THE STANDARD OF CARE IN MEDICAL NEGLIGENCE CASES

IT is unknown how often patients sue their doctors for negligence in Singapore and Malaysia. Whatever the current number may be, these actions are likely to increase with the growing public reliance on health care services and the corresponding increase in the number of hospitals and clinics in these countries. One important legal consequence of this will be the development of the law on medical negligence, particularly the standard of care owed by doctors to their patients.

The local courts have looked to English decisions for guidance on this issue and it is probable that this trend will continue. Accordingly, this article will discuss the standard of care expected of doctors in the light of both local and English decisions and, where instructive, some of the more recent Canadian cases as well.

DUTY OF CARE AND CAUSATION

Some preliminary issues should briefly be considered before a detailed discussion of the standard of care. Proof that a doctor has violated the standard of care owed by him to a patient is not of itself sufficient to establish his liability for negligence. Before the standard can apply, there must firstly be established a legal duty on the part of the doctor towards his patient to exercise skill and care.

In relation to a person presenting himself at a hospital, this duty arises as soon as that person is admitted or accepted by the hospital.[1] However, it may not always be easy to determine whether or not the patient has been admitted by the hospital. The English case of *Barnett* v. *Chelsea and Kensington Hospital Management Committee*[2] illustrates this point. The facts were that three night watchmen suffered severe abdominal pains and vomiting after drinking tea. They presented themselves at the accident and emergency department of the local hospital. The nurse on duty telephoned the casualty doctor with the details of their complaint. Without examining the men, the doctor told the nurse to send the men home, instructing them to call their own doctors. The next day, one of the men died from arsenic poisoning. There followed a claim by his widow alleging that her husband's death resulted from the hospital's refusal to diagnose and treat his condition. The claim failed on a point of causation, namely, that the death of her husband was inevitable by the time he presented himself at the hospital. The court, however, appears to have held that the hospital owed a duty of care since it ran an accident and emergency department to which the deceased had presented himself

[1] *Gold* v. *Essex County Council* [1942] 2 K.B. 273.
[2] [1969] 1 Q.B. 428.

with obvious symptoms of illness.[3] It might be that this duty arises only when the patient presents himself at the hospital and not, for example, when he merely describes his complaint to the doctor by phone.[4] In the latter situation, the courts might hold that the patient had not been accepted by the hospital so as to place a reasonable limit on the duty owed by the hospital.

A doctor in general practice will assume a duty of care and potential tort liability only upon agreeing to treat a patient. There is therefore no legal duty for a doctor to render professional services if requested to do so. This is because the law has hardly changed since the early eighteenth century case of *Coggs* v. *Bernard*,[5] the principle of which has been described as follows: "if a person undertakes to perform a voluntary act he is liable if he performs it improperly but not if he neglects to perform it."[6] Thus the English and local position is that a duty of care arises only when a doctor agrees to treat a patient but not upon his refusal to do so. Such a refusal amounts to an omission which, in tort law, does not entail any liability. As one authority has put it, our law continues to "condone the indifference of the Priest and Levite and to dismiss the solicitude of the Samaritan.'"[7]

Once a duty is established, the doctor is under a legal obligation to treat his patient with reasonable care and skill until (i) the patient unilaterally dismisses the doctor; (ii) treatment is no longer required; (iii) the doctor-patient relationship is dissolved by mutual consent; or (iv) the doctor gives his patient reasonable notice and opportunity to retain another physician.

Apart from the requirement of establishing a legal duty of care, it is also necessary, before a doctor is tortiously liable, that the injury to the patient is directly attributable to the negligent conduct of the doctor. In other words, there must be a causal connection between the doctor's conduct and the patient's loss.[8] In this connection, the patient's own conduct should be assessed for, if he is shown to be the author of his own misfortune, he will be precluded from recovering.[9] A patient who is not entirely at fault, but only partially so, will have his damages reduced by the extent of his fault.[10]

[3] See R.G. Lee, "Hospital Admissions — Duty of Care" (1979) New L.J. 567, for the proposition that B*arnett's* case acknowledged a common duty of care based on the existence of an accident and emergency department open to all comers and holding out to them available medical skill See also A. Samuels. "A Doctor's Duty to see his Patient" (1968) Sol. J. 1017.

[4] There are no local or English cases covering this point.

[5] (1703) 2 Ld Raym 909.

[6] *Skelton* v. *London North Western Railway* (1867) LR 2 CP 631, *per* Willes J. at p. 636.

[7] Fleming, *The Law of Torts* (5th ed., 1977) p. 143.

[8] This was the defence successfully raised in *Barnett* v. *Chelsea & Kensington Hospital Management Committee, supra,* note 2.

[9] See *Vellupillai* v. *Government of Malaysia & Anor.* [1970] 2 M.L.J. 63, where it was held that the sole negligence lay with the deceased nurse who had drunk poison from a labelled bottle kept in a refrigerator at the hospital in which she worked.

[10] See Contributory Negligence and Personal Injuries Act, Cap. 31, Singapore Statutes, Rev. Ed. 1970. The Malaysian position is governed by common law see *M.A. Clyde* v. *Wong Ah Mei & Anor.* [1970] 2 M.L.J, 183, *per* Gill F J at p. 187; *Foong Nan* v. *Sagadevan* [1971] 2 M.L.J. 24.

I. THE NATURE AND CHARACTERISTICS OF THE STANDARD OF CARE

The standard of care is the legal yardstick against which the conduct of a doctor is measured to determine his liability for negligence. This standard is the objective standard of the reasonable man:—

> Negligence is the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or something which a prudent or reasonable man would not do.[11]

Where professional men such as doctors are involved, the courts have altered this standard to the objective standard of a reasonable member of that profession. The Federal Court in *Swamy* v. *Matthews & Anor.* applied this modified standard when it said: "A man or a woman who practises a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession — be it the profession of an accountant, a banker, a doctor, a solicitor or otherwise."[12] This is sometimes said to be founded on the principle that a person who undertakes to do work which requires special skill holds himself out as having that skill and the lack of it then becomes blameworthy.[13]

It should be observed that the law does not judge a doctor against the outstanding specialist in his field but only to the average standard expected of a doctor of comparable standing. The Judicial Committee of the Privy Council in *Chin Keow* v. *Government of Malaysia and Anor.* supported this proposition by citing the following passage from an English decision:—

> Where you get a situation which involves the use of some special skill or competence,... 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.[14]

This is a fair position, for to judge the skill of an ordinary doctor against that of an outstanding doctor or a specialist would be intolerably harsh.

It would likewise be unfair to impose the standard of care and skill to be expected of a doctor at the time of a trial when that standard had yet to be reached when the alleged negligence occurred. Thus in *Roe* v. *Ministry of Health & Others*,[15] which reached the English Court of Appeal in 1954, the two plaintiffs had been given

[11] *Blyth* v. *Birmingham Waterworks* (1859) 11 Ex. 781, *per* Alderson B. at p. 784.

[12] [1968] 1 M.L.J. 138, *per* Barakbah L.P. at p. 139, citing with approval *Lanphier* v. *Phipos* (1883) 8 Car. & P. 475. See also *R.* v. *Bateman* [1925] All E.R. 45 which was approved of in *Elizabeth Choo* v. *Government of Malaysia & Anor.* [1970] 2 M.L.J. 171 and *Kow Nan Seng* v. *Nagamah & Ors.* [1982] 1 M.L.J. 128.

[13] This is the maxim *imperitia culpae adnumeratur.* See Winfield, *Tort* (llth ed., 1979) at pp. 87-88; Salmond, *The Law of Torts* (18th ed., 1981) pp. 220-221.

[14] [1967] 2 M.L.J. 45, *per* Sir Hugh Wooding, at p. 47, citing *Bolam* v. *Friern Hospital Management Committee* [1957] 1 W.L.R. 582, at p. 586. See also *Swamy* v. *Matthews & Anor.*, *supra*, note 12, *per* Ismail Khan J. at p. 144.

[15] [1954] 2 Q.B. 66.

a spinal anaesthetic in 1947. This was stored in ampoules which were kept in phenol as an antiseptic precaution. The evidence revealed that it was not then appreciated that there was any danger of the phenol seeping through microscopic cracks in the ampoules and contaminating the anaesthetic. This occurred, as a result of which the plaintiffs suffered serious and permanent incapacity. The court held that, in the state of medical knowledge in 1947, neither the anaesthetist nor any other member of the hospital staff had been guilty of negligence. A similar defence was claimed in *Chin Keow* where the defendant doctor had in 1960 given a patient an injection of penicillin from which she died. At the trial conducted in 1964,[16] the defence contended that the doctor's failure to inquire into the medical history of the patient before administering penicillin was not a negligent omission in 1960. The trial judge rejected this contention when he found that it was then already a well established fact that some patients might be fatally allergic to penicillin. The Federal Court,[17] however, reversed this decision and the case ultimately reached the Privy Council which restored the trial courts' holding. In the course of its judgment, the Privy Council noted that the trial judge had made it abundantly clear that he had not viewed "this 1960 case through 1964 spectacles."[18]

The English courts have further ruled that "it is not every slip or mistake which imports negligence."[19] Such mistakes were regarded as "errors of judgment" in the recent case of *Whitehouse* v. *Jordan.* In the Court of Appeal, Lord Denning drew a sharp distinction between such errors on the one hand and legal negligence on the other, and went on to hold that "in a professional man an error of judgment is not negligence."[20] However, the House of Lords decisively rejected this distinction and holding. In a strong opinion, Lord Edmund Davies ruled:—

> To say that a surgeon committed an error of clinical judgment is wholly ambiguous. For, while some such errors may be completely consistent with the due exercise of professional skill, others may be so glaringly below proper standards as to make a finding of negligence inevitable.[21]

In sum, doctors are not always protected against suits of negligence by submitting that their conduct amounted to an error of judgment. The courts may still determine that such an error fell short of the standard of care expected of the doctor and that he had therefore been negligent.

Policy Considerations

The preceding discussion shows that the legal standard of care requires a doctor to be careful, but not to the extent that he becomes an insurer against accidental slips. He cannot be held negligent if he exercises

[16] [1964] M.L.J. 322.
[17] [1965] 2 M.L.J. 91.
[18] *Supra*, note 14, *per* Sir Hugh Wooding, at p. 47. This was in reference to the remark made by Denning L.J. in *Roe* v. *Ministry of Health & Ors.*, *supra*, note 15, at p. 84, that "we must not look at the 1947 accident with 1954 spectacles."
[19] *Mahon* v. *Osborne* [1939] 2 K.B. 14, *per* Scott L.J. at p. 31.
[20] [1980] 1 All E.R. 650, at p. 658.
[21] [1981] 1 All E.R. 267, at p. 276. See also, *per* Lords Fraser and Russell, at pp. 281 and 284 respectively.

the care and skill of an ordinary competent practitioner in his particular field of medicine. The underlying policy considerations for this kind of standard have been explained at length and in very practical terms by Lord Denning: —

> If [medical men] are to be found liable whenever they do not effect a cure, or whenever anything untoward happens, it would do a great disservice to the profession itself. Not only to the profession but to society at large. Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high: and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England.[22]

The same may be said for Singapore and Malaysia. There is, additionally, the fear that a higher standard might lead to the practice of "defensive medicine", that is, the doctor placing his own interests in not being sued before those of his patient. This fear was vividly expressed by Barakbah L.P. in the Federal Court decision in *Swamy* v. *Matthews & Anor.*:—

> ... a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body — perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body.[23]

It would, however, be a misconception to view these policy considerations as having raised medical practitioners to a special position of privilege. The law places them "in the same position as any other men. Their acts cannot be free from restraint; where they are wrongfully exercised by commission or default, it becomes the duty of the courts to intervene."[24]

Factors in Assessment of the Standard of Care

It has been observed how a doctor is measured objectively against one who possesses and exercises the skill, knowledge and judgment of the normal prudent practitioner in his particular field of medicine. A subjective element is nevertheless involved in the application of the test:

[22] *Whitehouse* v. *Jordan, supra,* note 20, at p. 658. The opening lines of this passage are closely similar to those earlier expressed by the Federal court in *Swamy* v. *Matthews & Anor.*, *supra*, note 12, at p. 139 that "it would be wrong and bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community."

[23] I*bid*., at pp. 139-140.

[24] *Elizabeth Choo* v. *Government of Malaysia & Anor.* [1970] 2 M.L.J. 171, *per* Raja Azlan Shah J., at p. 172.

> Thus in order to decide whether negligence is established in any particular case the act or omission or course of conduct complained of must be judged, not by ideal standards nor in the abstract but against the background of circumstances in which the treatment in question was given.[25]

These circumstances fall into three broad categories: (a) the education and experience of the doctor; (b) the degree of risk involved in the procedure or treatment; and (c) the resources available to the doctor.

(a) *Education and Experience:*

In general, the greater the education and training of a doctor, the higher will be the standard expected of him. Evidence of extensive experience in a speciality will also raise the standard. However, like the general practitioner, the specialist is not an insurer. He will not be held liable for an error of judgment where he has exhibited the care, skill and knowledge of a reasonable and similar specialist.[26] The English case of *Moore* v. *Lewisham Group Hospital Management Committee*[27] illustrates this point. The plaintiff had been anaesthetised by means of spinal anaesthesia as a result of which she suffered paralysis of the left leg. She contended that, having regard to the risks of spinal anaesthesia, the operation should have been performed under one of the relaxant drugs. The court gave judgment to the defendant hospital authority after referring to expert evidence of eminent anaesthetists. It held that the anaesthetist's decision not to administer a relaxant drug "was one which could have been made by a competent and properly informed anaesthetist exercising a proper degree of skill and care."

The Malaysian High Court case of *Elizabeth Choo* v. *Government of Malaysia & Anor.*[28] provides a further illustration. The plaintiff was hospitalised for the purpose of a piles operation but she subsequently left the hospital without the operation being performed. Instead, another operation had to be performed for the repair of her colon which was perforated due to the alleged negligence of the anaesthetist during a pre-operative sigmoidoscopic examination. The court was satisfied on evidence that the anaesthetist had conducted many such examinations previously. It went on to hold that the anaesthetist was competent to perform the examination and that he had exercised the care and caution expected of a medical man with similar experience on the particular occasion in question.[29]

At this juncture, it should be noted that, while an acquisition of experience by a doctor may raise the standard expected of him, a lack of experience will not lower it. Once a doctor holds himself out as a specialist, he will be expected to practise his profession with the standard of care required of the specialist of his field. The problem

[25] H.L. Nathan, "Medical Negligence" (1957), pp. 22-23.
[26] S.R. Speller, "Law Relating to Hospitals" (4th ed., 1965) at pp. 137-138; Winfield, *op.cit.*, *supra*, note 13, at p. 88.
[27] *The Times,* Feb. 5, 1959, cited and discussed in Speller, *ibid.*, at pp. 135-136.
[28] *Supra,* note 24.
[29] *Ibid.*, at p. 173.

which arises here is one of balancing the protection of society against the encouragement of beginners: —

> The skill demanded from beginners presents an increasingly difficult problem in modern society. While it is necessary to encourage them, it is equally evident that they cause more than their proportionate share of accidents. The paramount social need for compensating accident victims, however, clearly outweighs all competing considerations and the beginner is, therefore, held to the standard of those who are reasonably skilled and proficient in that particular calling or activity.[30]

Hence a doctor who had never previously performed a particular operation was nevertheless held liable when he cut a nerve,[31] as was an anaesthetist who performed a trans-tracheal ventilation for the first time.[32] A large proportion of the damages may be borne by the hospital which employs such beginners. The hospital may be found negligent in allowing an inexperienced doctor to perform a task which he was unable to do properly.[33] Hospital boards should accordingly ensure that the assignments given to their doctors are strictly in conformity with their qualifications and experience.

General practitioners may, by the very nature of their practice, engage in treatment or operations usually reserved for specialists. This raises the question whether a general practitioner who does the work of a specialist should be judged by the standard applicable to specialists. Although not clearly indicated by authority, the position appears to be that the general practitioner is liable if he undertakes a medical procedure beyond his competence when he could have referred the case to a specialist.[34] The law thereby dissuades general practitioners from taking on complicated cases for purely monetary motives and the high risk of injury to the patients. Such a practitioner would, however, not be liable if he acted in an emergency and performed his best which, although inadequate, was what could reasonably be expected of a general practitioner in the circumstances.

Medical doctors are not the only professional group whose object is to diagnose and treat human illnesses. Similar objects are professed by such schools as chiropracty, chiropody, homeopathy, optometry and osteopathy.[35] Locally, to this list might be added the Malay medicine man (or "dukun") and the Chinese physician (or "sinseh"). The standard of care expected of a member of a particular school is the objective standard of a reasonable practitioner of that school according to the circumstances of each case. In the Singapore case

[30] Fleming *The* Low *of Torts*, *op.cit*., *supra*, note 7, at p. 110. For an analogous legal proposition applied to learner drivers, see *Nettleship* v. *Weston* [1971] 2 Q.B. 691.

[31] *McKeachie Alvarez* (1970) 17 D.L.R.(3d) 87.

[32] *Holmes* v. *Board of Hospital Trustees of London* (1978) *5* C.C.L.T. 1.

[33] For example, in the English case of *Jones* v. *Manchester Corporation* [1952] 2 Q.B. 852, the Court of Appeal placed 80% of the blame on the hospital for allowing an inexperienced medical officer to administer pentothal, an anaesthetic which required great care in its administration.

[34] Nathan, *op. cit*., *supra*, note 25, at p. 46; Speller, *op.cit*., *supra*, note 26, at p. 137. See *post* pp. 43-44.

[35] *Philips* v. *Whiteley Ltd.* [1938] 1 All E.R. 566; *Gibbons* v. *Harris* [1924] 1 W.W.R. 674; *Grawley* v. *Mercer* [1945] 3 W.W.R. 41; *Penner* v. *Theobald* [1962] 40 W.W.R. 217.

of *Ang Tiong Seng* v. *Goh Huan Chir*,[36] the plaintiff had his left arm amputated when it became gangrenous due to the very tight bandage applied by the defendant, a Chinese physician. The defence counsel submitted that since the defendant was not a qualified medical practitioner, the standard of care and skill to be expected from him was not as high as the standard to be expected from such a practitioner. Although the Court of Appeal refused to rule on the precise standard of care to be expected of a Chinese physician, it was willing to assume that the standard was one that was lower than that required of a qualified medical practitioner. The defendant was nevertheless held liable even on this lower standard because his treatment of the plaintiff was found to be grossly negligent. It is unfortunate that the court did not take the opportunity to clearly lay down the standard of care expected of Chinese physicians. Such a pronouncement would have significantly clarified the local position on this issue.

(b) *The Degree of Risk Involved:*

The standard of care expected of a doctor increases with the degree of risk involved in a certain treatment or procedure. This principle has been expressed succinctly as follows: the law in all cases exacts a degree of care commensurate with the risk.[37]

The risk must be one which the doctor either knew or ought to have known. It follows that the *probability* of a risk occurring is irrelevant as it does not depend upon the knowledge or experience of anyone.[38] Furthermore, no liability arises if the circumstances reveal that the particular risk in question was unknown to the doctor and could not be reasonably anticipated by him. Hence a patient with an abnormal sensitivity towards, say, a form of treatment cannot claim against his doctor if his abnormality was not known to the doctor nor was its occurrence reasonably foreseeable.[39] However, once it is established that the risk was either known or reasonably foreseeable, the doctor cannot plead in defence that the plaintiff was unusual for the law states that the defendant must take the 'victim' of his negligence as he finds him. So in the leading English case of *Smith* v. *Leach Brain & Co. Ltd.*,[40] it was held that if a victim of a negligent act suffers from a pre-cancerous condition which is activated by that act, the wrongdoer is responsible for all the disastrous consequences.

The knowledge and degree of risk was expressly considered in two Malaysian medical negligence cases. In *Chin Keow*,[41] the defendant doctor contended that the number of fatalities due to hypersensitivity to penicillin was comparatively few. This was supported by his own experience of administering an average of one hundred injections of penicillin each day with no previous mishap. The trial

[36] [1970] 2 M.L.J. 271.

[37] *Read* v. *J. Lyons & Co. Ltd.* [1947] A.C. 156, *per* Lord Macmillan, at p. 173. See also Nathan, *op. cit.*, *supra*, note 25, at p. 24.

[38] See *Roe* v. *Ministry of Health & Ors*., *supra*, note 15, where the risk of the anaesthetic being contaminated was commensurate with the probability of the ampoules having microscopic cracks.

[39] See *Ingham* v. *Emes* [1955] 2 Q.B. 366; *Smith* v. *St. Heler H.M.C. The Times*, May 10, 1956; C.L.Y. 5964, Devlin J.

[40] [1962] 2 Q.B. 405.

[41] *Supra,* notes 14, 16 and 17.

court and the Privy Council held that, though the risk was small, it was nevertheless reasonably foreseeable. In fact, the defendant himself had admitted that he knew of the possibility of a person developing hyper-sensitivity to penicillin when given a second dose of the drug, as was the case of the deceased patient. In these circumstances, having particular regard to the magnitude of the risk (i.e. the fatality of a second dose), the defendant owed a duty to each patient to make inquiries concerning the patient's history in relation to penicillin. The second case was *Elizabeth Choo*[42] where, it is recalled, the Malaysian High Court held that the anaesthetist had exercised reasonable care in performing the sigmoidoscopic examination on the plaintiff. The court partially reached this decision by allowing the possibility that the risk of perforation to the plaintiff's colon had been increased by her bicernuate uterus, a physical characteristic which the anaesthetist could not reasonably have foreseen.

Another illustration of how the degree of risk influences the standard of care is the Singapore coroner's court inquiry into the death of *Chen Jen Hau.*[43] The deceased was a patient who had undergone an operation for the removal of his inflamed appendix. The surgeon had removed a tubular piece of tissue which he thought was the appendix but was in fact only fat. The patient died two days after the operation and the autopsy revealed that death was caused by septicaemia due to perforated acute appendicitis. At the inquiry, expert evidence suggested that the particular operation was complicated because the patient was obese and his internal organs were stuck together by pus such that the identification of his appendix became difficult. The court was of the view that the surgeon, having realised the increased complications, should have been put on greater care as the occasion required.

It is therefore seen how the law applies the reasonable foresight test to determine whether a particular risk should be considered in assessing the standard of care. This is a just position for otherwise, there may be cases where a doctor would find himself strictly liable for an injury which he could not possibly have avoided.

(c) *Available Resources:*

Relevant circumstances affecting the standard of care may also include the facilities and equipment available to the doctor. For example, if medical aid had to be given by a doctor on the spot for a victim of a road accident, the risk would inevitably be greater than if the doctor had conducted the emergency operation in his own surgery. With the limited resources available, he could not be judged by the same standard as if he were working in his own surgery or *a fortiori* in hospital.

With regard to human resources, a doctor cannot excuse himself by saying that he was too busy with other cases to attend to a particular patient. While the law does not require that he devote his constant attention to his patients, liability will be imposed upon a doctor if the lack of attention leads to an "avoidable deterioration of the patient's

[42] *Supra*, note 24.
[43] Inquiry No. 1862/76.

condition."[44] In *Kow Nan Seng* v. *Nagamah & Ors.*,[45] the plaintiff had sustained minor leg fractures and was taken to hospital where he was treated by the defendant doctor. A complete plaster cast was applied to the leg but, owing to lack of proper skill in the application and observation in monitoring of the treatment, there was inadequate blood circulation which led to gangrene, necessitating the amputation of the leg. The Federal Court found the doctor negligent, rejecting her contention that the day in which the plaintiff most required care and attention was the doctor's operation day so that she could not properly attend to him.

The tools, or implements and devices, used by a doctor is another area involving resources. The main issue here is the effect on the standard of care when a new tool comes into use by some members of the profession but not by all. It would appear that a doctor need not employ the very latest tools to meet the standard of care but neither can he ignore them once they have found their way into common use. In the English case of *Whitehouse* v. *Hunter*,[46] the plaintiff was told that he had inoperable cancer and, with the belief that he had not long to live, he severed all ties with England and embarked for the United States where he was diagnosed as having chronic cystitus. Surgery revealed a condition of benign prostate hypertrophy but no cancer. He sued the English doctor on the basis that the doctor had not met the standard by failing to verify the diagnosis by a cystoscopic examination. However, the House of Lords held that there was no liability saying that, while the type of cystoscope required was in common use in the United States, it was rare in England at the time and the standard of care did not require the doctor, who did not possess one, to use it.

While the mere use of an older tool is not negligence *per se*, the availability of newer tools may raise the standard of care required when using the older tool. In one Canadian case,[47] the doctor had performed a mastoid operation using a surgical loupe and a chisel. The patient suffered facial paralysis and underwent a second operation by another doctor who used more modern tools, namely, a microscopic dental drill. The Supreme Court of Canada found the first doctor negligent, not for the use of the older method, but for exercising less skill than that of which he was capable. Since he knew that better vision could have been obtained with a microscope than with a surgical loupe, he ought to have exercised more care when checking for bone chips.

In the final analysis, the standard of care is higher both for the doctor who uses a very new tool and also for the doctor who continues to use an older one after his more progressive colleagues have moved to newer approaches.[48] This is therefore another instance where the law has regarded the paramount social consideration to be the compensation of accident victims.

44 Nathan, *op. cit.*, *supra*, note 25, at p. 42.

45 [1982] 1 M.L.J. 128.

46 [1950] W.N. 553; see also the case-note in (1950) Sol. J. 758

47 Eady v. *Tenderenda* [1975] 2 S.C.R. 599.

48 Nathan, op. cit., supra, note 25, at pp. 26 and 28.

II. PROOF OF THE STANDARD OF CARE

The law of negligence requires that a medical practitioner should not fall below the high standards expected by his profession. But who actually sets the standards — is it the courts or is it the medical men? In the terms of *Whitehouse* v. *Jordan,* when is an error of medical judgment a legal wrong?[49] The short answer is that the courts are the ultimate deciders of what the standard should be, although in most cases customary practice is accepted as the measure of this standard. This is consistent with statutory provisions concerning the role of expert evidence as facts for the court to consider. For instance, the Evidence Act states that:—

> When the court has to form an opinion upon a point of... science..., the opinions upon that point of persons specially skilled in such ... science,,.. are relevant facts.[50]

Subject then to the judicial discretion to rule otherwise, "the principle of law is well established that a practitioner cannot be held negligent if he treads the well-worn path; he cannot be held negligent if he follows what is the general and approved practice in the situation with which he is faced."[51]

There are a number of reasons for this legal position. Reference to custom invariably calls for expert medical witnesses who will assist the lay jury and the bench to adequately comprehend and evaluate the professional conduct of a doctor. It also means that the doctor is thereby reassured that his conduct is being evaluated by his professional brethren and not by persons who have no medical training. Furthermore, the courts have been apprehensive of the impact of jury bias on a peculiarly vulnerable profession.[52] Finally, customary practice prevents an arbitrary and shifting standard from being set. A doctor who is assured that adherence to common practice would normally be a sure proof defence, need not have to resort to defensive medicine.

It is important to note that medical science may permit differing methods of treatment for the same ailment or injury. The legal response has been equally flexible, holding that a doctor is not negligent if he conforms with a practice accepted at the time as proper by a responsible section of his profession even though there is a body of competent professional opinion which might adopt a different technique.[53] By way of illustration, in the Malaysian case of *Vellupillai*

[49] See *ante* p. 33.

[50] Evidence Act, s. 47(1), Cap. 5, Singapore Statutes, Rev. Ed. 1970; Evidence Act, s. 45(1), Act 56, Malaysian Acts, Rev. Ed. 1971.

[51] *Elizabeth Choo* v. *Government of Malaysia & Anor*., *supra*, note 24, *per* Raja Azlan Shah J., at p. 172, citing with approval the Privy Council decision in *Vancouver General Hospital* v. *McDaniel & Anor.* (1935) 152 L.T. 56.

[52] For instance, see *Whitehouse* v. *Jordan, supra,* note 20, *per* Lord Denning, at p. 658. Some Canadian jurisdictions prevent doctors from being tried by jury and most impose an exceptionally brief period of limitation: see J.P. McLaren, "Of Doctors, Hospitals and Limitations — 'The Patient's Dilemma'," (1973) Osg. H.L.J. 85.

[53] *Elizabeth Choo* v. *Government of Malaysia & Anor.*, *supra*, note 24, at 172, citing with approval McNair J. in *Bolam* v. *Friern Hospital Committee*, *supra*, note 14, at p. 586. See also *Kow Nan Seng* v. *Nagamah & Ors.*, *supra*, note 45, at p. 130. The doctor's own practice is, of course, irrelevant: see *Chin Keow* v. *Government of Malaysia & Anor*., *supra*, note 14; *Swamy* v. *Matthews & Anor*., *supra*, note 12, *per* Ong F.J. (dissenting) at p. 143.

v. *Government of Malaysia & Anor.*,[54] the deceased had been a staff nurse who had drunk from a bottle under the mistaken impression that it contained drinking water. The liquid was in fact eserine from which poisonous effect she died. Her father as administrator of her estate sued the defendants, contending that they had been negligent in treating the deceased by not immediately administering gastric lavage (or stomach pump treatment). The court rejected this contention after hearing expert evidence that medical opinion was, at least among a body of competent practitioners, moving away from this hitherto universally accepted treatment of poisoning.

Common practice therefore plays a most critical role so that negligence in diagnosis and treatment cannot normally be established without the assistance of expert testimony or in the teeth of conformity with accepted medical practice. However, lay judicial opinion may be substituted for an expert medical one in situations where the ordinary person is competent to judge. The court will not permit doctors to rely on expert evidence and custom where professional procedure fails to make provision for obvious risks. So it has been held that "neglect of duty does not cease by repetition to be neglect of duty."[55] Cases falling within this category often involve pre-cautionary measures. For instance, in *Chin Keow,* the trial judge ruled that a doctor should probe into a patient's medical history before administering penicillin although no clear support could be derived from the available expert evidence that this was then the generally accepted medical practice.[56] Other examples of cases where the courts have imposed the standard of the reasonable layman have involved the failure to remove a sponge[57] and an operating room explosion which was attributable to oxygen cylinders being improperly located.[58]

Medical Evidence

It might be pertinent at this point to state briefly a number of matters relating to the evidence of expert witnesses. The Federal Court in *Chin Keow* was of the view that a judge hearing a medical negligence suit should receive evidence from medical witnesses of the highest professional standing or that such evidence as there was should have been supported by references to the writings of distinguished medical men.[59] In rejecting this view, the Privy Council held that it was sufficient for the trial court to hear evidence from doctors of comparable professional standing as the defendant. This had been satisfied at the trial stage since the standard of care expected of the defendant was that of the ordinary competent medical officer exercising ordinary professional skill.[60] It follows from this decision that the type of expert evidence required by a court would depend on the professional standing of the defendant. Going a step further, it could

54 *Supra,* note 9.

55 *Bank of Montreal* v. *Dominion Gresham Guarantee and Casualty Co.* [1930] A.C. 659, *per* Lord Tomlin, at p. 666, and approved of by Ong F.J. in *Swamy* v. *Matthews & Anor., supra,* note 12, at p. 143.

56 *Supra,* note 16, *per* Ong F.J. at p. 325.

57 *Anderson* v. *Chasney* [1949] 4 D.L.R. 71; affirmed in [1950] 4 D.L.R. 223.

58 *Crits v. Sylvester* (1956) 1 D.L.R. (2d) 502. See also *Penner* v. *Theobald, supra,* note 35.

59 *Supra,* note 17, *per* Thomson L.P., at p. 94.

60 *Supra,* note 14, at p. 47.

also be said to depend on the nature of the alleged negligent act of the doctor. If the act, say, an operation, is ordinarily performed by a specialist, then expert witnesses in that special field should be called but if it can competently be done by an ordinary general practitioner, then the reports and testimonies of such practitioners should suffice.[61]

The other matter concerns communications between lawyers and medical witnesses. The courts will be wary of accepting medical evidence which has been "settled"[62] or tampered with by legal counsel. This was cogently expressed by Lord Wilberforce in *Whitehouse* v. *Jordan* as follows:—

> While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect but self-defeating.[63]

It can therefore be seen from this passage that the impartiality of expert witnesses is crucial to the weight to be accorded to their reports and testimonies. The obvious reason is that the standard of care in medical negligence cases is measured by the opinions of medical men and not by, or in conjunction with, the legal advisers of parties to a suit.

III. Specific Instances of the General Duty and Standard of Care

The general duty to use reasonable skill and care actually comprises many specific instances of such a duty. If a doctor fails to use reasonable care in the performance of any of these instances, he will automatically be in breach of the general duty. This multi-instance duty theory affords the patient additional protection because each act is independently evaluated. The standard of care will not be attained until each specific instance of the general duty has been assessed and found to be satisfied. Some of the more common of these instances will now be discussed.

(1) *Diagnosis and Treatment*

The doctor-patient relationship usually commences when the doctor begins his diagnosis. The case law indicates that a doctor should have a reasonable opportunity for examining the patient and he should exercise ordinary care and diligence in discovering the nature of the ailment or injury. Failure to exercise such care and diligence in diagnosis will render the doctor tortiously liable.[64] This duty is not

[61] Thus in *Elizabeth Choo* v. *Government of Malaysia & Anor., supra,* note 24, at p. 173, although the defendant was an anaesthetist, the standard of care required in performing the sigmoidoscopic examination was that expected of a doctor without specialist training. This was because the evidence revealed that even housemen were trained to perform such examinations.

[62] *Whitehouse* v. *Jordan, supra,* note 20, *per* Lord Denning, at p. 655.

[63] *Whitehouse* v. *Jordan, supra,* note 21, at p. 276, and approved of in the same case by Lord Fraser, at p. 284.

[64] *Swamy* v. *Matthews & Anor., supra,* note 12; *Elizabeth Choo* v. *Government of Malaysia & Anor., supra,* note 24, at p. 172, citing the Scottish case of *Hunter* v. *Hartley* (1955) S.L.T. 213; *Gibbons* v. *Harris, supra,* note 35; *Dale* v. *Munthali* (1977) 78 D.L.R. (3d) 588.

as onerous as it might seem; a doctor will be excused for a mistaken diagnosis if he has met the standard of care required of him when making it. The best judicial statement of this appears in an English authority:—

> ... no human being is infallible; and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession.[65]

One might add that a doctor should normally inquire into the patient's medical history in the course of his diagnosis.[66] Such a precaution could provide valuable information leading to both an accurate diagnosis and correct treatment.

A doctor who has doubts about his diagnosis should refer his patient to a better qualified physician,[67] Any treatment embarked upon in such cases should only be tentative and conducted with extra caution. In the Federal Court case of *Swamy*,[68] the plaintiff, an estate worker, was treated by the estate doctor for an itch. The doctor diagnosed the ailment to be either ringworm or psoriasis and injected the plaintiff with full doses of acetylarsan, an arsenical compound. The plaintiff's limbs subsequently became paralysed and he claimed against the doctor and his employer for negligence in treatment. The court, by a majority, gave judgment to the defendants after concluding that the paralysis was not caused by the injections of acetylarsan nor was the doctor negligent in administering them. However, Ong F.J., in his dissenting judgment, made the uncertainty of the diagnosis the crucial issue in the determination of liability. The following comment by the learned judge is instructive:—

> It is apodeictic that the disease or diseases affecting a patient should be identifiable before the nature of the treatment therefor can properly be considered. Where the symptoms do not enable a clear diagnosis to be made, it seems commonsense that the doctor ought to proceed with his treatment on a tentative basis; certainly not on the assumption of a positive identification of the disease *and its cause.* Therefore,... failure on the part of a physician to exercise proper care in diagnosis is a failure to stand up to the test of skill required of the ordinary skilled man exercising and professing to have his special skill,[69]

Ong F.J. went on to hold that, since the doctor was uncertain about his diagnosis, he should have initially given the plaintiff a test dose.

[65] Nathan, *op. cit., supra,* note 25, at p. 57, referring to *Mitchell v. Dixon* [1914] A.D. 519 (S. Africa, C.A.).

[66] *Chin Keow* v. *Government of Malaysia & Anor., supra,* notes 14 and 16; *Swamy* v. *Matthews & Anor., supra,* note 12. See also *Barnett* v. *Chelsea and Kensineton Hospital Management Committee, supra,* note 2, *per* Nield J., at p. 428.

[67] *Dale* v. *Munthali, supra,* note 64.

[68] *Supra,* note 12.

[69] *Ibid.,* at p. 142. Judge's emphasis.

The doctor was therefore negligent when he administered a full dose which far exceeded the amount specified by the drug manufacturers.

A doctor's treatment of a patient may also render him liable if it falls below the standard of care expected of a medical practitioner of comparable standing. As in the case of diagnoses, a doctor who is uncertain over the course of treatment should refer the patient to a more qualified physician unless this is impossible due to the situation being an emergency. Thus the general practitioner who undertakes a surgical procedure beyond his competence when he could have referred the case to a surgeon would be liable.[70]

A high proportion of medical procedures utilize drugs. An error in the administration of a drug, be it the wrong drug or the wrong dosage, often results in liability. The Singapore coroner's court inquiry into the death of *Lim Hong Bee*[71] illustrates this point. The deceased was a patient who had undergone a successful by-pass operation which removed a block in her right renal artery. The next day, the laboratory results showed that the serum potassium level of the patient was too low. As a corrective measure, the house officer administered a bolus dose of 20 c.c. of potassium chloride soon after which the patient died. The court found that, in accordance with general and approved practice, the potassium chloride should have been diluted and given slowly by drip over a period of several hours. Hence, although the correct drug had been given, the method of administration was wrong. The court went on to hold that if the house officer was uncertain as to how the drug was to be administered, other medical officers were available for consultation.

The standard of care is therefore elevated by the greater risks in the use of drugs, but liability is not automatic. The plaintiff must always prove negligence and because of the complexities of pharmacology and physiology, it may be difficult to prove the causal link between the drug and the injury,[72] even with the assistance of the evidentiary doctrine of *res ipsa loquitur*[73] If tests or precautionary measures are available or suggested in conjunction with drug therapy, the standard of care may require that they be carried out. For instance, it has been seen in *Chin Keow* how a patient who was allergic to penicillin was successful in a suit against a doctor who neither inquired nor checked her records prior to giving her an injection of penicillin.[74]

Complications following treatment with casts have also received the attention of the courts. These cases usually involve the patient's deteriorating condition which was ignored by the doctor. Unheeded circulatory problems can lead to loss of limbs, and the seriousness of this has moved the courts to impose a high standard of care in the

[70] Speller, *op.cit., supra,* note 26, at pp. 137-138.
[71] Inquiry No. 2031/76.
[72] For example, see the majority decision in *Swamy* v. *Matthews & Anors., supra,* note 12.
[73] In *Swamy* v. *Matthews & Anor., ibid.,* Ong F.J. (dissenting) at p. 143, applied this doctrine in the plaintiff's favour. For a detailed discussion of the application of this doctrine to local medical negligence cases, see A. Harding, "*Res Ipsa Loquiter* in Malaysia and Singapore," unpublished LL.M. Thesis, National University of Singapore (1983) at pp. 26-28.
[74] *Supra,* note 14.

follow-up treatment where casts have been applied. Thus in *Kow Nan Seng,* the doctor was held liable for the loss of the plaintiff's leg when the court determined that she had applied the cast too tightly and had failed properly to monitor the patient's response to the treatment after it was given.[75]

In sum, although the law permits certain clinical errors in diagnosis and treatment, errors falling below the legal standard of care will render a doctor tortiously liable. Careful diagnosis, caution in treatment and referrals of doubtful cases to more learned medical authorities are the best safeguards a doctor has against negligence suits.

(2) *Updating Knowledge and Experimentation*

The doctor's duty properly to diagnose and treat his patient is directly related to his duty to keep abreast with the latest developments in medical science. Since skilful diagnosis and treatment obviously depend on the knowledge of the doctor, he should diligently refer to the most accredited sources of medical information. The law, however, does not place members of the medical profession under the impossible duty of reading every technical paper as soon as it appears, still less of agreeing with the suggestions of every contributor to a medical journal.[76] This was illustrated in the English case of *Crawford v. Board of Governors of Charing Cross Hospital.*[77] The plaintiff suffered from permanent injury caused by his arm being wrongly positioned during an operation, when a blood transfusion to that arm had been administered. An article in a leading medical journal had appeared six months prior to the operation condemning the positioning of the arm which had caused the plaintiff's injury. The anaesthetist had only read letters written in the journal about the article but not the article itself. It was contended that he had been negligent on these grounds but the Court of Appeal held to the contrary. In the course of his judgment, Denning L.J. (as he then was) said:—

> It would, I think, be putting too high a burden on a medical man to say that he has to read every article appearing in the current medical press; and it would be quite wrong to suggest that a medical man is negligent because he does not at once put into operation the suggestions which some contributor or other might make in a medical journal.

Similarly, in *Chin Keow,* the courts rejected the plaintiff's contention that the defendant was negligent in failing to carry out certain suggested sensitivity tests before administering the injections of penicillin. This was because medical opinion was at that time divided as to the value of those tests.[78] However, "the time may come in a particular case when a new recommendation may be so well proved

[75] *Supra,* note 45. See also *Ares* v. *Venner* [1970] S.C.R. 608; *McCormick* v. *Marcotte* [1972] S.C.R. 18; *Vail* v. *MacDonald* (1976) 66 D.L.R. (3d) 530. For a local case involving the loss of an arm caused by a tight bandage, see *Ang Tiong Seng* v. *Goh Huan Chir, supra,* note 36.

[76] Clearly, a doctor would not be liable if the attention of the profession was first drawn to a particular risk only after his alleged negligent operation. See *Roe* v. *Ministry of Health & Ors., supra,* note 15.

[77] *The Times* Dec. 8, 1953, as quoted by Nathan, *op.cit., supra,* note 25 at p. 27.

[78] *Supra,* note 14, at p. 46; note 16 at p. 324; and note 17, at app. 95-95.

and so well known and so well accepted that it should be adopted."[79] A physician will be held liable should he "obstinately and pig-headedly carry on with the same old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion."[80] Hence doctors should keep reasonably abreast with on-going developments in medical science, not merely to avoid negligence suits but, more fundamentally, with the welfare of their patients in mind. These principles apply equally in cases involving the use of tools and equipment.[81]

An enterprising doctor might develop his own techniques and wish to experiment on his patient. It has been suggested that a doctor may "innovate somewhat... if it was done for the benefit of the patient after the established methods of treatment have proven unsuccessful."[82] He will, however, be found liable if his experimentation amounted to a "rash action."[83] The courts appear to have distinguished between experimenting with a new and untried technique and the "utilization of a new advance which carries with it unforeseen damages and difficulties."[84] It would therefore seem that liability will be imposed upon a doctor at the line which the courts draw between initiative and experimentation. A judicial policy in this regard should be developed which will not stifle initiative and discourage advances in techniques while keeping as a paramount consideration, the health and safety of the patient.[85] Doubtless, it is anticipated that the highest standard of care will be expected of a doctor using a new or experimental procedure or treatment. It is no coincidence then that, in these circumstances, the patient is entitled to a full explanation of all risks and it is this duty to inform him of such risks that will now be examined.

(3) *Informing Patients of the Nature and Risks of Treatment*

In addition to the above duties, a doctor has a duty to inform and warn his patient of all the pertinent facts of the case.[86] Failure to do so might constitute a lack of consent and render the doctor liable for technical assault as well as for negligence. The effect of this doctrine of informed consent has been to expand the liability of the medical profession, and the reason for this is quite simple. The law has recognised the truism that things can go wrong in the course of medical treatment without that treatment having necessarily been performed negligently. Hence a patient who is the victim, not of negligent performance of the treatment, but rather of the risks incident thereto

79 *Crawford* v. *Board of Governors of Charing Cross Hospital, supra,* note 77, *per* Denning L.J.

80 *Hunter* v. *Hanley, supra,* note 64, cited with approval in *Chin Keow* v. *Government of Malaysia & Anor., supra,* note 16, and *Bolam* v. *Friern Hospital Management Committee, supra,* note 14.

81 See *ante* p. 39.

82 A.H. McCoid, "The Care Required of Medical Practitioners" (1959) Vand. L.R. 549, p. 583.

83 *Slater* v. *Baker* (1767) 95 E.R. 860. See also *Halushka* v. *University of Sasketchewan* (1966) 53 D.L.R. (2d) 436.

84 Nathan, *op. cit., supra,* note 25, at p. 28.

85 See *Hunter* v. *Hanley, supra,* note 64; *Salmond, op. cit., supra,* note 13, at p. 232.

86 Since *Slater* v. *Baker, supra,* note 83. For a detailed discussion of this duty, see G. Robertson, "Informed Consent in Medical Treatment," (1981) L.Q.R. 102.

can still receive compensation from a doctor who has failed to warn him of these risks prior to undergoing the treatment.

The fundamental question that arises here is the extent of information and explanation required of the doctor. There are no local cases and relatively few English cases on this issue so that any conclusions must of necessity be tentative. It is, however, firmly established that a doctor must obtain the consent of his patient before undertaking treatment. In order for the consent to be valid it must be "real" in the sense that the patient must be informed of the *general* nature and purpose of the proposed treatment; a doctor will not be found negligent simply because he has failed to warn his patient of every risk involved in a proposed course of treatment.[87] More specifically the information given to the patient should include the risks inherent in the treatment. The English High Court in *Chatterton* v. *Gerson* expressed this requirement as follows:—

> In my judgment there is no obligation on the doctor to canvass with the patient anything other than the inherent implications of the particular operation he intends to carry out. He is certainly under no obligation to say that if he operates incompetently he will do damage. The fundamental assumption is that he knows his job and will do it properly. But he ought to warn of what may happen by misfortune however well the operation is done, if there is a real risk of a misfortune inherent in the procedure."[88]

The courts will decide whether a risk is "real" in the same manner as for the other duties of care, that is, by considering whether a reasonable doctor in similar circumstances would have disclosed it to his patient.[89]

The law also appears to have drawn some distinction between the silent patient and an inquiring one in relation to the extent of the doctor's duty to inform his patient of the risks inherent in a proposed treatment. Both types of patients are entitled to a reasonable disclosure of the "real" risks but, in addition, the inquiring patient is entitled to a reasonable disclosure of information relating to the risks about which he has specifically inquired. The clearest judicial statement can be found in the recent Canadian case of *Lepp* v. *Hopp*:—

> When specific questions are directed to the surgeon he must make a full and fair disclosure in response to them. This duty requires a surgeon to disclose risks which are mere possibilities if the patient's questions reasonably direct the surgeon's attention to risks of that nature and if they are such that the surgeon, in all the circumstances, could reasonably foresee would affect the patient's decision.[90]

The last remark in the above passage reflects the legal principle that a patient will succeed in his claim for negligence only if he can

87 *Hatcher* v. *Black The Times,* July 2, 1954, quoted by Robertson, *ibid.*, at p. 114; *Bolam* v. *Friern Hospital Management Committee, supra,* note 14; *Chatterton* v. *Gerson,* [1980] 3 W.L.R. 1003. See also *Smith* v. *Auckland Hospital Board* [1964] N.Z.L.R. 241; *Reibl* v. *Hughes* (1978) 89 D.L.R. (3d) 112.

88 *ibid.*, *per* Bristow J. at p. 1014.

89 *ibid.*, at p. 1013.

90 (1979) 98 D.L.R. (3d) 464, *per* Prowse J.A. (dissenting), at p. 470. See also *Smith* v. *Auckland Hospital Board, supra,* note 87.

establish that he would not have consented to the treatment had the risks been disclosed. The English cases suggest that this issue will be determined by asking whether or not the plaintiff himself would have consented to the treatment had he known of the risks rather than by adopting a purely objective test.[91] However, in testing the plaintiff's credibility and reliability, the court will invariably have to consider a number of objective criteria such as the extent to which the treatment was truly "elective,"[92] and the magnitude and nature of the risk involved.

The law therefore imposes a duty on doctors to inform their patients generally of the nature and risks of proposed treatment. This is based on a recognition of the patient's right to self-determination. The consequence for doctors is that they should realise that time spent in professionally advising their patients is not to be regarded as a favour to their patients but a legal duty owing to them.

CONCLUSION

It has been seen how the current liability of doctors towards their patients depends on establishment of fault. Under this system, the patient who cannot prove that his doctor was negligent receives no compensation for the harm he has suffered. The courts have only been able to express verbal sympathy for these plaintiffs, being resigned to pointing out that the reparation of this physical disadvantage is a wider social and economic task than that with which civil adversary litigation can hope to adequately deal.[93]

The law could, of course, adopt the theory of negligence without fault which seems to be the trend in, tort law today.[94] Under this scheme, a patient would receive compensation regardless of fault. This may be accomplished by providing an insurance scheme analogous to workmen's compensation. Applying loss distribution principles, the whole segment of an industry, both employers and employees or doctors and patients, bear the responsibility for compensation. It is submitted, however, that the doctor—patient relationship necessitates adherence to the fault theory of tort law. Much of this relationship is based on the trust and confidence that the patient has in his doctor. This close association would inevitably deteriorate to the extent that public confidence in the medical profession would be undermined if loss distribution principles are applied to doctors. This is because the currently existing personal or close relationship between a patient and his doctor would be lost to some general compensation scheme to which they both subscribe in a routine way. On the other hand, it is the constant threat of a negligence suit that keeps the medical standard of care high. The publicity given to the subject of medical

91 *Chatterton* v. *Gerson, supra,* note 87, at p. 1012; *Bolam* v. *Friern Hospital Management Committee, supra,* note 14, *per* McNair J. at pp. 590-591.

92 *Videto* v. *Kennedy* (1980) 107 D.L.R. (3d) 612, *per* Grange J., at pp. 622-623.

93 For example, see *Elizabeth Choo* v. *Government of Malaysia & Anor., supra,* note 24, *per* Raja Azlan Shah J. at p. 173; *Whitehouse* v. *Jordan, supra,* note 20, *per* Lawton L.J., at pp. 661-662.

94 A no-fault compensation scheme for patients has been proposed by various writers. For example, see A. Ehrenzweig, "Hospital Accident Insurance: A Needed First Step Towards the Displacement of Liability for Medical Malpractice," (1964) U. of Chicago L.R. 279; J. Finch "*Whitehouse* v. *Jordan*: The Epic that Never Was," (1981) New L.J. 253.

negligence will ensure that doctors adopt safe and reasonable practices in order to maintain their reputation. Thus the present law relating to the standard of care in medical cases appears adequate and ought to be retained since it protects both doctors and patients. Society does not seem to demand, nor does it seem practical, for loss distribution principles to be applied to medical negligence cases.

In conclusion, a doctor must care for his patients according to the duties and standards discussed in this article. The point should, however, be reiterated that the law does not regard him as a guarantor or insurer of good results. As one English judge had occasion to say:—

> It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way.[95]

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[95] *Roe* v. *Ministry of Health & Ors., supra,* note 15, *per* Denning L.J., at p. 83.

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