time). In these circumstances, medical negligence may not be established, as no possible medical treatment could have saved the patient. This 'but for' test operates as a preliminary filter to exclude events which did not affect the outcome; it cannot however resolve all problems of factual causation. As Fleming describes the 'but for' test as "...the defendant's fault is a cause of the plaintiff's harm if such harm would not have occurred without (but for) it".<sup>328</sup> The common sense approach means the 'but for' test is no longer the exclusive test used to causation. The application of the 'but for' test<sup>329</sup> is tempered by reference to value judgements and matters of policy. The need for such tempering is highlighted in claims involving several tortfeasors.

In Hong Kong, although the clinical significance of SARS epidemic which occurred in 2003 seems to be waning its legal implication is only beginning to unveil. The legal difficulty facing any SARS victim seeking compensation is that the victim has to establish that but for the negligence of the defendant, the plaintiff's injury or damage would not have occurred. In a Hong Kong case, a lawyer, Frankie Chu Hei Tak has been infected by SARS which he was admitted to Tseung Kwan O Hospital. His widow claims that her husband was only given anti-viral, steroid combination treatment belatedly. Her husband did not receive Ribavirin and Methylpredisolone until his sixth day in the hospital. One question is raised whether a reasonable

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<sup>328</sup>Fleming J. *The Law of Torts* (8<sup>th</sup> edn The Law Book Company , Sydney ) 1924.

<sup>329</sup>*Chappel v Hart* [1998]156 ALR 517.

doctor would have started the SARS antiviral-steroid treatment immediately after the admission of the lawyer to hospital for the benefit of the patients.<sup>330</sup> However, in dealing with newly emerged infection like SARS where no one has experience, it is impossible to hold certain defendants liable for death or serious health consequences suffered by a plaintiff because SARS was an unpredictable virus with no evidence based treatment, and it is even more difficult to prove that the omission of treatment directly contributed to the death of the patient.

Causation is no longer determined by applying a mere formula. Rather it must be considered from a common sense approach of value judgements and the facts of each case. As held by Hunter J.A. in the case of *Lee K.K. v Ocean Tramping Co. Ltd*, causation is essentially a matter for the judge, not the doctors. He is assisted by medical evidence but not dictated by it. Furthermore, law and medicine apply different standard as the former rely on and use of common sense.

## **6.2 Legal versus Medical Causation**

### **6.2.1 Bolitho v Hackney Hospital Authority**

Bolitho is an important case because their Lordships discuss many of the legal principles constituting negligence including causation.<sup>331</sup> The ‘but for’ test further

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<sup>330</sup>Srivastava D. ‘SARS in the HKSAR: Some Important Legal Issues’.(July 2003) Hong Kong Lawyer.

<sup>331</sup>*Bolitho v Hackney Hospital Authority* [1988] AC 232, HL.



demonstrated in *Bolitho v Hackney Hospital Authority*,<sup>332</sup> a child had a breathing problem was readmitted to hospital under the care of Dr H and Dr R. The boy suffered two short episodes with difficulty in breathing. On both occasions, the nurse on duty called the doctor on her pager, but the doctor did not come and the child suffered brain damage and died. His mother continued his proceedings for medical negligence as administrator of his estate. The Hackney Health Authority argued that even if the doctor visited the child at once, she would have recommended no treatment and the child would have died anyway. The court was prepared to accept that the omission could be treated as a cause of the death (on the facts it was held not so), and that in such a case, the determination of whether or not particular treatment or failure to treat was a cause should be determined by reference to a body of respected professional opinion.<sup>333</sup> The Court of Appeal by majority dismissed an appeal by the patient's mother and she appealed to the House of Lord. The House of Lords (per Lord Browne –Wilkinson) unanimously agree that:<sup>334</sup>

“In cases of diagnosis and treatment, there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence because in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible”

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<sup>332</sup> *Bolitho v Hackney Hospital Authority* [1988] AC 232, HL.

<sup>333</sup> *Bolam v Frien Hospital* [1957] 1 WLR 582.

<sup>334</sup> *Bolitho v Hackney Hospital Authority* [1988] AC 232, HL

Causation as defined by law is often a difficult concept for medical practitioners. Doctors' ideas of medical causation are based on different factors and may include their analysis of symptoms and signs, reference to appropriate articles in learned journals, and the drawing of inferences regarding a sequence of highly probable events. This process leads the doctor to a logical conclusion that fits the medical facts.<sup>335</sup> For example, a doctor might reason that the administration of intravenous adrenaline in error caused acute hypertension and cardiac dysrhythmia such that myocardial demand outstripped supply which resulted in acute myocardial infarction and death. Bolitho demonstrates the importance and value the Court places on expert medical opinion in reaching a decision in cases of medical negligence. The judge is entitled to prefer 'one respectable body of professional opinion to another', but for expert opinion to be rejected by the court, it has to be found 'not capable of withstanding logical analyses or irresponsible, unreasonable, and not respectable. It is because of the reliance of the Court places upon medical expert evidence that it is vital that the medical profession graciously and honestly continues to provide this important and vital service to the Hong Kong public.

### **6.2.2 The 'Lost Opportunity' Causation**

So far the discussion has focused on claims that the injuries suffered were 'new' in the sense that even though patients needed treatment for some existing illness or

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<sup>335</sup>Malcom Khan, Michelle Robson, Kristina Swift. *Clinical Negligence*. (Cavendish Pub, London 2002).

condition, it was the defendant's action which caused fresh or additional harm. The outcome is uncertain even with good treatment the doctor does not have a case to answer. These so called 'lost opportunity' cases are especially problematic for plaintiffs because they cover cases where a cure is uncertain despite proper treatment. In *Hotson v East Berkshire Health Authority*,<sup>336</sup> the claimant was a boy who broke his hip when he fell out of a tree. The defendant hospital negligently failed to diagnose the fracture for 5 days. The hip joint was irreparably damaged by the loss of blood supply to its cartilage. The court found that the fall had caused such damage to the blood vessels that there was only a 25% chance that enough had remained intact to save the joint even if there had been no delay in diagnosing the fracture. On this basis, compensation was refused. The legal burden is on the claimant to prove on a balance of probabilities that the defendant's negligence caused the injury or lack of improvement in the medical condition that is suffered. The claimant could not establish that it was more than 50% likely that 'but for' the delayed treatment he would have fully recovered. This was because there was a 75% chance he would have suffered from avascular necrosis even if he had been properly treated when he first attended hospital. This means that it is for the claimant to establish that there was a 51% likelihood that the breach of duty had caused or materially contributed to the injury. The court held that the boy was without a remedy. As Lord Ackner stated:

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<sup>336</sup> *Hotson v. East Berkshire Health Authority* [1987] AC 750, CA.

“the plaintiff was not entitled to any damages in respect of the deformed hips as the judge had decided that this was not caused by the admitted breach by the authority of their duty of care but was caused ... when he fell some 12 feet from a rope on which he had been swinging.”

The *Mc Grath v Cole*<sup>337</sup>(1994) case exemplifies this legal point. A young woman with pelvic infection was treated as urinary tract infection on a succession of visits to the GP who did not refer her to a Gynaecologist. The patient was eventually rendered sterile. The legal analysis is as follows. Problem was not obvious in early phase and hence no negligence or responsibility on the part of the doctor. However in the intermediate phase where appropriate management would probably have secured a better outcome. Better and early recognition could have made the difference and negligence is likely! But in the late phase, the negligence continued but the damage was complete, such that even with appropriate management the outcome would have been no different. However the plaintiff needs two expert witnesses to convince the judge that the period of consultation falls within the intermediate phase - 'the window of opportunity'. Then one can presume negligence and causation coincided.

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<sup>337</sup>Dr Li Chi Him. 'Medical Negligence and Profession Misconduct' (2002) September The Education Bulletin of the Hong Kong Paediatric Society No 5.

### 6.2.3 Several Possible Causes

There might have been several possible reasons for the patient's particular mishap which he suffered while in hospital under the doctor's care. Here, the court would have to ask: whether the defendant's breach of duty a necessary element in the chain of causation? Whether the defendant's conduct exposed the plaintiff to an added risk of harm? The next important decision of the House of Lords on causation was *Wilsher v Essex Area Health Authority*<sup>338</sup>, a junior doctor in a special care baby unit negligently put a catheter in the wrong place so that a monitor failed to register that a premature baby was receiving too much oxygen. The baby suffered retrolental fibroplasia ("RLF"), resulting in blindness. The excessive oxygen was a possible cause of the condition and had increased the chances that it would develop but there were other possible causes: statistics showed a correlation between RLF and various conditions present in the baby. But the causal mechanism linking them to RLF was unknown. There were five possible causes for the condition with which the plaintiff was afflicted. The Court refused to award compensation for the reduction in the chance of a favourable outcome. It was not proved on a balance of probabilities that the excessive oxygen caused or substantially contributed to the injury. It has been argued that if the chance of cure is reduced, even though the balance of probabilities is not affected, the patient has still suffered a loss which ought to be compensated for. In other words, with so many potential competing causes, the plaintiff lost his case for the simple reason that his condition could have

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<sup>338</sup> *Wilsher v Essex Area Health Authority* [1983] 1 All ER 416

resulted from any one of a number of different causes.

In *Ng Yuk Ha v Yip Siu Keung*,<sup>339</sup> a claim was brought against a medical practitioner for surgery on a neck mass in ST. Teresa's Hospital. Post-operatively the plaintiff suffered from a stroke with permanent brain damage with right sided weakness. The claim against the Defendant is that he failed to appreciate the risks that prolonged surgery manipulating a big tumour and dissecting it off the outer wall of the internal carotid artery was liable to temporarily obliterate the arterial lumen or cause spasm which renders post surgery occlusion of the artery lumen likely to occur. Expert opinion was sought and it was concluded that there was no prove of causal relationship between the surgery and stroke, as multiple factors including increased viscosity of blood, change in platelet adhesiveness and simple operative stress may contribute to the disaster. Upon occasion in the past, where no specific negligence could be pointed to claims were brought on the basis that the treatment must have been incorrectly administered leading to adverse outcome. In the current state of negligence claims, such a claim is liable to be stuck out for a lack of specificity.

Another factor that needs to be considered is to ascertain how much of the amount of damage can be attributable to the fault of the defendant. In *McGhee v National*

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<sup>339</sup> *Ng Yuk Ha v Yip Siu Keung* [2005] 969 HKCU 1.

Coal Board,<sup>340</sup> an employee of the defendant brought an action alleging that his dermatitis had come about because of the coal board's failure to provide him with proper washing facilities. This meant that he had to cycle home with the brick dust to which his work unavoidably exposed him. Applying *McGhee*, the trial court and the Court of Appeal decided in favour of the plaintiff as the plaintiff had established a breach of injury on the defendant's part that the defendant's conduct materially contributed to the harm suffered. After a detailed review of *McGhee's* case, Mustill LJ concluded that:

“If it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue, and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself in that way, and if the other party does suffer injury of the kind to which the risk related, then the first party is taken to have caused the injury by his breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained. ”

*McGhee* was approved in *Clark v MacLennan*<sup>341</sup> which held that where there was a precaution which could have been taken to avoid the precise injury which occurred. The defendant then had to prove that his failure to take his precaution did not cause the plaintiff's injury. In view of the above two cases, it is suggested that

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<sup>340</sup> *McGhee v National Coal Board* [1973] 1 WLR1.

<sup>341</sup> *Clark v MacLennan* [1983] 1 All ER 416.

the claimant has a better chance of success if the potential causes are inseparable as in McGhee. The situation suggests that there may be a distinction between cases in which there is a set of separate causes of the damage as in Wilsher. Nevertheless, the claimant will usually succeed in establishing causation if it can be proved that the act of negligence was sufficiently significant to be taken into account as a potential cause.

#### **6.2.4 'Material Contribution' Causation**

Any contribution to the injury which is not negligible may be taken to have 'materially contributed' to the injury. In McGhee, it was held that "A defender was liable in negligence to the pursuer if the defender's breach of duty had caused, or materially contributed to the injury suffered by the pursuer notwithstanding that there were other factors, for which the defender was not responsible, which had contributed to the injury. Accordingly the respondents were liable to the appellant." Nevertheless, the House of Lords took the view that the defendant employers were liable because the lack of washing facilities at work could certainly have increased the risk of dermatitis. The claimant had succeeded in proving that the breach of duty made the dermatitis more likely. The definitive element in the decision is that the defendants' conduct materially contributed to the plaintiff's condition even if it did not cause it. McGhee was also applied in *Chan Yik Kwan v Yuen Chak Man &*



Anor<sup>342</sup>, but in this case the plaintiff did not succeed. In this case an altercation had occurred between the plaintiff and the defendant after the defendant was reversing his vehicle for parking. It hit the plaintiff and caused minor physical injuries. The plaintiff claimed a rise in his blood pressure followed by a stroke. The plaintiff lost the case as the cause is impossible to identify or prove even on a balance or probabilities. The court was not convinced that the defendant's negligence materially contributed to the plaintiff's illness. In these circumstances, the patient's claim for medical negligence will only succeed and may result in full compensation if the alleged negligence of the doctor can be proven to have materially contributed to the injury suffered by that patient.

In the Scottish case of *Kay v Ayrshire and Arran Health Board*,<sup>343</sup> a child with meningitis was negligently given a substantial overdose of penicillin. On his recovery he was found to have become deaf. In a subsequent action for damages the plaintiff contended that, although there was no recorded case of deafness resulting from an overdose of penicillin, and although deafness is a common consequence of meningitis, nonetheless the overdose had created an increased risk of neurological damage and thus materially contributed to the deafness. The House of Lords held that where there were two competing possible causes of damage, it could not be presumed that the defendant's act materially contributed, in the absence of proof, to be actually capable of causing such damage, since there was no expert evidence of

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<sup>342</sup> *Chan Yik Kwan v Yuen Chak Man & Anor* [2000] 1 HKLRD A19.

<sup>343</sup> *Kay v Ayrshire and Arran Health Board* [1987] AC 1074.

cases where a penicillin overdose had caused deafness. The court held that the overdose could not be held to be a contributing factor to this condition whereas meningitis commonly did, even when properly treated. As a result the law regarded the deafness as being solely caused by the meningitis.

Whether or not the proven negligence can be shown to be the cause or to have materially contributed to the adverse clinical outcome, is the issue with which the law is concerned. In *Whiteford v Hunter*,<sup>344</sup> the defendant in this case had diagnosed carcinoma of the bladder, however a diagnosis which was subsequently found to be incorrect. A surgeon was found negligent in failing to use a special cystoscope and in failing to request microscopic examination, but the Court of Appeal determined that there had been no negligence in that the surgeon had followed a course approved by a responsible body of the profession. An important question was whether the defendant doctor should have used a cystoscope: he did not have one in his possession and it would have been difficult to obtain one. The court found that there was no negligence in the misdiagnosis, holding that the defendant had used methods which were in common use at the time. It must be determined whether a doctor's negligence is sufficiently likely to have caused the damage to justify compensating the patient.

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<sup>344</sup> *Whiteford v Hunter* [1950] W. N. 553; 94 S. J. 758 H. L..

### **6.3 Novus Actus Interveniens**

An intervening act or event occurring after the original act of negligence may operate to break the chain of causation with the result that the wrongdoer is not liable for loss caused by that event. There is no clear test to decide whether an act which may be of a third party or of the plaintiff himself, and may be lawful or unlawful, voluntary or involuntary, will break the chain of causation. The most useful test is to ask whether the act was reasonably foreseeable at the time of the original negligence. If the defendant ought reasonably to have anticipated such intervention and to have foreseen that he would be liable. The defendant cannot argue that a nurse who is injured was injured by a new cause when the management does not provide any protection against attacks by unstable psychiatric patients. Although a well-established principle of tort law which is usually known by its Latin tag of ‘novus actus interveniens’ (meaning a new act intervening), the courts have been very reluctant to allow defendants to take advantage of it in medical negligence cases.

In *A-G v Ho Hing Mui*,<sup>345</sup> the defendant surgical staff performed a sterilization operation on the plaintiff. The medical team negligently failed to remove a surgical swab from the plaintiff’s wound following the operation. Later, complaining of pain, the plaintiff consulted another physician who misdiagnosed her condition and performed an unnecessary hysterectomy. The Hong Kong Court of Appeal followed

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<sup>345</sup> *A-G v Ho Hing Mui* [1982] HKC 424.

the approach taken in *Knightley v Johns*<sup>346</sup> that proof of negligence on the part of the intervener was not conclusive on the question of *novus actus interveniens*, but that a negligent act was more likely to be a *novus actus* than a non-tortious one. The Court of Appeal took the view that the hysterectomy was something which the defendant could reasonably have foreseen as likely consequences of his own act. It was therefore not a *novus actus*. This later event (misdiagnosis and hysterectomy) was held not to break the chain of causation. The original defendant doctor should have foreseen that a doctor would be called upon to put the matter right. The original wrongdoer was held liable for the damage, including the hysterectomy. On the contrary in *A-G v Yiu Yun*<sup>347</sup>, the defendant doctor performed a gall operation on the plaintiff, the operating team failed to remove swab from her body. The plaintiff consulted a private doctor on many occasions with respect to her pain after the operation. However, the doctor could not find out the cause of her pain. After 20 years, the true cause of her pain was found by another private doctor. The Court of Appeal held that the private doctor's failure to reach the standard expected of him was so serious. It is important to note that the negligent intervention by the third party was so unreasonable so as to eclipse the original wrongdoing of the defendant. Here the failure by one of the plaintiff's doctors to detect the swab on the X-rays was found to be so unreasonable as to constitute a *novus actus interveniens*, breaking the chain of causation. It is important to note that the negligent intervention by the third party was so unreasonable so as to eclipse the original

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<sup>346</sup> *Knightley v Johns* [1982] 1 All ER 851.

<sup>347</sup> *A-G v Yiu Yun* [1990] 2 HKC 238.

wrongdoing of the defendant.

#### **6.4 Causation and Remoteness of Damage**

Establishing causation of medical negligence may prove difficult at times. Normally, the defendant will be liable for all of the damage resulting from his / her negligent act. However, in some cases, some or all of the damage may be seen as “too remote” and therefore will not be shifted to the defendant. The defendant may still avoid liability if it can be shown that the breach of the duty was not the legal cause for the harm and hence too remote from the actual damage.

Causation or remoteness of damage was an important issue in *Wong Wai Ming v The Hospital Authority*<sup>348</sup> where the defendant Hospital Authority argued that even if safety precautions such as a protective screen and an emergency button had been installed, the plaintiff receptionist would have been injured by the intruder’s corrosive acid anyway, because he would have left the reception counter to help others. In the event, the defendant’s argument did not persuade the Court of Appeal. That court affirmed the trial judge’s decision that causation was proved. Nevertheless, where one employment happens to be more dangerous than the other, a greater degree of care should be taken and the employer cannot eliminate the risk. The Hospital is required to take necessary precautions in order to alleviate accidents as far as possible. In *Gregg v. Scott*,<sup>349</sup> the claimant developed a lump under his

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<sup>348</sup> *Wong Wai Ming v The Hospital Authority* [2001] 3 HKLRD 209, CA.

<sup>349</sup> *Gregg v. Scott* [2005] 2 AC 176.

left arm. He attended the Defendant general practitioner and was advised that it was a benign collection of fatty tissue and that no treatment was needed. A year later, the claimant saw another general practitioner who referred him to a hospital for examination of the lump. It was diagnosed that the lump was non-Hodgkin's lymphoma. By that time, the tumour had spread into the claimant's chest. Treatment led to a remission in the condition but the claimant suffered a relapse and after further treatment, a second relapse. The claimant claimed compensation against the first general practitioner for the missed diagnosis. In some situations, if there is an unbroken chain of events between the original act of negligence and the damage, the person responsible for the first act will be liable for a large percentage of the damage. Sometimes liability may be apportioned between two or more defendants while several different individuals are involved in causing the damage especially in cases where the claimant was injured in an accident and then received negligent medical treatment.

In *Re Polemis*<sup>350</sup> and *The Wagon Mound* <sup>351</sup>( No 1 ), the court confirmed that there must be some foreseeability of the damage for negligence to arise. It is suggested

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<sup>350</sup> *Re Polemis* [1921] 3 K.B.560.

<sup>351</sup> *The Wagon Mound ( No 1 )* [1961] AC 388 PC. *The Wagon Mound* (No 1) postulates that the type or kind of harm must be reasonably foreseeable (it does not matter whether the extent is foreseeable). From the facts of this case, it can be inferred that damage by fire is not of the same kind of damage as other types of physical damage such as that caused by fouling by oil . However, on what basis is such a distinction to be made? Are they not both classifiable as property damage? At what level of abstraction should the distinction be made? Are they not both classifiable as property damage? When will damage be characterised as the same kind as that which was reasonably foreseeable? For instance, is personal injury a "kind" of damage, or is it to be sub-divided into types of personal injury?

that the damage complained of must be a direct and reasonably foreseeable consequence of the plaintiff's act. In this case the charterers were liable. The case shows that the specific kind of damage need not be foreseeable; the fact that some damage was foreseeable is sufficient. Here the stevedore should have foreseen that the dropping of the plank would result in some damage; the point that he could not have reasonably foreseen was not legally relevant. It does not matter that the extent of damage or the manner or infliction of damage were not foreseeable. The test requires that for damage to be recoverable, it must be the type of damage which was foreseeable as the result of the defendant's act. Consequently when determining types of medical injury, the courts have generally been more ready to accept that if some type of injury is foreseeable, then a similar type of injury is recoverable. As a result, the rejection of the *Re Polemis*' direct consequences' test and the adoption of the *Wagon Mound* 'foreseeability of type of damage' test has not made a great difference to the likely success of plaintiffs' claims. For instance, in the case of *Robinson v Post Office*,<sup>352</sup> a doctor was found to be negligent in not administering a test dose of an anti-tetanus serum before injecting a patient with it who had cut his leg. The claimant was injured at work as a result of negligence, and was later given an anti-tetanus injection by a doctor. The patient suffered a serious allergic reaction to the injection and developed encephalitis which led to brain damage and paralysis. The Court of Appeal said that the question (on this issue) was whether the negligence of the doctor 'had caused or materially contributed' to the plaintiff's

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<sup>352</sup>*Robinson v Post Office* [1974] 2 All ER 737.

injury and that the onus was on the plaintiff of proving on the balance of probabilities that it had. The Court of Appeal said that the judge had been right to conclude on the evidence before him that even if the test dose had been administered there would have been no observable reaction in the patient and that therefore the doctor would in any event have gone on to administer the injection. So the injury would have happened anyway. As Professor Fleming noted: “ Causation has plagued courts and scholars more than any other topic in the law of torts ”<sup>353</sup>

Causation is usually a more significant problem in healthcare negligence cases than in other cases involving personal injuries. The upshot of it all is that legal practitioners intending to practice in the area of medical negligence need to remain vigilant in their understanding of this area of law. Causation is an evolving area where subtle changes continue to alter our perception both of the civil standard of proof and our assessment of the causal nexus between breach and damage. Medical defendants and their respective Medical Defence Organisations are no doubt buffeted to some extent by the causation hurdle.

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<sup>353</sup> Fleming J, *The Law of Torts* (8<sup>th</sup> edn The Law Book Company , Sydney 1992) 192.



## **CHAPTER 7 MEDICAL LITIGATION & CLAIM FOR COMPENSATION**

### **Chapter Summary**

Most of the medical negligence cases end up in claim for damages with compensation awarded after litigation. The prevalence of medical negligence in Hong Kong can be appreciated from the statistic quoted by Medical Protection Society and Medical Council of Hong Kong. The statistics on disciplinary cases handled by the Medical Council showed a significant increase from 287 cases in 2002 to 465 cases in 2006. In the interview we conducted, the issues cited most frequently by physicians were the costs of malpractice insurance and lawsuits. Between 1994 and 2004, Government figures show that the quantum of damages awarded in individual cases in Hong Kong rose rapidly. During the period there was a 30% increase in the number of litigation cases involving medical malpractice. As can be seen, there is a general trend of increase in the number of claims in recent years in Hong Kong. This liberal and comprehensive insurance coverage for Hong Kong practitioners comes with a price. As the value of the claims influences the premium rates, doctors face increases of up to as much as 90 percent in insurance premiums due to the escalating amount of negligence claims. Obstetrics and Gynaecology (O&G) are ultra high risk specialities as witnessed by the increasing number of medical legal claims and rising compensation to clients. Naturally the insurance premium paid by O&G practitioners is the highest among all specialities and will be increasing further to cope with the rising number of claim and the high

pay out in each case, sometimes in term of 20 million. The rise in the number of claims also plays a part. The Medical Protection Society data showed that among the 200 cases of medical malpractice in Hong Kong in 2004, about 40 cases involved claims for compensation of more than HK\$1 million, and more than a dozen of those cases involved claims exceeding HK\$10 million. Also, there is an increase in both the defence costs and indemnity cost from claims in recent years.

And indeed, in this chapter, we look at the actual process of litigation and explain how damages are calculated in cases of medical negligence. The limitation of prosecution, the role of Medical Protection Society and alternative to litigation by Alternative Dispute Resolution through mediation are included in this chapter. For any claim to be substantiated, it must be proved that the doctor was in breach of the appropriate level of skill and competency imposed by the law. The plaintiff must have actually suffered some degree of harm from the physician's carelessness.<sup>354</sup> Lastly, the patient must prove that the doctor's mismanagement caused damage, one that is recognised by law as meriting compensation.

The use of Tort Law in assessing medical negligence is well established and helps to uphold justice in this field. However, the tort system of compensation for medical injury is often criticized as unfair, expensive, complicated and an obstacle to patient

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<sup>354</sup> Dr T Thirumoorthy, 'Understanding the basis of medical negligence'. (2006 ) May Medical Grapevine30.

safety. A “no fault” system<sup>355</sup> which is practiced in part of USA, New Zealand, Sweden and Finland is proposed as a remedy. Under this system, patients are compensated for avoidable medical injury without the need to prove negligence. An advisory panel assesses whether an avoidable injury was caused by health care and compensation is set according to agreed tariff. Thus, patients may be compensated quickly and fairly while trust and openness between doctor and patient is also reinforced. There are several arguments in favour of implementing a no-fault compensation system to replace civil court actions following alleged medical negligence. Any increase in rates of litigation is said to lead to the practice of so-called ‘defensive medicine’ – a term given to medical practises employed out of fear of litigation. For this reason, it is advantageous to patient care to minimise litigation rates. Furthermore, it is claimed that civil law is ineffective as a deterrent, because vicarious liability means the employer is sued rather than the individual. This argument was put forward by the Woodhouse Commission in New Zealand, which set in place the system in that country. The burden of proof is an obstacle for patients because it rests on establishing that a usual and reasonable practice exists, that it was not followed and no reasonable practitioner would have acted as the defender did. The role of expert evidence in examination, cross-examination and re-examination leads to time-consuming and complex cases. Medical negligence actions are uniquely difficult because biological information is intrinsically variable and unpredictable. This is problematic in the context of behaviour assessed on the

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<sup>355</sup>George Coppola, ‘Medical Malpractice- No Fault Systems’. (December 8, 2003)OLR Research Report.

basis of standard practice in the context of an inherently unpredictable situation. Split-second decisions are often the norm in medical practice, unlike other professional negligence fact scenarios. Damages awards are generally high and the problem exists of compensating for future loss (disability worse than expected, problems with prognosis, calculating potential income, etc.), except where an award for provisional damages is made. A non-fault system can allow for periodic, adjustable payments.<sup>356</sup> Although Hong Kong has implemented no-fault compensation schemes for workplace injuries, this does not apply to medical negligence cases nor does it signal a developing trend, and current formulations for tort liability will continue to require proof of fault as the determining criterion. This means that the process for obtaining compensation will inevitably be expensive, time-consuming and uncertain in the result. In Hong Kong, a typical tort action that proceeds to trial will take at least three or four years from date of accident to conclusion. Certainly, many other tort actions will be settled before trial. Nevertheless, many victims will not sue at all due to the difficulties inherent in our fault-based system. While the “no fault” system may be helpful to victim in whom compensation is justified, it has the danger of being abused by patient and stringent supervision by a committee with the necessary expertise is essential. As the system become more mature and sophisticated, it may be adopted for medical negligence cases in Hong Kong in the future.

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<sup>356</sup> Studdert DM, Brennan TA, ‘No-fault compensation for medical injuries: the prospect for error prevention’ (2001)286 JAMA217-223.

## 7.1 Medical Litigation Proceeding

“Litigation” means a legal dispute or lawsuit. Regarding “medical litigation”, a medical legal dispute is a form of civil action as opposed to criminal proceedings. In medical litigation, the patient or his family are usually the plaintiffs while the doctor or hospital is the defendant. Medical negligence cases are of course civil suits. Only in a small percentage of civil cases is medical expert evidence adduced, the majority is personal injury cases. However, very often medical practitioners will appear as experts in criminal cases.

Most people in our predominantly Chinese community still respect doctors and value harmony. Therefore, in terms of the number of medical malpractice cases, these are still relatively infrequent when compared to the situation in other countries. In the United States, damages from medical malpractice claims have become so high that President Bush has appealed for reform of America’s tort system. Two studies in the US have shown how the decision-making of doctors is affected by fear of litigation.<sup>357</sup> They found that high-fear doctors were less likely to discharge low-risk patients, but instead would admit them and order chest X-rays and tests.

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<sup>357</sup>In a study in the *Annals of Emergency of Medicine*, researchers studied the treatment of 1,134 patients with chest pain or other heart symptoms by 33 emergency doctors. Using a malpractice fear scale’ they classified doctors as high, medium-or low-fear, then analysed their treatment of patients. Please cite the study here.

However the researchers argue that there should be a better way of promoting better care without using too many resources.<sup>358</sup>

There is time limit to claim for damages. The period within which a patient may make a negligence claim usually dates from the time the patient becomes aware of the harm caused. There may be long delays between an incident and subsequent challenge, which could occur even after death. Furthermore, in the case of minors, the limit is usually extended to the age of majority and where permanent disability has been caused or in cases when mental incompetence resulted from negligence, the period may be indefinite.

Generally speaking, an adult claimant has three years from the date on which the cause of action accrued (the date of the negligence incident) or, if later, the date on which the existence of a cause of action for medical negligence became known. For an infant claimant (under the age of 18), the three-year period does not begin until the claimant reaches the age of 18. For a person of unsound mind, the three-year period does not begin until the date on which the person becomes sane. However, this restriction is also subject to the Court's discretion to allow the action to proceed despite the expiry of the three-year period. If the amount of compensation that you are claiming is over HK\$1,000,000, one must start one's action in the Court of First Instance of the High Court. Claims up to HK\$1,000,000 can be made in the District Court. Claims under HK\$50,000 can be pursued in the Small Claims Tribunal.

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## **7.2 Medical Negligence and Claims**

### **7.2.1 Who Pays the Compensation - The Medical Protection Society (MPS)**

“Litigation and Medicine” provokes doctors’ anxiety in medical negligence claims. The only purpose of legal action is to obtain compensation for a person harmed by the consequences of a medical mishap which is negligent. The Medical Protection Society (MPS) is not actually an insurance company but a mutual society of healthcare professionals originally formed in 1892 to provide support for doctors in facing legal claims and to expose charlatanism and quackery.<sup>359</sup> It does not serve the interests of third parties such as shareholders or commercial organisations. MPS gives members the assurance of protection whenever claims arise. In order to give members peace of mind, MPS provides an unlimited cover for all defence costs and settlements that may arise.<sup>360</sup> Nowadays, MPS offers peace of mind to more than 245,000 healthcare professionals representing the full spectrum of clinical specialities, from places as far apart as Ireland and New Zealand, Hong Kong and Jamaica. An MPS study of negligence claims against GPs in the UK indicates that

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<sup>359</sup> It has 200,000 members in more than 40 countries, the largest organisation of its type in the world. Nearly 7,000 private doctors in the Hong Kong Special Administrative Region (HKSAR) purchase insurance from the Medical Protection Society (MPS), based in the United Kingdom. It is a stable and secure organisation with assets amounting to more than £400 million, presumably enough to ensure the future security of members.

<sup>360</sup>The MPS policy is formulated by and on behalf of its members.

<<http://www.hkma.com.hk/members/newsletter/2004/nw200303special.htm>>accessed 11 August 2008.

some 60% relate to delays in making a correct diagnosis, the biggest single category being malignant disease. It goes without saying that a sound diagnostic process must be based upon a sound clinical assessment. In its recently updated advice, the General Medical Council makes it clear that good clinical care must include an adequate assessment of the patient's condition, taking full account of the history, the patient's views and further investigations where indicated. Psychological and social factors must also be considered. The MPS believe that patients who have been harmed through a member's negligence should receive fair and speedy compensation. As an ethical organization, MPS staffs have an important role to ensure that patients receive quality healthcare in order to enhance healthcare delivery.

### **7.2.2 The Problems of Awarding Damages in Medical Negligence**

Most medical procedures involve risk and where that risk is unavoidable, the practitioner will not be held liable. There are two main "battlegrounds" that will determine the effect of the claim: the "facts" of the case and the expert opinion based on these "facts". This is put in inverted commas because there is usually a great deal of dispute on "facts" between the doctor and the patient. The second "battleground" is a battle between the experts. To defend a negligence claim, it is important to have a supportive opinion from an eminent expert in the particular



field. However, experts can only base their opinion on available evidence. They should not attempt to contemplate on or argue any facts in dispute. The more information that an expert can obtain from the records, the more confident that the expert can express his opinion without any uncertainties.

In order to obtain compensation, the patient must prove that the doctor was at fault. And if he sues for negligence, he must show that the doctor's 'fault' caused him injury. Consequently, the doctor's mistake must be shown to have caused the patient harm. The patient will have a legal remedy only if he can show that the doctor's carelessness or lack of skill caused him injury that he would not otherwise have suffered. For instance, if a patient contracts an infection and is prescribed antibiotics that a competent doctor would have appreciated were inappropriate for his condition, the patient will be able to sue the doctor that the antibiotic prescribed caused him injury unrelated to his original sickness. In addition to this, the wrong treatment significantly delayed his recovery. To facilitate an action in negligence, the plaintiff must establish that the doctor owed him a duty of care. That the duty was breached and he suffered harm caused by that breach. However, merely exposing someone to risk is not something that could bring about litigation. There must be some actual loss as a result of the exposure. Surprisingly, acts of medical negligence are often overlooked or insufficiently investigated. These acts may be classified as either civil or criminal negligence. Civil negligence associates with conduct that does not meet a specified standard. The extent of liability for civil

negligence depends on the amount of damage done and not on the degree of negligence. Hence, if there is no damage done, no matter how severe the degree of negligence committed, no legal action will be forthcoming. There will be liability only if the negligence can be shown to have either caused or substantially contributed to the evident damage. Indeed, putting someone in danger could not bring about litigation. There must have occurred some actual detrimental consequences. On the other hand, gross negligence comprises actions that are “reckless” in addition to not fulfilling the specified standard. When gross negligence is committed resulting in the death of a victim, charges of criminal negligence may be made. Thus, criminal liability depends on both the amount and the extent of negligence.

### **7.2.3 Malpractice Claims Push Up Insurance**

Complaints of medical malpractice against private doctors are expected to increase by a quarter this year and that will boost insurance premiums, according to Medical Association member Cheng Chi-man. Nearly 7,000 private doctors in the SAR buy insurance from a non-profit United Kingdom organisation, the Medical Protection Society (MPS), which has 200,000 members in more than 40 countries. Private medical fees are unlikely to rise in the near future, even though doctors face rises of as much as 90 percent in insurance premiums.

The MPS's statistics show that among the 200 complaints of medical malpractice which received in Hong Kong in 2004, about 40 cases involved claims for compensation of more than HK\$1 million. The number of actual claims remains below average compared with other jurisdictions in which MPS operates. According to Cheng - who quoted the MPS statistics - the number of claims and compensation amounts in 2005 rose by 27% and 6.5% respectively. As a result, insurance premiums are also expected to increase. The main problems arise in the area of obstetrics and it is obstetricians who will be experiencing the greatest rises in 2005. Of the 200 cases they are handling, four of the claims total more than HK\$25 million. "Obstetric and gynaecology doctors, whose jobs hold higher risks and who may face larger compensation claims, have to pay as much as HK\$190,000 a year in premiums. That is a rise of almost 100 percent. " As a result, some older obstetricians may opt out of the field to avoid the high-risk procedures and enjoy lower insurance fees. Due to the keen competition between the private and public sectors, doctors are unlikely to raise their fees to cover the higher premiums.

An MPS study of negligence claims against GPs in the UK indicates that some 60% relate to delays in making a correct diagnosis, the biggest single category being malignant disease. It goes without saying that a sound diagnostic process must be based upon a sound clinical assessment. In its recently updated advice, the GMC makes it clear that good clinical care must include an adequate assessment of the

patient's condition, taking full account of the history, the patient's views , an examination where necessary , and further investigations where indicated . Psychological and social factors must also be considered.

In order to recover full damages, the plaintiff must have taken reasonable steps to mitigate his injury such as seeking and complying with medical advice. Compensatory damages are awarded for the real loss suffered. This consists of compensation for pecuniary loss such as due loss of wages and medical expenses or non-economic loss like pain, psychological trauma and suffering. Punitive damages are awarded in addition to actual damages to penalize the defendant. A trend for the percentage of claims reported each year is shown in the figure below.

### **7.3 Alternatives to Litigation**

#### **7.3.1 Arbitration**

As a general rule, it is always said that “claims” need not necessarily lead to “disputes”. When a dispute develops, it may not be necessary to refer the matters to senior management and settle the disputes in accordance with the arbitration clause (if there is one) in the contract. Alternative Dispute Resolution is a means of resolving problems and medical complaints other than court adjudication which would relieve the court system from work overload as well as prevent the

expenditure for high litigation costs.<sup>361</sup> A framework to settle medical negligence cases before they go to court is being brought in so as to help patients, doctors and hospitals avoid costly and lengthy legal action.

Balmford defines ‘alternative dispute resolution’ as referring to options which are available to the use of litigation and the court system.”<sup>362</sup> At first instance this definition seems reasonable and is probably in accordance with most people’s viewpoints and perceptions. However, some writers and experts would argue that this idea or the meaning can be attributed not only to litigation but would include all processes in which a third party imposes and compulsorily enforces a decision.

The relevance of ‘alternative dispute resolution’ in medical negligence and malpractice can be considered. The health sector and the public could explore alternatives to legal actions that would sustain a caring and nurturing relationship between the health professionals and the patients that would benefit the society in general.

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<sup>361</sup>The ADR Rules offer a framework for the amicable settlement of commercial disputes with the assistance of a neutral party. This is a generic term about all methods for reaching settlement other than litigation. The ICC ADR Rules offer a framework for the amicable settlement of commercial disputes with the assistance of a neutral party. They were launched in 2001 to replace the 1988 Rules of conciliation.

<sup>362</sup> J.D.Balmford, *The Resolution of Commercial Disputes*, (the Institute of Chartered Secretaries and Administrators, 16 May 1988). In other words, ‘alternative’ could mean alternative to litigation, arbitration and all other similar actions in which the dispute is concluded with a decision being dictated on the parties.

Although the independence of the judiciary has been written into the Basic Law governing Hong Kong Special Administrative Region after 1 July 1997, many international lawyers would still prefer to have disputes arbitrated in Hong Kong after 1997 under the UNCITRAL Model Law System adopted in the Fifth Schedule of the Arbitration Ordinance.<sup>363</sup> In this imperfect world, disputes inevitably arise; we should seek a proper form of ADR to resolve them with all that we can command of good sense, efficiency and understanding.

### **7.3.2 Mediation: Rebuild Trust between Patients and Health Care Workers**

Trust between patients and medical professionals are essential to sustain an efficient and effective health care system. The report of the House of Commons Health Committee <sup>364</sup> defined mediation as “a private confidential and without prejudice process in which a neutral person assists the parties in reaching an agreed resolution. In particular, the mediator is not a judge or arbitrator and cannot impose a solution on the parties. The confidential forum allows grievances and problems to be aired face-to face between the people involved; the process can address both the legal

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<sup>363</sup> This Ordinance will remain valid after 1997 as expressed in the Basic Law. THE UNCITRAL Model Law allows a minimum of court interference rather than the more interventionist system ruling in the UK, the PRC and in Hong Kong under the domestic regime

<sup>364</sup> House of Commons. Procedures Relating to Adverse Clinical Incidents and Outcomes in Medical Cases.

/factual issues and the more personal ones which inevitably feature in such disputes.”

It provides an alternative to adversarial processes of litigation in which the parties must agree not only to proceed to mediation but also agree to the terms of any settlement reached before they are bound by it, as a method of bringing both parties together to work out the essential elements of their case. It promotes democratic participation and provides opportunities for each party to find workable solutions that satisfy the interests of all parties. In Hong Kong, most complaint cases are settled out of court and writs are not issued. It is in the interests of hospitals to keep cases out of the courts is to avoid messy public discussions of medical missteps. The Authority said in a written response to MetroNews that they were aware that some 20 writs were issued against Hospital Authority alleging medical negligence in 2003. But they refused to disclose the details of each individual case as well as other statistics on the grounds that the authority is bound by a “confidentiality obligation”.

Unlike court litigation with judgment, mediation is a non-litigative settlement and it is able to establish the trust between the parties concerned and even achieve reconciliation between them. Compared with litigation, mediation is much cheaper and usually less time-consuming. A large number of medical blunders had been settled out of court was not happy with the reply saying they were incomprehensible and unsatisfactory. Secretary for Health, Welfare and Food Yeoh Eng-king

revealed that all the 88 cases settled out of court occurred between 2000 and 2003 and the compensation amounting to HK\$45.96 million “has been borne by the Hospital Authority”. The numbers show that a significant number of patients have sought redress over their treatment in Hong Kong hospitals, but medical malpractice cases are handled with extreme secrecy and details of incidents and settlements are kept confidential. In most such cases, complaints are settled out of court and writs are not issued. Over 2,000 applicants granted legal aid for medical blunders and personal injury claims. Alleged medical blunders in both public and private hospitals have resulted in thousands of applications for legal aid and substantial out-of-court payments to aggrieved patients. Of 4,510 applications for legal assistance related to personal injuries and medical negligence received by the government's Legal Aid Department last year, 2,373 cases were granted aid. That compared with 4,956 claims in 2002, of which 2,202 cases were approved. In 2003, we are aware that some 20 writs [were] issued against HA alleging medical negligence. It refused to disclose the details of each individual case as well as other statistics on the grounds that the authority is bound by a “confidentiality obligation”.

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The Dental Council and recently Medical Council of Hong Kong have set up a mediation committee to settle dispute between doctors and patient complainant. It

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<sup>365</sup>Matthew Lee and Marcol Joanilho, ‘Health Chief Yeoh admits authority used taxpayers money to pay for medical mistakes’ *Hong Kong Standard* (Hong Kong 2008)B01.



seems to be a satisfactory and cost effective resolution for both parties and more and more cases are being handled in this way.

#### **7.4 Possible Compensation**

The main objective of compensation is to place the claimant or plaintiff in the position that they would have enjoyed had the medical negligence incident not occurred. The usual remedies will be discussed below:

##### **7.4.1 Assessment of Damages - Pain, Suffering and Loss of Amenities**

In assessing the amount of compensation to be awarded, the claimant's age, previous and current medical condition, time spent in hospital, the kind and number of treatments or operation received, cosmetic or facial injuries and psychological problems will be considered. In Hong Kong, the courts tend to follow a set of guidelines in determining the amount of the award for Pain, Suffering, Loss of Amenities (PSLA). This set of guidelines was established by the Hong Kong Court of Appeal in the case of *Lee Ting Lam v Leung Kam Ming* [1980] HKLR 657, according to whether or not the injury was classified as “serious” (HK\$60,000-\$80,000), “substantial” (HK\$80,000 - \$100,000), “gross disability” (HK\$100,000-\$150,000) or “disaster” (\$150,000 and upwards). Cons JA of the Court of Appeal described the four categories as follows:

Serious Injury: This is the lowest category. It covers those cases where the injury leaves a disability which mars general activities and enjoyment of life, but allows reasonable mobility to the victim, for example, the loss of a limb replaced by a satisfactory artificial device, or bad fractures leaving recurrent pain. The general range of awards is from \$60,000 to \$ 80,000.

Substantial Injury: This category extends to injure which require treatment in hospital for many months and leave the victim with a much reduced degree of mobility, for example, a leg amputated from the thigh, so that an artificial leg cannot be used satisfactorily; or multiple injuries which leave a condition requiring regular treatment for the rest of the victim's life. Awards at this level range from \$80,000 to \$ 100,000.

Gross Disability: This complies injuries which leave the victim with very restricted mobility or cause serious mental disability or behavioural changes. This bracket includes paraplegics who, particularly if young, can expect to be placed at the upper end of the bracket. Awards in this category range from \$100,000 to \$150,000.

Disaster: This is where the victim requires constant care and attention and is incapable of ever leading or appreciating an independent adult life. This bracket includes tetraplegics and those reduced to "living cabbages" or left with the mental age of very young children. Awards are from \$150,000 upwards."

The guideline for compensation was changed after the recent case of *Chan Pui Ki (an infant) v Leung On & Anor*<sup>366</sup>, the court was asked by the plaintiff not to adopt the conventional multiplier<sup>367</sup> but to receive actuarial evidence as to what was the appropriate multiplier. The plaintiff also asked the court to increase the award under general damages for pain, suffering, and loss of amenities to make reference to awards made in the United Kingdom and also to take into account wage inflation. Five judges of the Court of Appeal laid down guidelines for award of general damages for pain and suffering. The awards for “Disaster” category was put at upward of \$ 1 million. Consequently, the plaintiff was awarded \$6,419,093 in damages. The final decision by the Court significantly raised the future compensation for claims against damage including medical negligence cases. Although the adjustment in compensation seems reasonable, it surely will increase the insurance premium for doctor and add further financial burden to the profession.

#### **7.4.2 Loss of Earnings Capacity**

Depending on the claimant's medical condition, the claimant is entitled to claim in full for loss of earnings during the sick leave period and for any subsequent loss of

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<sup>366</sup>*Chan Pui Ki (an infant) v Leung On & Anor* [1995] 3 HK. The plaintiff was knocked down by a double decker bus in 1989 at the age of ten and sustained serious injuries to her head. The plaintiff commenced by her mother and next friend, proceeding against the defendants for damages for personal injury. Liability was agreed between the parties to be apportioned at 80% to the defendants and 20% to the plaintiff.

<sup>367</sup> The conventional multiplier, which was based on the range of return at discount rates (i.e. the differential between the rate of investment return and the rate of earnings increase for the period of the plaintiff's working life) of 4-5, was not capable of giving the plaintiff a fair compensation to cover her loss of earnings measured at the date of trial.

earnings (full or partial) that may be caused by disability resulting from the alleged medical negligence. Any income that is earned by the claimant after the negligence incident will be taken into account when assessing the claimant's entitlement to claim for loss of earnings. The claimant's age and the earnings of comparable workers are also relevant in determining claims for loss of earnings.

In *Moeliker v Reyrolle & Co. Ltd*<sup>368</sup>, it was said that this head of damages should be considered in two stages. First, the court must ask if there is a substantial or real risk that the plaintiff will lose his present job at some time before the estimated end of his working life. If there is, the court must quantify the present value of the risk of financial damage which he will suffer, having regard to the degree of risk, the time when it may materialise, and the factors, favourable and unfavourable, which will or may affect his chances of getting a job at all, or an equally well-paid job.

#### **7.4.3 Other Special Damages (various expenses)**

The claimant is entitled to be compensated for other amounts that are reasonably incurred as a result of the negligence incident. Common items include hospital fees, private doctor's expenses, tonic food expenses and travelling expenses. On occasions, other damages can be made based on the particular needs of the claimant, such as expenses for certain equipment, subject to their need and reasonableness being established. In *Brunzo Atzori and Dr Chan King Pan*,<sup>369</sup> the plaintiff who

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<sup>368</sup>*Moeliker v Reyrolle & Co. Ltd* [1997] 1 WLR 132.

<sup>369</sup>*Brunzo Atzori and Dr Chan King Pan* [1999] 3 HKLRD 77. HCP1000792/1998. In that case, the plaintiff who suffered pain in his left hip consulted the defendant doctor who decided to operate.

suffered pain in left hip consulted the Defendant Doctor who decided to operate. After surgery, the plaintiff suffered from weakness of his left knee, ankle and foot and atrophy of muscles. The Defendant was held to have fallen below the Bolam standard both as regards the decision to perform the operation , which was now proven to have been unnecessary, and as regards the performance of the surgery. Mr Brunzo, a 59 year old Italian businessman claim for damage after operation by Dr Chan in Adventist Hospital. Mr Brunzo has been an active sportsman in a wide range of activities including athletics, skiing and swimming. His build and carriage are those of a fit looking, active; tall man. Since 1993, he has been reduced to swimming as a sporting activity and his walking and standing have been limited.

The quantum of the claim was firstly general damages for pain and suffering and loss of amenity . The plaintiff suffered from weakness of left knee, ankle and foot and atrophy of the muscles of the left thigh and calf with areas of diminished sensation. He can walk for up to an hour but is unable to resume skiing and tennis. He has some difficulty with steps and slopes with occasional night cramps. His right leg has to bear extra burden in daily activities and there is risk of early patello-femoral arthritis in left lower limb and early degeneration of right knee and ankle. He had to undergo an unnecessary operation which left him significant disability and restriction on his general amenities. The general damages were \$525,000. As to medical expenses, it was entirely reasonable in circumstances for

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After surgery, the plaintiff suffered from weakness in his left knee, ankle and foot and atrophy of muscles.

the plaintiff to incur expenses in Italy and total of \$110,000 was awarded. The travelling and other expenses including restaurant meals and airfare accommodation, walking aid was allowed \$36,290 in total. Thence, the grand total awarded was \$ 671,290. This case demonstrated how the mistake of a doctor is bore by other members of the Medical Protection Society as a group. Even though the amount of compensation is not excessively high for a single case, the cumulative compensation paid for different members over the years may be alarming.

### **7.5 Claims for Compensation push up Indemnity**

In the recent compensation concerning antenatal injury in an Obstetrical claims in Matilda Hospital of Hong Kong. The father of a disabled child is suing a doctor for HK\$500 million. It is the largest claim of its type for alleged medical negligence.<sup>370</sup> Mr Singh alleges his daughter, Anjali Amber Sofia Singh, had developed a disability owing to the medical negligence of the defendants. The Singhs, who now live in Britain, intend to call four experts from the UK. Mr Justice Geoffrey Ma Tao-li yesterday granted permission for British Queen's Counsel James Badenoch to represent the couple. The court was told that on July 2, 1998, Mr Singh's wife was admitted to Matilda International Hospital to deliver her baby daughter. Dr Depasquale - the doctor in charge of her delivery - was not in the hospital and

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<sup>370</sup> In a writ filed in 2003, Raminder Singh is suing Joseph Depasquale, a doctor for Matilda International Hospital, and Raffles Medical Group (HK) Limited in the Court of First Instance. Doctor sued for HK\$ 500m over disabled baby birth. In the High Court of the Hong Kong Special Administrative Region Court of First Instance Persona Injuries No 717 of 2003.

allegedly instructed the midwives to administer medicine to Mrs Singh to speed up the labour. The court heard that the instructions were given to the midwives over the phone while Dr Depasquale was at another clinic. The court was told that after the medicine was given to Mrs Singh the baby's heart beat kept declining for half an hour before the delivery. Mr Singh claims his daughter suffered brain damage as a result of the treatment. The claim has great impact on compensation and significantly increased the insurance premium charged by the Medical Protection Society especially for Obstetricians.

There is rising concern of the medical profession about the rise of premium for professional indemnity insurance and capping of compensation as practised in USA and Australia is put forward as a resolution. Nevertheless, under Common law, compensation in tort is aimed to restore the victim in a way that his original position can be restored so far as can be done by money. Any artificial capping of the quantum for compensation is inconsistent with the common law principle. Further, any capping of damages may decrease deterrence and lower the incentive to maintain high professional standard and risk management. It may also transfer the burden from the wrongdoers to the victims and community.

In short, medical negligence litigation is highly contentious and emotional not only on the side of the patient and his family, but is equally frustrating for the doctor involved. It is not just the stress and serious consequences of losing the legal battle

and money. The simple fact that a doctor is sued for medical negligence is already a grave tarnish on his reputation which necessitates years of hard work to build up.



## **CHAPTER 8 GOOD MECHANISM TO AVOID MEDICAL NEGLIGENCE RECOMMENDATIONS AND SUGGESTIONS.**

### **Chapter Summary**

Prevention is better than cure. This statement not only applies to the medical profession, but also to legal profession alike. Even though medical negligence cannot be totally avoided as all human err, legal advisors have the responsibility to advice on how to minimize medical negligence. This thesis offers some recommendations and suggestions to doctors after analyzing common causes of error based on available cases of medical blunders in Hong Kong.

As the problem of medical malpractice and indemnity is serious in the health profession and is increasing in Hong Kong. Patients who are harmed may blame doctors for lack of openness and transparency in explaining to them after the adverse events. The Authority should urgently look into the matters.

### **8.1 Reduce the Number of Complaints – Good Communication**

In the medico-legal field, poor communication is the underlying problem in the majority of cases that Medical Protection Society deals with. According to a 15-year study, doctors who ignore the importance of good communication with their patients are more likely to be sued.<sup>371</sup> An effective communication about harms and risks is an essential component of medical care and it requires learning,

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<sup>371</sup>Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P, 'Patient Complaints and malpractice risk' (2002)287JAMA 2951-7.

preparation and rehearsal. The onus lies with professionals to persuade and to teach patients to play their part in coming to an informed decision about treatments.<sup>372</sup>

The case was in relation to an operating room nurse administered 300mg of Protamine - an antidote for anticoagulants – instead of the intended 30mg as prescribed during an operation on blood vessels for the 74-year-old man. The nurse discovered the discrepancy when she was about to input information about the dosage into the computer system. The surgeon was informed and treatment was given immediately. The patient was sent to the intensive care unit for close monitoring and no complication was found. After an investigation, Queen Elizabeth Hospital said that communication training on verbal prescription and counterchecking processes had been reinforced.<sup>373</sup> Good communication prevents problems and claims from arising and bad communication results in the reverse. A senior doctor once said that the science of medicine could be learned in the medical school, but the art of medicine would take a life time of clinical practice to perfect.<sup>374</sup>

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<sup>372</sup> Dr Tim Hegan, the International Operations Manager of the MPS, ‘Good communication in all aspects of medical practice is essential’. *Casebook No.16* February 2002.

<sup>373</sup> ‘Trusting Hong Kong doctors’ August 2007 <[http://hong-kong-doctors\\_e6431e5f-7349-97dc](http://hong-kong-doctors_e6431e5f-7349-97dc)> accessed 19 December 2008.

<sup>374</sup> Dr E K Yeoh, The Plenary Session III. Proceedings of the Hospital Authority Convention 1997, ‘The Art of Medical Practice and the Science of Care’ <[http://ww.haorg.hk/archives/hacon\\_97/contents/56.pdf](http://ww.haorg.hk/archives/hacon_97/contents/56.pdf)> accessed 21 December 2008.

### **8.1.1 Communicating with Patients**

Communication between a doctor and his patient usually begins with history taking and this is the area we have to pay serious attention. As usual, it is important that full history and examination should be performed on new patients and these should be properly documented. Very often, the lay public is under the impression that doctors, with all the “high tech” equipment at their disposals, are infallible: the first diagnosis should always be the correct one and all treatments are guaranteed to cure without any risks of complications. They would hold the doctor responsible for any incorrect diagnosis, any unsuccessful treatments or complications. Therefore, the doctor should explain the provisional diagnosis and possible alternative diagnoses. Further, treatment options, failure rates and complications should also be explained clearly. However, in history taking, doctors use their knowledge and experience in deciding what questions they should ask the patient.<sup>375</sup> It is not a usual practice to have a check list of the questions that must or should be asked. From time to time, cases are encountered in which doctors forget to ask patients some basic and important questions when a history is taken. One example is whether the patient is allergic to any drug.

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<sup>375</sup>May Ann Benitez & Lilian Goh, ‘Hospitals left gauze and tube inside patients’. *South China Morning Post* (Hong Kong 2007).

Take the example again of drug allergy. A patient consults a doctor for the first time. The doctor asks the patient whether he is allergic to any drug. The patient answers no and the doctor duly writes down “nil” in the box for drug allergy on the medical record. The patient later learns that he is allergic to a non-prescription drug after he has obtained from a drug store. The next time the patient consults the same doctor, he forgets to tell the doctor about the newly found allergy. The doctor does not ask the question again, but on seeing the “nil” word in the drug allergy box on the medical record, gives the patient drugs which the patient has newly found to be allergic. The patient takes the drugs and suffers a serious allergic reaction. The above example shows that it is important for the doctor to repeat the must-asking questions to the same patient if the answers to these questions may change with time. In most instances, patients are lay persons with no medical knowledge. Whether a piece of history is or is not relevant to a doctor’s diagnosis and treatment of a patient can only be determined with medical knowledge. Without medical knowledge, even a most intelligent and educated person may wrongly think that a piece of information is irrelevant and decide not to tell to the doctor. It is therefore risky for a doctor to think: “Oh, the patient is so intelligent that, if he had this and that, he would tell me and therefore I need not ask him”. Sometimes, for various reasons, a history cannot be taken from the patient but can only be provided by his relatives. In this situation, the doctor must take special care because some

information provided by the relatives may not be accurate. A proper history taking requires time. However, often the doctor is hard pressed for time because he has to finish seeing many patients within a finite period. Since common things come first in differential diagnoses, the pressure to time sometimes leads the doctor to assume that the patient has a common problem when, given a bit more time, he would find out that the patient actually has an uncommon problem. It has to be recognised that the pressure of time is commonplace and not new, and there is often no easy solution. The pressure of time is usually not a defence if, because of it, a doctor misses some important history which would have led the doctor to discover the true problem the patient had.

### **8.1.2 Non –verbal Communication**

Medicine is probably the only profession that requires one person to put the trust of his life on the advice of another, who may be a total stranger, all in a matter of a few minutes of meeting with the stranger. Meeting his patient for the first time, a doctor often has only a few minutes to establish a doctor-patient trust. There are no statistics but it would probably be fair to say that most claims against doctors are from patients who have only seen the doctors for the first time, or for the first few

times. Therefore, doctors must be especially alert when patients consult them for the first time, when a firm doctor-patient trust has not yet been established. A courteous greeting with good eye contact and a hand shake would always help to establish trust. Actions against doctors may be triggered off by what the patient perceived as an arrogant and uncaring manner, for example, that the doctor has not once looked up from his desk during the whole of the consultation! It is important to remember that although the doctor might think that the patient only has a common and trivial disease, the patient might perceive his illness completely different. Good manners may not prevent any future mishaps but a patient may find it much more difficult to complain against the doctor who always smiles and greets him like an old friend. Doctors must also be aware that patients, especially new ones, might be too embarrassed to tell their full history to a stranger so careful and patient listening is essential. The doctor should be careful not to interrupt too often and should not assume that the first thing the patient said would be the most important concern in the patient's mind. The danger of not listening is that a doctor might become impatient and leap into a diagnosis far too quickly. The doctor might then be led down a blind alley, convinced of his initial diagnosis and ignoring any subsequent clinical features that might point towards an alternative diagnosis.

### **8.1.3 Maintain Good Manners**

It is important to maintain good manners and be a good listener. A surgeon's tone of voice may also influence a patient's decision to sue. An analysis of 114 conversations between 57 orthopaedic and general surgeons and their patients showed that surgeons who sounded less concerned and more dominating were more likely than other surgeons to have been sued.<sup>376</sup> The doctors should be sympathetic and should discuss medical matters with the patient. However, the doctor should avoid discussing legal matters like liability, fault or compensation. If such matters are raised, the doctor should inform the patient that these are legal matters and he has to seek advice first. Even if the patient has raised a request for compensation, it is usually helpful if the doctor can still maintain a good dialogue with the patient. This may help any future negotiation and to prevent the case from escalating. Useful information like the patient's current medical condition may also be obtained if a good dialogue is maintained. In order to assure the quality of health care, it is important that patients are provided with adequate knowledge and information to judge the quality of that care and to express their concerns and dissatisfactions.

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<sup>376</sup>Ambady N, Laplante D, Nguyen T, Rosenthal R, Chaumeton N, Levinson W, 'Surgeon's tone of voice: a clue to malpractice history'. (2002)132 Surgery 5-9.

#### **8.1.4 Public-Private Interface – Better Communication between Private and Public Health Care Setting**

In the United Kingdom in 2002, the National Confidential Enquiry into Perioperative Deaths<sup>377</sup> showed that shortcomings in teamwork and communication contributed to the lack of improvement in the number of patients in England and Wales who died within 3 days of surgical intervention. The newly introduced Public-Private Interface which allows private practitioners to view patient history and treatment by Hospital Authority through the internet allows better communication and easier care for patients. With the great support from the Hong Kong Medical Association, the Doctors Union and the Association of Licentiates of Medical Council of Hong Kong, the Public-Private Interface – Electronic Patient Record Sharing Pilot Project (PPI-EPR) has been introduced since April 2006.<sup>378</sup> In order to enhance continuity of patient care among private and public health care settings, a web-based electronic system to allow integrated, real-time patient-based information to be shared between private and public health care setting. Up till December 2007, there were 700 private healthcare providers and 17,103 patients enrolled.<sup>379</sup> The Public-Private Interface aimed to reduce the health-cost by

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<sup>377</sup> - - Functioning as a team; ‘the report of the National Confidential Enquiry into Perioperative Deaths. NCEPOD’ 2002.

<sup>378</sup>Such data may encompass (i) personal particulars for identification and contact (e.g. name, identification, date of birth, contacts, etc (ii ) health data (e.g. weight, height, blood type, vaccination records, drug allergies,etc),and (iii) medical data (e.g. diagnosis, prescriptions, laboratory test results, radiological images and hospital discharge summaries, etc).

<sup>379</sup>Dr. KM Choy & Dr. NT Cheung, ‘Public- Private Interface – Electronic Patient Record Sharing Pilot Project’ (2008) January Hong Kong Medical Association News 42.



minimizing repetitions of investigations, and to minimize risks of medical error by obtaining up-to-date medical history.

## **8.2 Good Drug Dispensing**

Another high-risk area in the hospital is medication error. On every occasion when a doctor prescribes a medication for the patient, he takes a risk however small for the patient in that he/she may be sued for medical negligence. Urgent attention needs to be given to ensure that the possibility of doctors dispensing the wrong medication is minimized. The common pitfalls faced by doctors and tips to deal

with each of them are time constraints, failure to check on a patient's allergies and current medication as well as unfamiliar with dosages and frequencies of medications. However, the best way to deal with these complicating factors is to take time to talk about drug allergies with each patient particularly the young and elderly. The older he or she is, the lower and slower new medication should be started with. While in doubt, check references for frequency and dosages rather than guess. It is best to communicate with other prescribers. This is particularly important if the patient has more than one doctors looking after him or her. The doctors should encourage patients to return with their remaining drugs on follow-ups.

### 8.2.1 Three Checks and Seven Rights

Drug dispensing is an area where risk management is very important.<sup>380</sup> The doctors should ensure that there are proper procedures in each step of the process to minimize the risk of any mistakes. Where a doctor works in a hospital or institution, most of the steps in the process will be taken care of by other professionals. However, in private practice where usually a doctor runs his/her clinic, the entire responsibility falls upon the doctor himself. With particular reference to private practice, the “Good Dispensing Practice Manual” points out the important areas and highlights the mistakes that often occur.

While in Hong Kong hospitals, many hospitals still stick to their old practice of Three Checks and Seven Rights. The Three Checks are checking the container label before taking a container from the shelf, checking the container label against the prescription during actual dispensing, checking the container label before putting the container back to the shelf. The seven rights are right date, right patient, right drug, right dose, right route, right frequency, and right container. These recommendations are further emphasized by the Hong Kong Medical Association in the recent Good Dispensing Practice Manual.<sup>381</sup> Although these steps cannot totally

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<sup>380</sup>Medication Incident Reporting Programme. (2008) July High Risk Medications Bulletin. <<http://www.ha.org.hk/haho/ho/hesd/mirp21.pdf>> accessed 22 August 2008.

<sup>381</sup>‘Good Dispensing Practice Manual’, <[http://www.hkma.org/download/others/Good Dispensing 2007](http://www.hkma.org/download/others/Good_Dispensing_2007)>accessed 11 August 2008.

avoid human error and may be difficult to follow in a busy private clinic, it acts as a good defense in case medical litigation occurs.

In a related case, a 21-year-old woman who had acute lymphoblastic leukaemia was given an injection of Vincristine into her spinal canal, which surrounds the spinal cord, instead of intravenously. The patient died on July 7. An injection mix-up claimed the life of a leukaemia patient at Prince of Wales Hospital was a signal improvement to the hospital system for administering drugs were needed. Ian Tannock, the professor of medical oncology at Princess Margaret Hospital in Toronto said that human error and system flaws were involved<sup>382</sup>. It is necessary to

improve a system to alleviate human error. Among the WHO recommendations was that the drug should be prepared in small intravenous bags. The Prince of Wales Hospital had begun using “mini-bags” instead of syringes so that the drug could not be administered to the spine. The hospital was also taking steps to separate “by time and place, drugs that should be given into the vein from those that should be given around the spine.” The Good Dispensing Practice Manual advises that “it is the doctor’s responsibility to ensure that the drugs are properly dispensed to the patient.” It includes guidance on premises, dispensary design and equipment; stores procurement and stock management, dispensing; incident reporting; education, training and development; relationships with patients, public and other health care

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<sup>382</sup> Professor Ian Tannock, ‘Report on a Medication Incident of Intrathecal Administration of Vincristine in Prince of Wales Hospital’ *The Hospital Authority Report* 24 August 2007.

professionals; and administration and management.<sup>383</sup>

### 8.2.2 Patient Education

It would be useful to educate the patient and/or caregiver about each medication, including the dosage and frequency of medication to be used, the therapeutic goal for it, the cost and potential adverse effects or drug interactions. Also, the doctors should encourage the patient to take home with the written instructions for reference. Nevertheless, when mistakes happen, there should also be a system in managing such incidents in recording and reporting the incident, managing the patient's condition, giving a suitable apology and investigation. Remedial measures should be taken and notification of the doctor's Professional Indemnity's legal advisers if needed. In any case, the doctor should keep track of the identities and amount of drugs in the patients' hands. A common example could be where a doctor keeps repeating the same prescriptions and this may result in a stock-piling of "old" and "new" medications. The patient, for some reasons, cannot distinguish the "old" and "new" medications and decides to take all the medications on hand and has an overdose.<sup>384</sup> In this regard the proposed Office for Patient Education may serve a worthwhile purpose.<sup>385</sup>

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<sup>383</sup> 'Good Dispensing Practice Manual' (2008) March The Hong Kong Medical Association.  
<<http://www.hkma.org/english/downloadarea/pb>> accessed 13 March 2008.

<sup>384</sup> Brach P, Small S.D. 'Reporting and Preventing Medical Mishaps: Lessons from Non-medical Near Miss Reporting Systems' (2000)320 MJ753-763.

<sup>385</sup> McTigue A, 'How to Communicate with Care', (2004) *Casebook* 12(4) 11-12 ,

### 8.2.3 Double-Check System in Private Clinic

As practitioners, some of the pitfalls in setting up a private clinic should be noted. Drug dispensing covers many potential pitfalls for the doctors. Any mistake might mean civil or even criminal liability. The case involved a three-year-old girl who was taken to a Tuen Mun doctor and given cough medicine that burned her throat. Her worried parents had rushed her to the Casualty and discovered by the hospital to reveal that the syrup contained the disinfectant Isopropyl alcohol which can cause death if swallowed in large quantities.<sup>386</sup> The incident shows that there is no mechanism existed to ensure the doctors to adopt best practices and to abide by the highest professional standards. While Hong Kong Medical Council usually intervenes only after a complaint is lodged. Nevertheless, a doctor must not allow his professional ethics to be compromised by such commercial pressure. It had been emphasized that the Professional Code and Conduct imposes on every doctor and all members of the profession an obligation to ensure compliance with the Code. Members of the profession who administer or operate medical schemes and organizations were also reminded that they have a professional obligation to ensure that the schemes or organizations do not contravene the provisions of the Code. And that the doctors who practise under the schemes and organizations are not put into a position where their professional ethics might be compromised.

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<sup>386</sup> Mary Ann Benitez, 'Test showing girl's syrup two-thirds disinfectant' *South China Morning Post* (Hong Kong April 24 2007).

To err is human, after all. However, honest mistakes rarely wash when it comes to our foremost priority in our health. For the majority of doctors who end up in private practice, the chances of a claim against them are greater. The whole process spans the ordering of medications, storing and stocking of the medications, auditing of stock and disposing of expired stock, writing of prescriptions by the doctors, labelling of the prescription bags, dispensing by nurses to patients and subsequent proper recording of any dangerous drugs dispensed. The doctor should personally order the drugs in proper form and he should also personally check the identity of the medications upon receipt of the stock. The doctors **are** responsible for supervising the dispensing of drugs and must ensure the correct identity, dosages etc. of the drugs, and further that the drugs dispensed are not expired. As such, there should be a “double-check” system before dispensing any drugs to patients whereby the doctors “double-check” all drugs to be dispensed and also that the prescription bags are correctly labelled. Failure to properly label a prescription bag will put the doctors at risk of proceedings. It is also the responsibility of the doctors to advise the patients on the use of the drugs. Often doctors rely on their nurses to inform patients how to take the drugs or to advise the importance of completing a course of antibiotics.<sup>387</sup> It will be well remembered that if the nurse forgets to do so, the liability will invariably fall on the doctor.

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<sup>387</sup> The Health and Medical Development Advisory Committee was briefed on the Consultancy on Health Care Review carried out by the Harvard team on 13 September 1999. Legislative

#### **8.2.4 Relieve Doctors of the Role of Pharmacist**

Public faith in our medical system still remains high. In the public hospital setting, a new mechanism is being put in place to monitor the prescription of “big guns”, a selected group of broad spectrum antibiotics. When a physician prescribes a “big gun” his order form will be examined by a microbiologist or pharmacist. If the prescription is found to be inappropriate and an alternative antibiotic with narrower spectrum can be used, immediate feedback and advice will be given to the physician. This action is hoped to eventually improve drug prescribing practices of physicians for more effective outcomes. This new mechanism encourages professional interaction and enhances communication for better understanding. The release of the third edition of the Inter-hospital Multidisciplinary Programme on Antimicrobial Chemotherapy (IMPACT) Guideline is a timely updated one which includes optimal selection of antibiotics, dose and duration of their use. It has been a popular reference for local clinicians and copies have been sent to Hospital Authority physicians and stakeholders in the private sector.<sup>388</sup> All in all, we all make honest mistakes and doctors are not an exception. The most stringent and possible system has to relieve doctors of the role of pharmacist which is the

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Counsel Panel on Health Service. Issues discussed by the Health and Medical Development Advisory Committee. The HMDAC noted that the Department of Health (DH) would conduct a review of its dispensary service and its staffing situation.

<sup>388</sup> Hospital Authority’s Papers & Presentation, ‘Interhospital Multidisciplinary Programme on Antimicrobial Chemotherapy (IMPACT) Guideline Third Edition’ (2005).  
<<http://www.chp.gov.hk/files/pdf/>>accessed 11 July 2008.

simplest way to achieving this.

### **8.3 Safeguards for Doctors**

#### **8.3.1 Keeping Good Drug Stock Records**

Good drug stock management involves a system for ensuring delivery of correct and non-expired drugs. This will include: avoiding mix-ups, proper containers, storage locations, proper storage condition, auditing for identifying expired drugs and avoiding over-stocking and locking up of Dangerous Drugs. Cases against doctors dispensing expired drugs are not uncommon. These cases are avoidable if efficient auditing systems are put in place. Failure to lock up Dangerous Drugs is a criminal offence. Failure to keep proper Dangerous Drugs records is also a criminal offence.<sup>389</sup> The doctor would have to face criminal prosecution if his Dangerous Drugs records in any way deviated from the format specified in the Dangerous Drugs Regulations. It is the responsibility of the doctor, as the person who is authorised to prescribe Dangerous Drugs, to ensure that there are proper Dangerous Drugs records and it is not a defence to say that he has delegated the responsibility to his nurse or someone else. Furthermore, although the government is promoting digitalization of medical records, it must be remembered that computer records and printing of dangerous drug is not accepted and there has been a case in Hong Kong where medical negligence was established by the Council concerning a doctor due

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<sup>389</sup>Chapter 134 Dangerous Drugs Ordinance Part 1 of the First Schedule Regulation 5 (1)(a) and 5(7) of Dangerous Drug Regulation.



to a lack of a written record of dangerous drugs. A doctor must upgrade the dispensing skills of his/her dispensing staff by encouraging them to take up courses in dispensing which may soon be mandatory or a legal requirement.<sup>390</sup> Right alerts in right locations are also suggested, such as “Confused Drug Name List” in pharmacy, “Standard Abbreviation List” and “Do not Crush List” in word. The Coroner’s court decision on the Chuk Yuen cases in May had tremendous impact on the dispensing rights of.

### **8.3.2 Keeping Proper Medical Records**

The importance of keeping good records has been stressed repeatedly by the Medical Protection Society. Good and detailed contemporaneous records could help to persuade the Court that the ‘facts’ according to the doctor is the truth. The simple fact is that a doctor sees many patients a day and after even a few weeks he would have seen a few hundreds patients. If without any proper contemporaneous records to aid his memory, he would find it difficult to convince the Court that he could recall the exact details of one consultation. On the other hand, the patient has probably only seen the doctor on a few occasions. His memory of the event would likely be clearer, or at least likely to be accepted by the Court as having a clear memory. Obviously, in an actual trial, the judge would consider also other factors in order to decide whether one witness was more truthful than another, such as the

demeanours of the witnesses. However, one would wish to avoid the situation where a case is entirely decided by one's words against another because this adds a high degree of uncertainty. For this purpose, some specific points are discussed below.

Do not just record the positive findings. A case may be considered indefensible because there is no evidence that a doctor has performed an examination at all. If there is the case where a patient died unexpectedly of an acute abdomen and there is no record of an abdominal examination, it will not be easy to convince the Court that the doctor has, in fact, examined the abdomen but found nothing abnormal. On the other hand, the case may be defensible if the records show that a detailed examination of the abdomen has been performed but nothing abnormal was detected. This is because it may be more difficult for any expert to opine, without some degree of speculation, that a reasonable doctor should have detected something at that stage. Very often, doctors may not have recorded a consultation in detail contemporaneously but wish to put more details afterwards. The doctor may do so but he should date the late entry at the date the entry was made. For example, the doctor may add to his record: "On 15/3/2000, I recall further details of the 13/3/2000 consultation as follows. Do not attempt to alter records." Examination

of the ball-point pen ink can show non-contemporaneous entries on the records and once the credibility of the doctor is lost, the case is often lost.<sup>391</sup>

This situation of using a colloquial saying, “the mouth arguing with the nose”, will change if the doctor has good medical records to back up his version of what happened. The Judge will definitely give significant weight to the medical records because they were made at the time of the consultation. It is therefore important to know that keeping good medical records **is crucial** to enable a doctor to continue to provide good medical management to his patient.

### **8.3.3 The Presence of Chaperon**

Medical Protection Society has issued guidance on the use of chaperones during medical examinations.<sup>392</sup> The Code of Professional Conduct of the Medical Council of Hong Kong only makes it a recommended measure. Paragraph 1.2.4 of the Code of Professional Conduct reads : “ An intimate examination of a patient is recommended to be conducted in the presence of a chaperone to the knowledge of the patient. If the patient requests to be examined without a chaperone, it is also recommended to record the request in the medical records.” In most countries, it is left to the individual practitioner and the patient to judge whether a chaperon is

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<sup>391</sup> -- The Medical Council of Hong Kong. Paragraph 1.1.2 of the Professional Code and Conduct of the Medical Council of Hong Kong. (Revised in January 2009).

<sup>392</sup> ‘When to use a chaperon’. (2007)Autumn Medical Protection Society, United Kingdom. <<http://www.medicalprotection.org/Default.aspx?>> accessed 12 December 2008.

appropriate. However, the presence of a chaperon during intimate examination of patients is recommended for the doctor's protection unless the patient prefers to be examined without one. Nevertheless, the request should be honoured and recorded in the medical record.<sup>393</sup> Indeed, chaperon is not limited to female patients. Misunderstanding can occur irrespective of the sex of the doctor or the patient. Allegation of indecent assault can engage in a male doctor and a boy; a female doctor and a boy.<sup>394</sup> A criminal charge of indecent assault is a grave concern to a doctor which potentially could damage the doctor's reputation. The doctor is at serious threat of being found guilty as it is very much the patient's words against his words. Even though it is recognised that practical situation make it difficult for a nurse to be present during every consultation. It is advisable that a nurse should always be present while a male doctor conducts a physical examination on a female patient. The value of having a chaperone nearby can support the doctor in refuting the complaint.

### **8.3.4 Consultation Fees**

It is also fair to say that money seems to be the root of many disputes. One of the disputes which often happen between doctors and patients is regarding doctor's fees.

The Medical Council has promulgated rules of professional conduct regarding the

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<sup>393</sup> Johnson Stokes & Master, 'Risk Management VIII- Physical Examinations' (2007) November *Hong Kong Medical Association* 38.

<sup>394</sup> Speelman A, Savage J, Verburgh M, 'Use of chaperones by general practitioners' (1993)307 *British Medical Journal* 986-7.

communication to patients of doctor's fees.<sup>395</sup> The loss of doctor-patient trust is often caused by the perception by the patient that the doctor is putting money before the interest of the patient. Points to be noted are the doctors should be careful not to "over-sell" a treatment even if it is perfectly indicated, especially to a new patient. A doctor should exhibit a notice in his clinic informing patients about their right to know the fees involved. The doctor should discuss with his patients the doctor's fees, hospital fees and other miscellaneous fees for the options advised, and he should always allow the patient ample time to think about the options. Where the patient seems to be in doubt, the doctor should consider offering a referral for a second opinion.

#### **8.4 Laws and Regulations**

The use of tort law in assessing medical negligence is well established and helps to uphold justice. However, there are flaws in implementing the principles by the legal and medical professions. This is especially true in Hong Kong. Most of the Ordinances related to health care were set up years before and needs modification in order to keep in pace with the rapidly changing world. Some of the Ordinances should be critically evaluated with suggestions to change. Laws and regulations

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<sup>395</sup>Section 13.1 of the Professional Code and Conduct of the Medical Council. The relevant paragraphs are: Consultation fees should be made known to patients on request. In the course of investigation and treatment, all charges, to the doctors' best knowledge, should be made known to patients on request before the provision of services. A doctor who refuses or fails to make the charges known when properly requested may be guilty of professional misconduct.

should be amended to define the responsibility of all parties involved in medical negligence cases in order to better protect patients.

Firstly, the Clinic Ordinance in Hong Kong should incorporate requirement for the professional standard of clinic assistants. As can be seen from cases of medical negligence in Hong Kong, clinic assistants may directly or indirectly contribute to the occurrence of medical errors. Medical practitioners should be responsible for ensuring a reasonable and, more preferably, continuous, medical education for clinic assistants. This may play a crucial role in decreasing medical blunders. Meanwhile, the Medical Registration Ordinance also leaves much to be desired. There should be health or age limit requirement for doctor in addition to continuous medical education before renewal of annual practitioner certification so as to ensure that the public is under the care of a knowledgeable and healthy doctor. Furthermore, the Dangerous Drug Ordinance requires doctors to keep record of stock and prescription details of all dangerous drugs in a fixed format. Ironically, computer records are not accepted in sharp contrast to the increasingly digitalised global society.

## **8.5 Others: Good Management Practices**

### **8.5.1 Additional Resources or by Redistributing the Workload**

It is clear that excessive workload is likely a significant contributing factor to recent mistakes or negligent conducts. How to relieve this burden needs to be considered

either by providing additional resources or by redistributing the workload towards greater reliance on doctors in the private sector. Hong Kong's consultant or senior public doctors complain that they are overburdened with administrative tasks which are unrelated to bedside clinical duties.<sup>396</sup> While investing time in developing good management practices is essential, other non-clinical tasks such as compiling statistics or attending a number of outside medical committee meetings may detract from the duty to look after patients. As patient care must be the priority, it is time to examine whether the administrative burden is excessive, or could be re-assigned to other medical personnel. Doctors must be given sufficient time to do their job well. A majority of doctors (85%) thought that the increasing the number of nurses in hospitals and improving hospitals systems may help in preventing medical errors. About 90% of the public thoughts that more time should be spent with their patients, providing better training of health professionals (80%), and only physicians specialized in the particular field should handle the respective patients.<sup>397</sup> In any case, the recent publicity offers an opportunity to raise the level of discourse about Hong Kong's health care. We should seize this chance and work with medical professionals to make our health care system a source of pride and trust for Hong Kong people, and a leading competitor in the Asia-Pacific region. We should also open up Hong Kong medicine to greater international participation in order to promote a free flow of information and talent, and to encourage diversification into

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<sup>396</sup> Dr Choi Kin, 'Health Care Reform Consultation Document' (2008) June The Hong Kong Medical Association.

<sup>397</sup> Annex of Thesis : Views of Medical Profession and the Public on medical negligence : An Interview

public medicine. In general, a doctor must always maintain the highest standards of professional conduct as well as practice his profession uninfluenced by sole-motive of profit.

### **8.5.2 Automated Patient Identification**

Not surprisingly, patient misidentification is again a global healthcare issue. The common causes of such errors are well understood, which may involve unintentional human errors. Practitioners save procedural time by conducting single identification (in most cases, bed number) instead of double identification (name and bed number/ patient number). A typical error of such kind is illustrated in the following short story.

“Digital Imaging Department called the Medical Ward to arrange a patient for an X-ray film taking. However, staff from Digital Imaging Department only gave the patient’s bed number. The staff from Medical Ward took the patient with respective bed number without further enquiry. However when the X-ray film was given to doctor the next day it was found that the doctor did not order any X-ray film taken



for the patient. Later on it was found that Digital Imaging Department communicated with Medical Ward with the wrong bed number.”<sup>398</sup>

In order to alleviate the patient identification errors, new technologies such as automated patient identification may help solving the problems. Fully automated patient identification could be achieved with wristbands that either contain a barcode or RFID (Radio Frequency Identification) tag issued at the point of admission to the hospital. The wristbands can then be read by handheld mobile computer terminals at any location or ward around the hospital. Nevertheless, there is big room for improvement.

### **8.5.3 Continuous Medical Education Is Essential**

The training of undergraduates in Hong Kong is done by the University of Hong Kong and the Chinese University of Hong Kong and they provide only limited spaces for candidates.<sup>399</sup> Being a doctor has always been the dream of youngsters and their parents. However, with poor preparation, it can be the beginning of a nightmare. There has been a lack of emphasis on law and ethics in the undergraduate programme in medical school. Reform should be done to increase

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<sup>398</sup> Billings C.E, ‘Some Hopes and Concerns Regarding Medical Event-Reporting Systems: Lessons from the NASA Safety Reporting System’ (1998) *Archives of Pathology and Laboratory Medicine* 214-215.

<sup>399</sup> Course Description – Undergraduate Studies in Chinese University of Hong Kong and Li Ka Shing Faculty of Medicine, University of Hong Kong 2008.

teaching and training in communication skill, patient psychology, medical ethics and the law governing medical practice. The Medical Council considers that health service providers should either obtain continuing medical education or demonstrates through other means, and that they have maintained standards in their field of activity in order to be eligible for practicing certificate renewal. During the course of their career, Continuous Medical Education is essential after graduate and practice in society. The Hong Kong Doctors Union has been running Continuing Medical Education (CME) for members for many years. Many doctors have regarded CME as extremely important to keep up themselves on medical advances through seminars, discussion groups and journal readings. In the following discussions, there will be an evaluation of some recent trends and a prediction of future patterns in the delivery of healthcare.

## **8.6 An Effective and Trusted Incident Reporting System**

An effective and trusted incident reporting system is a vital element of managing risk. A wall of silence after an adverse incident can provoke formal complaints and legal actions. The Hospital Authority must drop its punitive outlook and stand against the face-saving culture that prevents doctors from admitting to mistakes.

It is anticipated that in the near future disclosing medical errors will be a routine part of medical care. This will allow honest communication between health care

professionals and patients, and facilitate quality improvement when things go wrong. The earlier discussions or interventions take place, the less likely the patient will feel that no one care about what has happened. The situation can be discussed honestly with the patient without using language (such as “that was the dumbest thing I ever did”) that might provoke a visit to a lawyer. “I am sorry it happened” is NOT an admission of fault.<sup>400</sup> It may be counterintuitive to physicians that admission of error accompanied by sincere apology can help avert a malpractice suit, but such acknowledgment may mollify an unsatisfied patient.

Recently, there have been voices from the community demanding the use of market force in reducing the occurrence of medical blunders, namely increasing supply of doctors through intake of medical students, and setting up more stringent laws and regulations. These ideas do not stand on solid ground. Limiting the intake of medical students and thence doctors in practice guarantees the selection of an elite group of youngsters with passion in medical service. While it is difficult for the community to judge professional, we should provide a reasonable reward for them both through job satisfaction and financial gain, thence making them commit to their job and avoid unorthodox practice. Laws and regulations give guideline for doctors but is by no means an effective way in guarding against medical malpractice.

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<sup>400</sup>Gallagher TH, Waterman AD, Ebers AG, et al, ‘Patients’ and physicians’ attitudes regarding the disclosure of medical errors’ (2003) 289 JAMA 1001-1007.

## **CHAPTER 9 CONCLUDING REMARKS**

It is indeed not an easy time to be a doctor in Hong Kong. Rarely a day passes now without the mass media focusing on issues of medial dispute, medical ethics or medical litigation. Doctors find themselves in the limelight with radical changes in their image: one day hailed as a saviour and the next condemned as dictatorial or uncaring. The number of actions for malpractice against doctors, once almost unknown in Hong Kong, is growing quickly. Meanwhile, in an increasingly pressurized working environment, doctors must learn and balance more technical information, longer working hours, tougher competition from peers. They are now far less certain about the law's demands and future directions. My questionnaire survey on medical negligence clearly highlights the ordeal in Hong Kong and the roles of medical professionals as well as the public on medical blunders.

In the past, there is a general belief that professionalism is the 'spirit' of good doctors who put patients' interest as the priority and are not influenced in any way by self interests. Early descriptions from scholars and leaders of professional bodies put much emphasis on the linkage of professionalism and self – regulation. Donald Irvine, the former president of the General Medical Council; wrote that medical professionalism rests on three pillars which together constitute the basis of

independence or autonomy: expertise, ethics, and service<sup>401</sup>. Expertise is derived from a body of knowledge and skills; utility of which is constantly invigorated by the results of research. Ethical behaviour flows from a unique combination of values and standards. Service embodies a vocational commitment to put patients first.<sup>402</sup> Independence is equally important because it gives doctors the authority to decide about standards of professional practice and education, the organization of medical work and discipline<sup>403</sup>. Furthermore, independence gives doctors self-respect which motivates them to perform well and, as a profession with a strong sense of ethical duty, to make an important contribution to the society. Nevertheless, doctors' behaviours need to be regulated because there is a special relationship between doctors and patients, who fully rely on the professional skills of doctors. Patients trust their doctors and allow them to intrude into their private lives, gaining access to their private information. A doctor can affect his patient in many ways: from simply advising on his life-style to performing mutilating surgery for the treatment of illness. Thus, it is necessary to identify doctors who are for some reasons not fit to practice as they may pose danger to their patients, and actions need to be taken to stop them from practicing until they are fit to do so. In other words, simply assuming that all doctors are good doctors who will act in

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<sup>401</sup>Dr Donald Irvine, President of General Medical Council proposed a modern expression of medical professionalism, founded on sound self regulation, that should bring the public's and the profession's interests together successfully.

<sup>402</sup>Irvine D, 'The performance of doctors. i: professionalism and self regulation in a changing world'. (1997 May) 314 BMJ1540.

<sup>403</sup>Irvine D, 'The performance of doctors. II: Maintaining good practice, protecting patients from poor performance'. (1997) 314 BMJ1613.

patients' benefit is dangerous and not practical. Therefore, it is the responsibility of the profession and the society to guard against the occurrence of medical negligence in the interest of the public. The profession itself is trusted to undertake proper regulatory action when individuals do not perform competently or ethically.<sup>404</sup> In Hong Kong, while looking into the medical negligence, the Hong Kong Medical Council is the regulatory body at work. My thesis investigates the set up and procedures during hearing in Medical Council which may be at fault, providing comments and suggestions. Hopefully, this may improve the situation while preventing appeal and overturn of decision made by the Council as seen in a recent case in Hong Kong.<sup>405</sup>

The knowledge on medical negligence is incomplete without understanding its legal basis. In order to prove a medical negligent case and claim for reasonable compensation, we have to go back to the tort law - the foundation for this area. The three pillars for proving medical negligence in medical litigation are: duty of care, breach of duty and causation. For a plaintiff to be successful in the legal process, he must prove that all three elements are present and operative in his case. The Bolam test and Bolitho case have formed the cornerstone in judgments. The Bolam test basically judges the standard conduct of a doctor by referring to the standard conduct of his peer at the time of occurrence of the event. However, an exception

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<sup>404</sup>Ibid

<sup>405</sup>Dr Chan Hei Ling, Helen v The Medical Council of Hong Kong in the High Court of the HKSAR made on 31 st October 2006. Civil Appeal No 403 of 2006. (On Appeal from the Order of the Medical Council. CACV 403/2006).

occurred in the cases of Bolitho and Siderway when the risk to the patient is so great that the judge could not conclude the action of the defendant as reasonable even though he is supported by his peer and expert advice. Although the application of Bolam test makes life simple, it may ultimately be unfair as medical professionals tend to protect their colleagues. Conversely, the overturn of Bolam may result in judges deciding on unfamiliar medical issues which are difficult to understand, arousing anxiety in doctors, consequently leading them to practice self-defensive medicine. Clearly, another problem that arises will be that the substitution of the court's view for an expert opinion may not be appropriate in certain circumstances. The body of opinion relied upon must have a basis in logic, and the judge must be satisfied that the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter. Under the Bolam test, a doctor is not negligent if what he has done is accepted by a responsible body of medical opinion. But the court must be satisfied that the body of opinion rests on a logical basis.

Despite the dispute in court for medical-legal litigation, poor communication is the underlying problem in the majority of cases dealt with by the Medical Protection Society. In reality, time pressures and the stresses of workload make it difficult to give patients adequate time and attention they deserve. Nevertheless, we should make it a habit to be courteous to patients and colleagues alike. Doctors with poor communication skills or who are rude and arrogant are more likely to be the subject

of a claim or complaint even when nothing has gone wrong or, more importantly, when patients think things have gone wrong. Put simply, patients tend to sue people they dislike. The best advice to give to doctors is to engage with patients- treat them and their relatives as you would like to be treated yourself. Ultimately, there is no clear correlation between clinical expertise and vulnerability to complaints and claims. As a matter of fact, some less clinically competent doctors can go through their whole career without attracting a legal or disciplinary challenge. Through case analysis, the pitfalls in delivery of medical practice were outlined and appropriate precautions with special emphasis made in obtaining consent for surgical procedures were recommended. Of all the common pitfalls in a doctor's practice, a breakdown in communication is again the most common cause of accusations against doctors for breach of duty. On the contrary, with improvement in communication among medical personnel, medical service can be delivered accurately and less human error may occur. Good communication among doctor, the patient and his relatives lead to a better understanding of the disease, its treatment modality and possible complication that may arise. The rapport between doctor and patient is then better established and less complaint on medical negligence may arise.

In order to improve the present situation, different suggestions have been put forward to decrease the occurrence of medical negligence and its detrimental effect on the public and doctors. Among these are effective communication, better ethical education for medical students and update of ordinance governing practice of



medicine in Hong Kong to keep abreast of time. Furthermore, improvement in public education, better understanding of culture and more efficient delivery of medical services are all of paramount importance to achieve our aim.

Fortunately, the traditional Chinese attitude to lawsuit may limit the number of litigations lodged by patients. The ancient Chinese view of lawsuit is best described by an old proverb- “It is better to die of starvation than to become a thief; it is better to be vexed to death than to bring a lawsuit.”<sup>406</sup> The long-established view to dispute resolution in the community is related to the concept of harmony. In the Confucian’s point of view, the greatest ideal is the establishment of a harmonious social order – “da tong”.<sup>407</sup> When potential conflicts occur, the approach would be self-criticism and giving concessions to others instead of claiming self-rights and bringing the matter to the court; thus making medical professionals relatively protected from litigation.

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<sup>406</sup> Justice Robert F. Utter, *Tribute: Dispute Resolution in China*, (1987) 62 Wash L. Rev. 383, 396 n. 2, citing Cohen, ‘Chinese Mediation on the Eve of Modernization’, (1966) 54 Calif. L. Rev. 1201.

<sup>407</sup> The Record of Rites, sook IX 孔子-<[http : www.9dog.net/7000.html](http://www.9dog.net/7000.html)> accesssed 12 August 2008.

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**Useful websites:**

Action for Victims of Medical Accidents: [www.avma.org.uk](http://www.avma.org.uk)

British Medical Association: [www.bma.org.uk](http://www.bma.org.uk)

Hong Kong Department of Justice. Bilingual Laws Information System:  
<http://www.legislation.gov.hk/chi/index.htm>

## **ANNEX**

### **VIEWS OF MEDICAL PROFESSION AND THE THE PUBLIC ON MEDICAL NEGLIGENCE --- AN INTERVIEW**

#### **A.1 Background of Interview**

A total of 30 medical health care professionals (including 10 public hospital doctors, 10 general practitioners in the private sector and 10 nurses were interviewed ) as well as 20 University Students and 10 people working in non-medical sectors were interviewed for their views about medical negligence. The interviews were conducted face-to face and by telephone. University students and 10 other people were conducted by telephone interview late in the evening. This might be due to the fact that those are busy in the day – time, thus they preferred to be interviewed by telephone after office hours. Interviewees were asked about the causes of and solutions to the problem of preventable medical errors on the basis of recently occurred medical blunders. Seven questions which focused on ‘medical errors’ were included in the interview. The interviewees were asked to state in their own words what they considered to be the most important problems errors with health care .To avoid any possible tension during the process of interviews; cassette tape recording was not adopted.

The questions are as follows:

1. What is the nature of your job?
2. Do you /your family members have experiences with medical errors?
3. Do you think understaffing of nurses in hospitals and overwork, stress, or fatigue on the part of the health professionals are the possible causes of medical errors?
4. This year seemed to have many reported medical blunders, who do you think should hold more responsibility, the health care professionals or the hospitals and the health care system?
5. Is the media fair when channelling complaints? Are there any particular disadvantages with the system? Can you explain if there are any problems that might have arisen so far?
6. Do you think that sufficient information or informed consent is always given before implementation of medical treatment in Hong Kong?
7. The possible ways by which medical negligence in Hong Kong can be lessened?

8 Do you think that doctors should be charged with in case of severe medical error that involves death of patients?

## **A.2 Results of interview**

No 2

Do you /your family members have experiences with medical errors?

The public (70%) was more likely than medical personnel (30%) to have experienced errors on their own or by a family member. In general, the public reported more personal experience with medical errors that had serious consequences, including death, long term disability, and severe pain respectively.

No 3

Do you think understaffing of nurses in hospitals and overwork, stress, or fatigue on the part of the health professionals are the possible causes of medical errors?

A majority of both groups viewed medical errors as one of the most important problems in health care today. When asked whether mistakes made are related to understaffing, overwork, stress or fatigue of medical personnel in hospitals, the majority of interviewees in both groups thought that the above mentioned causes were very important causes relating to medical errors. Most of the doctors believe that they do mistakes in our day to day practice- from oversight, neglect, tiredness



from a 32 working hours shift etc. However, in the eyes of the public, their mistakes are less tolerable. They also called for an increase in the number of nursing staff to provide more reasonable medical care to patients.

No 4

This year seemed to have many reported medical blunders, who do you think .....should hold more responsibility, the health care professionals or the hospitals and the health care system?

Further, physicians were more likely than the public to hold the hospitals responsible for the error whereas the majority of the public (90%) believed that physicians should hold individual responsible for medical errors. A minority of the interviewees in both groups think that both the health professionals and hospital system should bear responsibility to the consequence of medical errors.

No 5

Is the media fair when channelling complaints? Are there any particular disadvantages with the system? Can you explain if there are any problems that might have arisen so far?

The public has expressed concern about the credibility and transparency of handling mechanisms in receiving complaints. Both the public and the doctors believe that

reporting of serious medical errors should be made public whereas only 10 % of doctors believe that reports of errors should be kept confidential. 90 % of the public interviewed thought that the health professionals should take all reasonable steps to prevent harm to patients and should harm occur, disclose it to the patient immediately. While all the public interviewee thought that report of medical blunders by mass media is fair and should be encouraged, all medical professional hold the view that mass media exaggerate the event and is unfair to medical professional. In general, most of the public firmly supports the principle of increasing market transparency.

No 6

Do you think that sufficient information or informed consent is always given before implementation of medical treatment in Hong Kong?

90% of medical profession thinks that adequate information and informed consent is given before medical treatment which only 10% of the public is satisfied with the extent of information given to them before implementing treatment. The discrepancy shows that expectations of patients is not fully met by medical professions and create a challenge to doctor – patient relationship.

No 7

The possible ways by which medical negligence in Hong Kong can be lessened?

A majority of doctors (85%) thought that the increasing the number of nurses in hospitals and improving hospitals systems may help in preventing medical errors. About 90% of the public thought that more time should be spent with their patients, providing better training of health professionals (80%), and in particular only physicians specialized in the particular field should handles the respective patients. (80%).Most of the public believes that the doctors should be sued for malpractice and fined and that the doctor's license should be suspended as well as to support sanctions against the hospital. Although few physicians believe that an increase in malpractice suits would be effective in preventing individual errors, many believe that health professionals who make errors with serious consequences should be subject to lawsuit.

No 8

Do you think that doctors should be charged with in case of severe medical error that involves death of patients?

The majority of the public and physicians differ in their beliefs about the charges of. The public strongly agreed that medical professionals should be charged with in cases of severe medical errors leading to death of patients. . However only 5% of the doctors viewed suspension of the licenses of health professionals as a very

effective way to reduce medical errors as most doctors do not deliberately cause the harm..

### **A.3 Conclusions**

Both physicians and the public identified medical errors as one of the most serious problems in health care today. The issues cited most frequently by physicians were the costs of malpractice insurance and lawsuits. However in the public, the problems cited most frequently were the cost of health care in the private sector and the long waiting list for the operation in the public hospitals. To err is human, after all. However, honest mistakes rarely wash when it comes to our foremost priority in our health. Most of the doctors believe that they do mistakes in our day to day practice- from oversight, neglect, tiredness from a 32 working hours shift etc. In the eyes of the public, their mistakes are less tolerable. Physicians were also upset when errors happen but worried that an apology creates legal liability. The prevention of serious errors in medical care has long been of concern to health professionals, as well as courts and legislatures. There are a number of mechanisms in place for monitoring the quality of care which patients and professionals alike benefit from. In line with this, the government of Hong Kong has proposed improvement measures to its existing mechanism. These include the setting up of a committee constituted of a significant number of lay members to address standards, improve transparency and formulate guidelines to assist complainants. Despite the best efforts of health care practitioners, medical errors are inevitable.

## **APPENDIX 1 :The *Bolam* Case**

### ***Bolam v Friern Hospital Management Committee (1957) 1 WLR 582***

The plaintiff patient was suffering from mental illness and had to undergo electroconvulsive therapy(ECT). He had not given informed consent. During the ECT, he was not given any relaxant drugs and was also largely unrestrained. The patient sustained dislocation of both hip joints and fractures of the pelvis.

The court held that the doctors did not breach their duty when deciding against restraining the patient. McHair J said:

Where you get a situation which involves the use of some special skill or competence , then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest 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.

#### The Bolam Test

The *Bolam* case considered that the standard of care was that of professional colleagues, which must accord with a “responsible body of medical opinion”. The doctor is not measured by the standard of the reasonable man in the street but by the standard of the reasonable doctor. In deciding whether a doctor is negligent, the court will rely on the expert professional opinion. Under the *Bolam* test, a doctor is not negligent if he has conformed to responsible professional practices.

## **APPENDIX 2 :The *Bolitho* Case**

### ***Bolitho v Hackney Health Authority (1997) 4 All 771***

P, a two-year-old boy, who had a history of hospital treatment for croup, was readmitted to hospital under the care of two doctors, Dr H and Dr R. The following day, P suffered two short episodes at 12:30 p.m. and 2 p.m. during which he turned white and had difficulty breathing. Dr H was called in the first instance; in the second instance, she delegated to Dr R to attend to P. However, neither doctor attended to P, who at both times appeared to return quickly to a stable condition.

At around 2:30 pm, P suffered total respiratory failure and a cardiac arrest resulting in severe brain damage. P died later. P's mother as the administrator of P's estate sued for medical negligence. The defendant health authority accepted that Dr H had breached her duty of care to P, but alleged that the cardiac arrest could not have been avoided even if Dr H had attended to P earlier than 2:30 p.m.

It was known that intubation to provide an airway would have ensured that respiratory failure did not lead to a cardiac arrest and that such intubation should have been carried out after the first episode.

P's lawyer had expert evidence that a reasonably competent doctor would have intubated the patient in such circumstances. The defendant doctor had her own witness (Dr D) to say that non-intubation was a clinically justifiable response.

The High Court judge found that the views of the two experts, though diametrically opposed, represented a responsible body of professional opinion espoused by distinguished and truth experts.

The court held that Dr H, if she had attended to P and not intubated him, would have met the standard of a proper level of skill and competence according to Dr D's

views, and that it had not been proven that the defendants' admitted breach of duty caused the injury to P. The Court of Appeal dismissed an appeal by P's mother, who later appealed to the House of Lords.

The House of Lords held that a doctor could be liable for negligence in respect to diagnosis and treatment despite a body of professional opinion sanctioning his conduct, where it had not been shown to the judge's satisfaction that the body of opinion relied on was reasonable or responsible.

In most cases, the fact that distinguished experts in the field was of a particular opinion showed the reasonableness of that opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge could hold that the body of opinion was not reasonable or responsible. As the House of Lords accepted Dr D's views as reasonable, the appeal was thus dismissed.

### **The *Bolitho* Test**

The body of opinion relied upon must have a basis in logic, and the judge must be satisfied that the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter.

Under the *Bolam* test, a doctor is not negligent if what he has done is accepted by a responsible body of medical opinion. But the court must be satisfied that the body of opinion rests on a logical basis.

### **APPENDIX 3 :The *Chester v Afshar* Case**

#### ***Chester v Afshar* (2005) Lloyds L.R. 109**

The recent English case of *Chester v Afshar* alters the law on informed consent. The defendant neurosurgeon had performed surgery on the patient plaintiff who was suffering from low back pain. Her consultant rheumatologist had given her epidural and sclerosant injections. An MRI scan showed disc protrusions. She was referred to a neurosurgeon for elective lumbar surgical procedure. Prior to the surgery, the defendant neurosurgeon had negligently failed to warn the patient plaintiff of the small 1-2% risks of cauda equine syndrome (CES). The patient had a disectomy to treat her low back pain. The surgeon performed the procedure competently without negligence. Unfortunately, the patient suffered cauda equine damage as an unavoidable complication of this surgery and subsequent disability. She sued the surgeon claiming that he failed to warn her about this particular risk.

As the surgeon lacked documentary evidence that he had warned the patient of CES risk, the court accepted the patient's allegation, and liability for failure to warn was established. Under traditional causation principles, the next step was to convince the court that the patient would not have undergone the procedure had she been aware of the risk (i.e. causation). The patient, however, took a different approach in this case. She agreed that she might still have had the surgery after being warned about the risks, but added that she would have taken time to think about it and schedule the surgery for another day, possibly by a different surgeon.

Thus, had an appropriate warning of the risk of cauda equine damage been given by the surgeon, the patient would not then have agreed to surgery on that day, but would have taken further opinion as to whether surgery was necessary. Lord Hoffman said that it "was about as logical as saying that if one had been told , on



entering a casino, that the odds on No. 7 coming up at roulette were only 1 in 37 . One would have gone away and come back next week or gone to a different casino.”

By a majority the judges found that the patient had established a causal link between the breach (i.e. failure to warn of CES risk) and the injury (i.e. nerve damage) the patient had sustained, and held that the surgeon was liable for damages. But for the surgeon’s negligent failure to warn the patient of the small risk of serious injury, the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. The patient’s injury was the product of the very risk that the patient should have been warned about when she gave her consent. As a result of the surgeon’s failure to warn the patient , the patient could not be said to have given informed consent to the surgery in the full legal sense.

The court took the view that the negligence to inform of risk that led to injury was satisfied on policy grounds, the policy being that the patient’s autonomy and dignity should be respected by allowing her to make an informed decision. The patient’s right of autonomy and dignity could and should be vindicated by a narrow and modest departure from traditional causation principles. Thus, legally, the patient’s injury was considered to have been caused by the breach of the surgeon’s duty of medical care that prevented the patient from giving a proper informed consent.

The implication of the new ruling of the *Chester* case now makes it more important than ever to take extreme care in ensuring that patients, including human subjects in clinical trials, are fully informed, that they understand the information given to them, and that they are given sufficient time to digest the information. Careful and comprehensible warnings about all significant possible adverse outcomes must be given.

#### **APPENDIX 4: The *Donoghue v Stevenson* Case**

*Donoghue v Stevenson* [1932]AC 562

The appellant and a friend went to a café, where the friend ordered some ginger beer for the appellant, served in an opaque bottle. The bottle was apparently contaminated by a decomposed snail. The appellant drank some of the ginger beer before discovering the decomposed snail, and became ill. She sued the respondent, the manufacturer of the ginger beer, in the tort of negligence. The respondent applied on a preliminary point of law to have the action struck out on the basis that, in these circumstances, a manufacturer owed no duty of care to a consumer. The action was struck out, and so the appellant appealed to the House of Lords.

Lord Atkin....

The sole question for determination in this case is legal: Do the averments made by the pursuer in her pleading, if true, disclose a cause of action? The case has to be determined in accordance with Scots law; but it has been a matter of agreement between the experienced counsel who argued this case, and it appears to be the basis of the judgments of the learned judges of the Court of Session, that for the purposes of determining this problem the laws of Scotland and of England are the same....

It is remarkable how difficult it is to find in the English authorities statements of general application defining the relations between parties that give rise to the duty. The Courts are concerned with the particular relations which come before them in actual litigation, and it is sufficient to say whether the duty exists in those circumstances. The result is that the Courts have been engaged upon an elaborate classification of duties as they exist in respect of property whether real or personal, with further divisions as to ownership, occupation, or control, and distinctions

based on the particular relations of the one side or the other, whether manufacturer, salesman or landlord, customer, tenant, stranger and so on. In this way, it can be ascertained at any time whether the law recognizes a duty, but only where the case can be referred to some particular species which has been examined and classified. And yet the duty which is common to all the cases where liability is established must logically be based upon some element common to the cases where it is found to exist. To seek a complete logical definition of the general principle is probably to go beyond the function of the judge, for the more general the definition the more likely it is to omit essentials or to introduce non-essentials. The attempt was made by Lord Esher in *Heaven v Pender* (1883) 11 Q.B.D.503 at 509, in a definition to which I will later refer. As framed, it was demonstrably too wide, though it appears to me, if properly limited, to be capable of affording a valuable practical guide.

## **APPENDIX 5 :The Code of Professional Conduct**

The Code of Professional Conduct was originally published as a Warning Notice in 1957 and as the Professional Code and Conduct in 1994. Recognizing the need for medical ethics to evolve with changing social circumstances, the Medical Council keeps the Code under continuous review. International practices, local peer opinion, legal requirements, public expectations and moral obligations have all played important roles in the development of the Code.

The Code embodies two cardinal values of the medical profession. It is committed to maintain high standards of proper conduct and good practice to fulfill doctors' moral duty of care. Importantly also, the Code upholds a robust professional culture to support self-governing through identifying role-specific obligations and virtues of the medical profession. These obligations and virtues define the morale ethos and shape the professional identity of the medical community. The Code emphasizes that the hallmark of a profession is its distinctive identity and continuous self-development. The Code marks the profession's commitment to integrity, excellence, responsibility and responsiveness to the changing needs of both patients and the public in Hong Kong.

The Code is only a guide and is by no means exhaustive. It will be updated from time to time and subsequent amendments will be published in the website of the Medical Council ([www.mchk.org.hk](http://www.mchk.org.hk)) and the Council's newsletters. It is not a legal document and should be given a fair interpretation in order to attain the objects of the relevant provisions. Unless the context requires otherwise, words in the masculine gender include the feminine gender and words in the singular include the plural, and vice versa; and "Council" means "the Medical Council of Hong Kong".

Contravention of this Code, as well as any written and unwritten rules of the profession, may render a registered medical practitioner liable to disciplinary proceedings. All doctors should familiarize themselves with the Medical Registration Ordinance and its subsidiary legislation, in particular the following: \_

1. Medical Registration Ordinance ( Cap 161)- sections 19 to 19B, 20A and 21 to 28.
2. Medical Practitioners ( Registration and Disciplinary Procedure) Regulation ( Cap 161E) – sections 6 to 42.
3. Medical Registration ( Miscellaneous Provisions) Regulation ( Cap 161D) – sections 6, 8 and 9.

The Ordinance and the Regulations are published in the website [www.legislation.gov.hk](http://www.legislation.gov.hk).

### **The International Code of Medical Ethics**

The International Code of Medical Ethics is adopted by the World Medical Association. It is endorsed by the Medical Council of Hong Kong, except where the contrary intention appears from the context of this code of Professional Conduct. The Council will have regard to the International Code in the exercise of its disciplinary power.

The latest version of the International Code of Medical Ethics published by the World Medical Association in 2006 is reproduced below. Members of the profession are advised to check any subsequent amendments at the World Medical Association's website ([www.wma.net](http://www.wma.net)).

## **Duties of Physicians in General**

A PHYSICIAN SHALL always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.

A PHYSICIAN SHALL respect a competent patient's right to accept or refuse treatment .

A PHYSICIAN SHALL not allow his/her judgment to be influenced by personal profit or unfair discrimination.

A PHYSICIAN SHALL be dedicated to providing competing medical service in full professional and moral independence, with compassion and respect for human dignity.

A PHYSICIAN SHALL deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

A PHYSICIAN SHALL not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.

A PHYSICIAN SHALL respect the rights and preferences of patients, colleagues, and other health professionals.

A PHYSICIAN SHALL recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.

A PHYSICIAN SHALL certify only that which he/she has personally verified.

A PHYSICIAN SHALL strive to use health care resources in the best way to benefit patients and their community.

A PHYSICIAN SHALL seek appropriate care and attention if he/she suffers from mental or physical illness.

A PHYSICIAN SHALL respect the local and national codes of ethics.

### **Duties of Physicians to Patients**

A PHYSICIAN SHALL always bear in mind the obligation to respect human life.

A PHYSICIAN SHALL act in the patient's best interest when providing medical care .

A PHYSICIAN SHALL owe his/her patients complete loyalty and all the scientific resources available to him/her . Whenever an examination or treatment is beyond the physician's capacity, he /she should consult with or refer to another physician who has the necessary ability.

A PHYSICIAN SHALL respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.

A PHYSICIAN SHALL give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.

A PHYSICIAN SHALL in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.

A PHYSICIAN SHALL not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

### **Duties of Physicians to Colleagues**

A PHYSICIAN SHALL behave towards colleagues as he/she would have them behave towards him/her.

A PHYSICIAN SHALL NOT undermine the patient-physician relationship of colleagues in order to attract patients.

A PHYSICIAN SHALL when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

### **DECLARATION OF GENEVA**

Adopted by the 2<sup>nd</sup> General Assembly of the World Medical Association, Geneva, Switzerland, September 1948.

and amended by the 22<sup>nd</sup> World Medical Assembly, Sydney, Australia, August 1968

and the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983.

and the 46<sup>th</sup> WMA General Assembly, Stockholm, Sweden, September 1994.

and editorially revised at the 170<sup>th</sup> Council Session, Divonne-les-Bains, France, May 2005 and the 173<sup>rd</sup> Council Session, Divonne-les-Bains, France, May 2006.

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION;



I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due.

I WILL PRACTISE my profession with conscience and dignity.

I WILL RESPECT the secrets that are confided in me, even after the patient has died.

I WILL MAINTAIN by all the means in my power, the honor and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed , ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honor.

## **APPENDIX 6**

### **Case 1**

香港醫務委員會

**The Medical Council of Hong Kong**

#### **DISCIPLINARY INQUIRY**

#### **MEDICAL REGISTRATION ORDINANCE, CAP. 161**

Date of hearing: 21 May 2009

Defendant: Dr LI Sai Lai Ronald (李世澧醫生)

1. The charges alleged against Dr LI Sai Lai Ronald are that:

“He, being a registered medical practitioner:-

(a) on or about 3 January 2005, after an order for Simethicone had been placed with a pharmaceutical supplier for use in his medical practice, failed to take adequate steps to ensure the drug received from the said supplier was in fact Simethicone; and/or

(b) between January 2005 and May 2005, having prescribed Simethicone to about 153 patients, failed to take adequate steps to ensure that the drug dispensed to the said patients was in fact Simethicone.

In relation to the facts alleged, he has been guilty of misconduct in a professional respect.”

#### **Facts of case**

2. The Defendant Doctor operated a clinic in Chuk Yuen Shopping Centre, Wong Ta Sin.

3. The Defendant Doctor was included in the General Register from 1 January 2005 up

to the present.

4. At the material time, he had in his employment three clinic assistants. These persons did not receive any formal medical or paramedical training.

5. On 2 January 2005 a clinic assistant, Ms. Kwan Mo Yin, placed an order for Quali-Ampclox capsules and Simethicone tablets.

6. On 3 January 2005 two drugs were delivered to the Defendant Doctor's clinic together with an invoice and a Poison Order Form. The two drugs were Quali-Ampclox capsules (3 x 1000 capsules) and Qualizide Tab 80mg (3 x 1000 tablets). The Defendant Doctor signed the Poison Order Form but did not check whether these were the drugs ordered by the clinic. The clinic assistant, Ms. Wong Oi Lan, received the drugs.

7. The clinic assistants Ms. Kwan Mo Yin and Ms. Wong Oi Lan noticed that the name of the drug, size of the bottle and pill size were different from Simethicone. It is unclear whether the clinic assistant Ms. Kwan Mo Yin telephoned Mr. Mar Lick Hang of Quality Pharmaceutical Laboratory Ltd to enquire whether the drug delivered was Simethicone. Nevertheless the bottle that contained Qualizide was labeled by hand as "Simethicone" by clinic assistant Ms. Wong Oi Lan.

8. From the period between January and May 2005 the Defendant Doctor prescribed Simethicone to about 153 patients but the drug dispensed was actually Qualizide. The Defendant Doctor did not personally check the drug dispensed. The dispensing was done entirely by the clinic assistants.

9. In May 2005 the Defendant Doctor was alerted to the fact that he was dispensing Qualizide instead of Simethicone. He then proceeded to cross out "Simethicone" and

wrote "Diamicron" on the bottle of Qualizide tablets.

10. The above facts are not in dispute.

Charge (a)

11. Registered medical practitioners in Hong Kong have the privilege of dispensing drugs to patients. Coupled with this privilege is the responsibility to ensure that drugs they obtained for use in medical practice are in fact the ones they sought to obtain. Should the registered medical

practitioner delegate this duty to non-qualified persons, he must exercise effective personal supervision and retain personal responsibility.

12 We are satisfied that the Defendant Doctor failed to take adequate steps to ensure the drug received from the supplier was in fact Simethicone. He signed the Poison Order Form but did not check whether the drugs received were the ones ordered by the clinic.

13 We are satisfied that the Defendant Doctor's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that his conduct constitutes professional misconduct. We find him guilty of charge (a).

Charge (b)

14. Registered medical practitioners in Hong Kong have the privilege of dispensing drugs to patients. Coupled with this privilege is the responsibility to ensure that the correct drug is dispensed to his patients. This is a responsibility that cannot be delegated to non-qualified persons.

15. The dispensing of wrong drugs may lead to dire consequences to the patients. It may lead to death, permanent disability or unnecessary prolongation of the patient's

illness.

16. We are satisfied that between January 2005 and May 2005, the Defendant Doctor, having prescribed Simethicone to about 153 patients, failed to take adequate steps to ensure that the drug dispensed to the said patients was in fact Simethicone. The Defendant Doctor did not personally check the drug dispensed. The dispensing was done entirely by the clinic assistants.

17. We are satisfied that the Defendant Doctor's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that his conduct constitutes professional misconduct. We find him guilty of charge (b).

### **Sentencing**

18. The Defendant has a previous record. We note that the previous conviction involved the failure to keep a proper register of Dangerous Drugs.

19. Although the nature of the drugs are different, both incidents involved a lack of proper care in the handling of drugs.

20. There is no mitigating factor of weight apart from the fact that the Defendant has been cooperative in the Inquiry and has admitted all the facts.

21. The dispensing practice of the Defendant has resulted in wrongly giving Qualizide instead of Simethicone to about 153 patients over a period of five months. We would like to emphasize that Qualizide is classified as a Part I, Schedule 3 poison, whereas Simethicone is not. The wrong dispensing of Qualizide can lead to serious and potentially fatal consequences.

22. In general, any wrong dispensing of drugs can have serious consequences, and

registered medical practitioners must take adequate steps to prevent this from happening.

23. Having regard to the gravity of the case and the mitigating factors, we order that the Defendant's name be removed from the General Register for two years. We further order that such order shall take effect upon its publication in the Gazette. This will prevent delay of removal by further legal procedures of appeal. We have taken this move as we are satisfied that the Defendant's substandard dispensing practice poses a danger to the public and the immediate removal is necessary for the protection of the public.

24. We would have imposed a heavier sentence of three years if not for the Defendant's cooperation in the Inquiry.

25. Although any application for restoration to the General Register is a matter to be decided when the application is made, we recommend that the Defendant should present plans for improved dispensing of drugs to the satisfaction of the Council.

## **Case 2**

### **DISCIPLINARY INQUIRY**

Date of hearing: 13 December 2007, 5 May 2008, 7 May 2008, 9 May 2008, 12 June 2008, 19 July 2008 and 20 July 2008

Defendant: Dr. SIU Ting Wing (蕭定榮醫生)

1. The charges alleged against Dr. SIU Ting Wing are that:

“He, being a registered medical practitioner, disregarded his professional responsibilities to his patient in that:

(a) on or around 12 May 2004 he failed to ensure that the medicine bag containing “Qualicana Tab” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication and (ii) a name that properly identified the patient;

(b) on or around 12 May 2004 he failed to ensure that the medicine bag containing “Xenical” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication and (ii) a name that properly identified the patient;

(c) on or around 12 May 2004 he failed to ensure that the medicine bag containing “Redusa” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication and (ii) a name that properly identified the patient;

(d) on or around 19 May 2004 he failed to ensure that the medicine bag containing “Soment” dispensed to him was properly labeled with the name of doctor or means of identifying the doctor who prescribed the medication;

(e) in or about May 2004 he failed to ensure that the medicine bag containing “Redusa 15” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication and (ii) the date of dispensing;

(f) in or about May 2004 he failed to ensure that the medicine bag containing “Xenical” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication and (ii) the date of dispensing;

(g) in or about May 2004 he failed to ensure that the medicine bag containing “Sutamin 10mg” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication; (ii) the date of dispensing; and (iii) the trade name or pharmacological name of the drug;

(h) in or about May 2004 he failed to ensure that the medicine bag containing “Triacin” dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication; (ii) the date of dispensing; and

(iii) the trade name or pharmacological name of the drug;

(i) in or about May 2004 he failed to ensure that a medicine bag containing the medication dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication; (ii) the date of dispensing; and (iii) the trade name or pharmacological name of the drug;

(j) in or about May 2004 he failed to ensure that a medicine bag containing the medication dispensed to him was properly labeled with (i) the name of doctor or means of identifying the doctor who prescribed the medication; (ii) the date of dispensing; and (iii) the trade name or pharmacological name of the drug;

(k) in or about May 2004 he prescribed to the patient an inappropriate anti-obesity medication, namely Qualicana tab;

(l) in or about May 2004 he failed to provide appropriate monitoring for the possible side effects of the anti-obesity treatment.”

2. While it was not expressly stated in the charges, it is clear that they are charges of the offence of professional misconduct contrary to section 21(1)(b) of the Medical Registration Ordinance. We suggest that the Legal Officer should make this clear in future cases.

3. The patient was 18 years old when he sought weight reduction treatment from a beauty consultancy, namely Be A Lady Limited, in 2004, and decided to join an anti-obesity programme which included treatment by registered medical practitioners.

4. Treatment by doctors started on 3 May 2004 in the Mongkok branch by Dr. Yeung. Each time the patient was accompanied by his mother. As there were too many people at the Mongkok branch, from the second treatment onwards the patient switched



to the Shatin branch. On 12<sup>th</sup> and 19<sup>th</sup> May 2004 and 2<sup>nd</sup> and 9<sup>th</sup> June 2004, treatment was provided by Dr. SIU Ting Wing at the Shatin branch. Medicines were prescribed and dispensed in each treatment. A few days after the treatment on 19 May 2004, the patient began to develop serious mood swings, insomnia and aching in the chest. He would shout aloud and sweep things onto the floor. On 2 June 2004, the patient told Dr. SIU about his conditions and asked whether they were related to the medicines. Dr. SIU said maybe or maybe not, nevertheless he continued to prescribe similar medicines to the patient. After taking the medicines for several more days, the patient had a serious depression and very much wanted to commit suicide. He then stopped taking the medicines. On 9 June 2004, the patient again told Dr. SIU that he still had the depressive conditions. Dr. SIU then told him that he would stop prescribing one of the medicines. No physical examination was conducted.

5. As the mood swings and suicidal thought continued, the patient's mother took the patient to see a psychiatrist on 11 June 2004. Psychiatric treatment by various psychiatrists continued for over three and a half years afterwards.

6. The Defendant maintained that he had no memory of having provided treatment to the patient. He claimed that he worked in various branches of Be A Lady including the Shatin branch from May to August 2004 on a part-time basis, only providing Dysport and tissue filler injections to clients but was not involved in weight reduction treatments at all. He also claimed that he never prescribed medicine to clients in Be A Lady.

7. The crucial question for us to resolve is whether the Defendant had provided treatment to the patient. The patient was unable to identify the Defendant as the doctor who provided treatment to him. The patient's mother also failed to do so initially when she was asked to see whether the doctor was present in the inquiry. Later she was given the opportunity to observe each person at close distance after she revealed that she had

problems with her vision. After looking at various persons at close distance, she pointed out the Defendant but with the remark that Dr. SIU “*was not that young and not that fair*”. At the conclusion of her evidence when being excused from the witness stand, she further volunteered that the defendant “*really looks like Dr. SIU Ting Wing*”. When she was told that her evidence was finished, she again said that “*I think he looks very like him*”.

8. We note that the mother’s evidence in this respect was corroborated by a Defence witness who worked at Be a Lady as a Business Development Manager in 2004. When he was asked about whether there was any change in the Defendant’s appearance, he said that the Defendant now obviously has fairer skin and darker hair, and his hair style looked better and with more hair. He also said that the Defendant’s spectacles had changed.

9. There is ample evidence to show that the Defendant was in fact Dr. SIU Ting Wing who provided treatment to the patient. Both the Chairman of Be A Lady and the slimming consultant responsible for handling the patient gave clear evidence that there were only two doctors who worked in the Shatin branch at the relevant time, namely the Defendant and Dr. Yeung who had treated the patient on 3 May 2004 at the Mongkok branch. There was no other doctor called Dr. SIU. The slimming consultant would introduce the doctor to the patient by referring to the doctor’s name. A Defence witness who was a former customer of Be A Lady also confirmed that the slimming consultant would introduce the doctor to her.

10. We also note that the patient continued to receive treatment from Dr. Yeung at Be A Lady on 11 subsequent occasions from 26 June 2004 to 20 September 2004. When the mother told Dr. Yeung about the problems with Dr. SIU’s medicines, Dr. Yeung made a comment on Dr. SIU’s practice of prescription, suggesting that Dr. Yeung also acknowledged that Dr. SIU had provided treatment to the patient. In September 2004 the patient’s mother also complained to the officer-in-charge of Be A Lady about the

medicines prescribed by Dr. SIU Ting Wing. While the duty rosters of attending doctors were not available at this inquiry because the rosters were not kept for so long, the rosters must be available at that time when the patient just completed treatment in September 2004. Be A Lady never disputed that Dr. SIU prescribed those medicines to the patient.

11. Having regarded all the evidence, in particular the mother's identification and corroboration by other witnesses, we are satisfied that the Defendant did provide treatment to the patient on the 4 occasions in May and June 2004.

12. We further have to consider whether the Defendant prescribed the medicines to the patient. There was clear and consistent evidence that during the consultations the doctor would write down the prescriptions which would then be dispensed by a staff of Be A Lady. Although the medicines were not handed over to the patient directly by the doctor, the staff dispensed the medicines under the authority and on behalf of the doctor who made the prescription. Therefore, if the medicines were not properly labeled in accordance with paragraph 10.1 of the Code of Professional Conduct, the doctor failed to discharge his professional responsibility to ensure proper labeling of the dispensed medicines.

13. We are satisfied that the medicines set out in charges (a) to (j) respectively were prescribed and dispensed by the Defendant. It is obvious from the medicine bags that the medicine were not properly labeled as described in the charges. We are satisfied that the Defendant has disregarded his professional duty to his patient, and his conduct has fallen below the standard expected of registered medical practitioners. We are satisfied that this constituted professional misconduct. We find him guilty of charges (a) to (j).

14. We then turn to charge (k) which involves prescription of an inappropriate medication, namely Qualicana, to the patient. There is clear expert evidence that

Qualicana which is the trade name for tiratricol may cause serious health consequences including heart attacks and strokes. It is not approved by both local and American regulatory authorities as a treatment for weight reduction. We are satisfied that the medicine was not appropriate for the patient's weight reduction treatment. We are satisfied that the Defendant's conduct in prescribing the medicine for the patient's treatment has fallen below the standard expected of registered medical practitioners and constituted professional misconduct. We find him guilty of charge (k).

15. As to charge (l) which involves failure to provide appropriate monitoring of the side effects of the treatment provided to the patient, we accept the evidence of the experts that the treatment provided by the Defendant was an aggressive regime of a cocktail therapy with drugs which can have adverse physical and psychiatric side effects. One of the medicines, namely Redusa, acts on the central nervous system and may precipitate various mental symptoms and illnesses, including depression and insomnia. Sutamin can substantially increase blood pressure and cause mood changes. Triacin may cause dizziness, drowsiness and excitation.

16. The patient must be carefully assessed and monitored for any adverse side effects, including monitoring of the patient's weight, blood pressure, pulse and other side effects. The Defendant failed to provide such monitoring, despite the fact that the patient complained to him of the side effects which had manifested. We are satisfied that the Defendant's conduct had clearly fallen below the standard expected of registered medical practitioners. We find him guilty of charge (l).

17. In conclusion, the Defendant is found guilty of all 12 charges.

### **Sentencing**

18. The Defendant has three previous convictions for disciplinary offences:-

- (i) conviction on 9 December 2004 for practice promotion, for which a warning letter was served on him;
- (ii) conviction on 12 April 2006 for 3 charges of failure to properly label dispensed medicines, for which he was ordered to be removed from the General Register for a period of 3 months, but the operation of the removal order was suspended for 1 year;
- (iii) conviction on 16 April 2008 for one charge of failure to properly label dispensed medicine and one charge of improper prescription and failure to advise on side effects of the prescribed medicine, for each charge he was ordered to be removed from the General Register for a period of 3 months and the orders shall run concurrently.

19. As conviction (i) was of a different nature, we shall disregard it for the purpose of sentencing in the present case.

20. The misconduct in conviction (iii) was committed in July 2005. As the incidents in the present case took place in May and June 2004, we shall also disregard conviction (iii) for the purpose of sentencing in the present case.

21. Conviction (ii) is of the same nature as charges (a) to (j) in the present case, and the misconduct was committed on 23 September 2003 although the conviction was on 12 April 2006. It must be taken into consideration in determining sentence.

22. This is a case involving the use of medicine which is not approved for use in weight reduction treatment. It is well known that tiratricol (Qualicana) which has thyroid hormone activity may cause serious side effects including depression, heart attacks and strokes. Medical practitioners must know that it should not be used for weight reduction. Its side effects are too serious for it to be used for this purpose.

23. The case also involves the use of potent medicines which require close monitoring of the patient's condition. Nevertheless, despite the manifestation of serious side effects including suicidal ideas the Defendant failed to deal with the problems. If not for the

mother's close attention and seeking psychiatric treatment for the patient, the patient could have committed suicide and died. The Defendant's attitude is completely irresponsible.

24. We can see no mitigating factor at all. Having regard to the gravity of the case, including the nature and potential danger of the medicines involved, we order that:-

(i) in respect of charges (a) to (j), the Defendant's name be removed from the General Register for a period of 6 months;

(ii) in respect of charge (k), the Defendant's name be removed from the General Register for a period of 10 months;

(iii) in respect of charge (l), the Defendant's name be removed from the General Register for a period of 9 months.

(iv) the orders in sub-paragraph (i), (ii) and (iii) above shall run concurrently, but shall be consecutive to the 3 months removal order made on 16 April 2008.

25. We have considered the suitability of suspending operation of these orders. Given the Defendant's record and the gravity of the case, we do not consider that the orders should be suspended.

26. We feel obliged to repeat the observation of the disciplinary panel in the case on 16 April 2008 that being an employee of a beauty centre is no excuse for a doctor to disregard his professional responsibility to his patients. As is again demonstrated in this case, similar to that case in April 2008, the patient reposed a high degree of trust in registered medical practitioners and would comply with their instructions without question. We must protect the public by preventing unscrupulous members of the medical profession from abusing that trust and jeopardizing the health of the patients.

27. The Defendant mitigated on the ground that the failure to label the name of the prescribing doctor was a measure of the beauty centre to prevent clients from seeking

treatment directly from the employed doctor thus undermining the commercial interest of the beauty centre. That clearly demonstrates his lack of insight into his misconduct, as no doctor should allow any commercial consideration to compromise his professional responsibility to patients.

28. In light of the increasing number of cases involving weight reduction in beauty centers, we wish to take the opportunity to remind the public to exercise particular care to ensure that weight reduction by use of medicine is administered only by registered medical practitioners, and the identity and status of persons administering such medical treatment are ascertained and recorded in order to ensure that follow up action can be taken in case any problem arises.

**Case 3**  
**DISCIPLINARY INQUIRY**

Date of hearing: 11 April 2001

Defendant: Dr. TUNG Hiu Ming (董曉明)

Perforation of the colon during colonoscopy is a well-recognized complication of the operation. It was agreed by both parties and supported by expert witnesses that the perforation of the colon in this case was not the result of the telephone conversation by Dr. TUNG during the colonoscopy. The Council finds that the complainant's evidence was not reliable because expert evidence indicated that the sedation drugs the complainant received would have given rise to amnesia and his recollection would be highly unreliable. His account of the colour of the doctor's gown, the absence of face mask, his wearing of spectacles during operation and his return to the ward by wheelchair was not compatible with the routine practice in the Queen Mary Hospital.

The facts of the case found by the Council are quite different from what has previously been published by the media. These include:

1. The Council is convinced that the first telephone call by Dr. TUNG was made before the commencement of the colonoscopy;
  
2. The second telephone conversation was not made deliberately, but rather inadvertently. There was no evidence to show that Dr. TUNG intended to receive the telephone call. When he received the call, evidence showed that he took steps to stop the conversation and concentrate on the operation; and
  
3. The widely publicized story of the second telephone conversation about talking to a car salesman about sale of car was not supported by evidence. Indeed, evidence showed that no mention of car was ever made during the second telephone conversation. The Council is aware that conversation during some part of medical and surgical procedures is not an uncommon practice in operating theatres. But attention to the patient and his condition must not be compromised in any way. The Council finds that the defendant Dr. TUNG has given a credible account of the incident and supported by evidence. He has not disregarded his professional responsibility and he is not guilty of misconduct in a professional respect.