

Medical Negligence in Hong Kong and How to Avoid It

An Introductory Guide

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Contents

List of Figures	vii
List of Tables	viii
Foreword	ix
Preface	xi
Disclaimer	xiii
List of Cases	xiv
List of Statues	xix
Part I: The Development of the Law of Medical Negligence	1
Chapter 1: Negligence in Common Law	3
1.1: Negligence as a Concept	3
1.2: Elements of Negligence	7
1.3: <i>Res Ipsa Loquitur</i> and Strict Liability	13
1.4: Defenses to the Tort of Negligence	17
1.5: Negligence Claims in Hong Kong	20
1.6: Chapter Summary	23
Chapter 2: The Law of Medical Negligence in Hong Kong	25
2.1: Duty of Care	25
2.2: Breach of Duty	31
2.3: Causation	39
2.4: Assessment of Damages	43
2.5: Disclosure and Consent	48
2.6: Intentional Wrongs	55
2.7: Criminal Negligence	61
2.8: Chapter Summary	66
Chapter 3: Medical Negligence Cases in Hong Kong	67
3.1: <i>Atzori v Chan King Pan</i>	69
3.2: <i>Law Yiu Wai v The Medical Council of Hong Kong</i>	73
3.3: <i>Chan Po Sum v The Medical Council of Hong Kong</i>	76
3.4: <i>Chan Chun Chau v Hospital Authority</i>	79

3.5: <i>Fung Chun Man v Hospital Authority</i>	84
3.6: <i>Luk Mary v Hong Kong Baptist Hospital</i>	87
3.7: <i>Nip Mun Wing v The Medical Council of Hong Kong</i>	90
3.8: <i>Koo Kwok Ho v The Medical Council of Hong Kong</i>	92
3.9: <i>Lai Wing Cheung v Yep Chau Chung</i>	95
3.10: <i>Yu Yu Kai v Chan Chi Keung</i>	97
3.11: Chapter Summary	100
Part II: Practical Issues in Medical Negligence	105
Chapter 4: Risk Management	107
4.1: Medical Records	107
4.2: Confidentiality	111
4.3: The Doctor-Patient Relationship	116
4.4: Informed Consent	119
4.5: Disclosure of Errors	125
4.6: Apologies	126
4.7: The Good Samaritan Doctrine	130
4.8: Doctors and the Media	135
4.9: Defensive Medicine	136
4.10: Chapter Summary	139
Chapter 5: Legal Proceedings	140
5.1: Lodging a Complaint with the Medical Council	140
5.2: Insurance for Medical Professionals	145
5.3: <i>Prima Facie</i> Cases	151
5.4: Evidence and Investigation	153
5.5: The Coroner	157
5.6: Expert Witnesses	159
5.7: Time Limits	163
5.8: Litigation in Hong Kong	167
5.9: Chapter Summary	170
Chapter 6: Alternative Dispute Resolution	172
6.1: Settlement	172
6.2: Alternative Dispute Resolution in Hong Kong	175
6.3: Mediation in Hong Kong	178
6.4: Mediation for Medical Negligence	181
6.5: Chapter Summary	185
Afterword	186
Glossary	188
About the Author	193
Index	194

Figures

Figure 1.1: The court system in Hong Kong	22
Figure 4.1: Outcomes of hospital admissions	117
Figure 5.1: Average indemnity costs for MPS members	148
Figure 5.2: The role of the coroner	157
Figure 6.1: Ways of resolving a medical negligence dispute	176

Tables

Table 2.1: The key differences between criminal negligence and civil negligence	63
Table 5.1: Complaints received by the Medical Council	141
Table 5.2: The work of the Preliminary Investigation Committee	143
Table 5.3: Medical and dental cases opened by the Medical Protection Society	146
Table 5.4: Breakdown of cases opened by the Medical Protection Society	148
Table 5.5: Medical Protection Society subscription rates	149
Table 5.6: Common verdicts for a coroner's inquest	158
Table 6.1: Settlement costs for medical negligence cases	174
Table 6.2: The major differences between litigation and mediation	178
Table 6.3: Mediation reports in the District Court	180
Table 6.4: Mediation reports in the Court of First Instance	181
Table 6.5: Medical claims in the Hospital Authority	183

Foreword

Medical negligence has been a hot topic recently, especially because suspected cases occurred in public hospitals where over 90 percent of patients in Hong Kong received in-patient services. In addition to growing public interest, the booming number of news reports reflects an increasing awareness of the quality of healthcare services. Patients need to wait for prolonged periods of time for specialist medical services, while healthcare professionals suffer from fatigue due to long working hours. Tension among different stakeholders leads to an increasing number of medical negligence lawsuits. One of the effective ways to alleviate the tension would rely on an enhanced understanding of the subject. This book is a good reference for a variety of stakeholders, ranging from policy makers, healthcare professionals, journalists, family members of patients to patients themselves.

Forward-looking policy makers should be aware that, with an ageing population, healthcare demand would be more overwhelming than ever. The number of patients who suffer from chronic diseases and geriatric conditions are expected to rise exponentially, which would exert heavier pressure on the local healthcare system. Occurrence of medical negligence would be expected to rise if the volume of healthcare labor did not match up with the growing demand for healthcare services.

Frequent movement of personnel across the mainland border for work or retirement calls for cross-border healthcare collaboration with mainland China. The Hong Kong healthcare system and those of the cities in the Greater Bay Area are starkly different. We structure, manage, monitor, and evaluate our healthcare services in different ways, and expectations of patients differ as well. Notion of telemedicine would be more commonly put into practice. To prepare for better integration and synchronization of healthcare systems and adoption of technology. It is about time we reviewed whether the law catches up fast enough.

Healthcare professionals are entitled to professional negligence insurance protection coverage, but proper risk management should go beyond reliance on insurance. A positive attitude towards risk management should

include better understanding of relevant law, including duty of care, definition of criminal negligence, and assessment of damages. Apart from healthcare professionals, management teams in the healthcare service industry should be well informed of medical negligence law. Such knowledge would help them plan response mechanism and develop operation guidelines that prevent risks.

Current patient-doctor relationship is characterized by strong reliance on healthcare professionals in terms of healthcare information and knowledge. However, there is a gradual change in patient-doctor relationship as the baby-boomers begin to age. Patients and family members would play a more active role and become more empowered to make well-informed decisions and protect themselves and assert their rights. Legal knowledge also helps them identify various channels to follow up on suspected medical negligence cases, such as by lodging complaints with the Medical Council of Hong Kong, assisting in investigations, or resorting to further legal actions.

Self-health management is not only about behavioral changes such as the adoption of healthy diets and regular exercise. It is also about how one manages one's own health from a holistic perspective. Patients should be empowered to plan their healthcare finances and can communicate with different stakeholders in the healthcare decision-making process. Likewise, patients should be well informed about their rights to take legal actions when they suspect that medical negligence is involved.

Stories about personal rights are always eye-catching. Journalists are therefore inclined to report cases about patients who are alleged to be deprived of their rights in public hospitals, and on cases in which a lack of informed consent and improper medical treatment might have been involved. With legal knowledge, journalists can introduce one more perspective to their readers or audience. The understanding of the legal principles and precedents under the common law system helps journalists develop stronger narratives and more meaningful discourse in society.

Knowledge of the existing law formulates the foundation for further discussion of application and law reform. The law is the backbone of our society's functioning and order and represents the values upheld by our society as a whole. It is anticipated that through better understanding of the law on medical negligence, its risk and occurrence can be minimized over time.

Dr. Lam Ching-choi
Member of the Executive Council of Hong Kong

List of Cases

Note: The numbers refer to sections.

<i>Andrew Graham Young v Ho Chun Kit Peter</i> HCPI 583/2010	2.3
<i>Anns v Merton London Borough Council</i> [1977] UKHL 4, [1978] AC 728, [1977] 2 All ER 492, [1977] 2 WLR 1024	1.2
<i>Arthur JS Hall and Co v Simons</i> [2000] UKHL 38, [2000] 3 All ER 673, [2000] 3 WLR 543	2.2, 5.6
<i>Attorney General v Ho Hing Mui</i> CACV 61/1982	1.4
<i>Attorney General v Yiu Yun</i> [1990] 2 HKC 238 (CA)	1.4
<i>Atzori v Chan King Pan</i> [1998] 2 HKLRD 77	2.2, 3.1
<i>Baker v Willoughby</i> [1969] UKHL 8, [1970] AC 467, [1969] 3 All ER 1528	2.3
<i>Bank of Credit and Commerce International (Overseas) Ltd v Price Waterhouse (No. 2)</i> [1998] BCC 617 (CA)	1.2
<i>Barnett v Chelsea & Kensington Hospital Management Committee</i> [1969] 1 QB 428	2.3
<i>Blyth v Birmingham Waterworks Company</i> [1856] 11 Ex Ch 781, [1856] 156 ER 1047	1.1, 1.2, 2.2
<i>Boccasile v Cajun Music Limited</i> [1997] SCR 694 A2d 686	4.7
<i>Bolam v Friern Hospital Management Committee</i> [1957] 1 WLR 582	2.2, 2.3, 3.1, 3.3
<i>Bolitho v City and Hackney Health Authority</i> [1997] UKHL 46, [1998] AC 232, [1997] 4 All ER 771, [1997] 3 WLR 1151	2.2, 2.3, 3.3
<i>Caparo Industries PLC v Dickman</i> [1990] UKHL 2, [1990] 2 AC 605	1.2, 3.6
<i>Cassidy v Ministry of Health</i> [1951] 2 KB 343, [1951] 1 All ER 574	1.2, 2.2, 3.6
<i>Chan Chun Chau v Hospital Authority</i> DCPI 1424/2001	3.4
<i>Chan Po Sum v The Medical Council of Hong Kong</i> [2015] 1 HKLRD 330 CACV 103/2013	1.1, 3.3, 3.8, 5.1
<i>Chan Pui Ki v Leung On and the Kowloon Motor Bus Co Ltd</i> [1996] 2 HKLR 401	2.4
<i>Chatterton v Gerson</i> [1981] QB 432, [1980] 3 WLR 1003, [1981] CLY 2648	2.5, 2.6
<i>Cheng Man Chi v Tam Kai Tai Carl</i> HCPI 1094/2006	2.2

<i>Chester v Afshar</i> [2004] UKHL41, [2005] 1 AC 134, [2004] 3 WLR 927, [2004] 4 All ER 587	2.2, 2.5, 3.3, 4.4
<i>Chung Man Yau v Sihon Co Ltd</i> CACV 199/1996	1.3
<i>Crouch v King's Healthcare NHS Trust</i> [2004] EWCA Civ 1332	6.1
<i>Daniel Wagner (an infant) v The Hong Kong Adventist Hospital</i> [1999] HCPI 981/98, 3 HKLRD 420	5.7
<i>De Freitas v O'Brien and Connelly</i> [1995] PIQR P281	2.2
<i>Derrick v Ontario Community Hospital</i> [1975] 47 Cal App 3d 145	3.6
<i>Donoghue v Stevenson</i> [1932] UKHL 100, [1932] AC 562	1.1, 1.2
<i>Dorset Yacht Co Ltd v Home Office</i> [1970] 2 All ER 294, [1970] AC 1004, [1970] UKHL 2	1.2
<i>Doughty v General Dental Council</i> [1988] AC 164, [1987] 3 All ER 843	3.8
<i>Eckersley v Binnie and Partners</i> [1988] 18 Con LR 1	2.2
<i>Elan Neeson v Phyllis Agnew and Others</i> [2009] NIQB 10	1.3, 3.4
<i>Emeh v Kensington and Chelsea and Westminster Area Health Authority</i> [1985] QB 1012	2.3
<i>Evans v Liverpool Corporation</i> [1906] 1 KB 160	3.6
<i>Fairchild v Glenhaven Funeral Services Ltd</i> [2002] UKHL 22, [2003] 1 AC 32, [2002] 3 WLR 89, [2002] 3 All ER 305, [2002] ICR 798, [2002] IRLR 53	1.2
<i>Fardon v Harcourt-Rivington</i> [1932] All ER Rep 81, [1932] 146 LT 391	2.2
<i>Fish v Wilcox and Gwent Health Authority</i> [1994] 13 BMLR 134 (CA)	2.4
<i>Fung Chun Man v Hospital Authority</i> [2006] HCPI 1113	3.5, 5.3
<i>Ghosh v General Medical Council</i> [2001] 1 WLR 1915, [2001] UKPC 29	3.7
<i>Hall v Brooklands Auto Racing Club</i> [1933] 1 KB 205	2.2
<i>Hedley Byrne & Co Ltd v Heller & Partners Ltd</i> [1964] AC 465, [1963] 2 All ER 575, [1963] 3 WLR 101, [1963] UKHL 4	1.2
<i>Ho Yee Sup and Another v Dr May Chan Yuk May and Others</i> [1991] 1 HKC 499 HCA003490A/1986	2.2
<i>Horsley v MacLaren</i> [1972] SCR 441	4.7
<i>Hotson v East Berkshire Area Health Authority</i> [1988] UKHL 1, [1987] AC 750, [1987] 2 All ER 909	2.3
<i>Hung Sau Fung v Lai Ping Wai and Others</i> [2011] CACV 240, [2009] HCPI 204	4.2
<i>Hunter v Hanley</i> [1955] SLT 213, [1955] Scot CS CSIH 2, [1955] SC 200, [1955–95] PNLR 1	3.1
<i>Jacqueline Stewart v Nicholas Wright</i> [2006] NICA 25	2.5, 4.4
<i>Jobling v Associated Dairies Ltd</i> [1982] AC 794	2.3
<i>Kelly v Hazlett</i> [1976] 75 DLR (3d) 356	2.6
<i>Khoo James v Gunpathy d/o Muniandy</i> [2002] SGCA 25	4.9
<i>Koo Kwok Ho v The Medical Council of Hong Kong</i> [1988] HKCA 278 CACV0023/1988	1.1, 1.5, 3.8

<i>Lai Wing Cheung v Yep Chau Chung</i> [2005] HCPI 43	3.9
<i>Lamb v Camden London Borough Council</i> [1981] EWCA Civ 7, [1981] QB 625	2.3
<i>Law Yiu Wai Ray v The Medical Council of Hong Kong and Others</i> [2015] HCAL 46	3.2, 5.1
<i>Law Yuk Kwan v Kwok Kwan Ho and Another</i> [2010] DCPI 2177, [2008] HKEC 1862	5.7
<i>Lee Fai and Another v Tung Wah Group of Hospitals</i> [1997] CACV 40	1.2
<i>Lee Suk Yin and Others v National Insurance Co Ltd</i> [2001] HCPI 439/2000	2.4
<i>Leonard Leach v Hospital Authority</i> HCPI001285/2000 [2001] HKLRD 134	5.7
<i>Leung Shu Piu v The Medical Council of Hong Kong</i> [2008] CACV 374	3.3
<i>Leung Sik Chiu v The Medical Council of Hong Kong</i> [2004] CACV 92	3.3
<i>Li Kai Cheong v Lam Ying Wai</i> [2001] 3 HKLRD L18	1.3
<i>Li Ping Sum v Chan Wai Tong and Others</i> [1985] HKLR 176, [1985] AC 446	2.4
<i>Lochgelly Iron and Coal Co v McMullan</i> [1933] UKHL 4, [1934] SLT 114, [1934] AC 1, [1933] SC (HL) 64	1.2
<i>Luk Mary v Hong Kong Baptist Hospital</i> [2006] HCPI 151	3.6, 4.2
<i>Maynard v West Midlands Regional Health Authority</i> [1985] 1 All ER 635	2.2
<i>McFarlane v EE Caledonia Ltd</i> [1994] 2 All ER 1	4.7
<i>McGhee v National Coal Board</i> [1972] 3 All ER 1008, [1972] 1 WLR 1	1.2, 2.3
<i>McKew v Holland</i> [1969] 3 All ER 1621	1.2
<i>Mead v Legacy Health System</i> [2009] 231 Or App 451, [2009] 464, 220 P3d 118	2.1
<i>Mok Lai Fong v Ng Po Shui</i> [2011] HCPI 549/2010	5.7
<i>Montgomery v Lanarkshire Health Board</i> [2015] UKSC 11, [2015] Med LR 149, [2015] SCLR 315, [2015] 143 BMLR 47, [2015] SLT 189, [2015] 2 WLR 768, [2015] 1 AC 1430, [2015] 2 All ER 1031, [2015] WLR(D) 123, [2015] PIQR P13	2.5, 2.7, 3.3, 4.4
<i>Muir v Glasgow Corporation</i> [1943] AC 448, [1943] 2 All ER 44, [1943] SC (HL) 3, [1943] UKHL 2	2.2
<i>Nettleship v Weston</i> [1971] 2 QB 691	1.2, 2.2
<i>Ngan Ching Pai v Chan Wai Lam</i> [1999] HCA 10002/1991	5.7
<i>Nip Mun Wing v The Medical Council of Hong Kong</i> [2014] CACV 231	3.7
<i>Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd</i> [1961] UKPC 2, [1961] AC 388, [1961] 1 All ER 404	1.2
<i>R v Adomako</i> [1994] 3 WLR 288	2.7, 4.2
<i>R v Bateman</i> [1925] 19 Cr App R 8	2.7
<i>R v Garg</i> [2012] EWCA Crim 2520, [2013] 2 C App R (S) 30 CA (Crim Div)	2.7
<i>R v General Medical Council (Mulhem)</i> [2004] CO 3276	2.7
<i>R v Ghosh</i> [1982] EWCA Crim 2, [1982] 3 WLR 110, [1982] QB 1053, [1982] 2 All ER 689	2.6

<i>R v Jordan</i> [1956] 40 Cr App R 152	1.4
<i>R v Kovoali</i> [2013] All ER (D) 48	2.7
<i>R v Sellu</i> [2016] EWCA Crim 1716, [2016] All ER (D) 114	2.7, 4.9
<i>R v Stevenson</i> [2007] EWHC 2132 Admin	2.7
<i>R v Turner</i> [1975] 1 All ER 70	5.6
<i>R (Walker) v General Medical Council</i> [2003] EWHC 2308 (Admin)	2.7
<i>Ratcliffe v Plymouth & Torbay Health Authority</i> [1998] EWCA Civ 206, [1998] Lloyd's LR Med 162	5.3
<i>Re Medical Defence Union Ltd and MJ Bascombe</i> [1991] 1 HKLR 429	5.5
<i>Re Polemis & Furness, Withy & Co Ltd</i> [1921] 3 KB 560	1.2
<i>Ricks v Budge</i> [1937] Utah Sup Ct 91 Utah 307, [1937] 64 P 2d 208	2.1, 2.6
<i>Robert Hung Yuen Chan v Sing Tao Ltd and Another</i> [1996] 4 HKC 539 HCA009418/1994	4.6
<i>Roe v Minister of Health</i> [1954] 2 QB 66 CA, [1954] 2 All ER 131	2.2, 3.6
<i>Roe v Wade</i> [1973] 410 US 113, [1973] 93 S Ct 705, 35 L Ed 2d 147, [1973] US LEXIS 159	2.1
<i>Rylands v Fletcher</i> [1868] UKHL 1, [1868] LR 3 HL 330	1.1
<i>Sanfield Building Contractors Ltd v Li Kai Cheong</i> [2003] 3 HKLRD 48	5.3
<i>SEM v Mid-Yorkshire Hospital NHS Trust</i> [2005] EWHC B3 (QB)	2.5
<i>Shepherd v H West and Son Ltd</i> [1963] UKHL 3, [1963] 2 All ER 625, [1963] 2 WLR 1359, [1964] AC 326	2.4
<i>Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital</i> [1985] 1 All ER 643, [1985] 2 WLR 480, [1985] AC 871, [1985] UKHL 1	2.5, 2.6, 3.3
<i>Sin Chung Yin v The Dental Council of Hong Kong</i> [2014] 4 HKLRD 337, CACV149/2013	3.7
<i>So Sau Man v The Hospital Authority</i> [2001] 1 HKLRD 280, HKCU82/2001	2.4
<i>Southampton Container Terminals Ltd v Hansa Schiffahrts GmbH (The Maersk Colombo)</i> [2001] EWCA Civ 717	6.1
<i>Stanley v McCarver</i> [2004] CV 03 99 PR	2.1
<i>Sullenger v Setco Northwest</i> [1985] 74 Or App 345, [1985] 702 P2d 1139	2.1
<i>Surgical Consultants, PC v. Ball No. 88–538. Court of Appeals of Iowa 447 N.W.2d 676 (1989)</i>	2.6
<i>To Chun Fung v The Medical Council of Hong Kong</i> [2002] 1 HKC 571	3.8
<i>Tse Fung Sin v Tung Wah Group of Hospitals</i> [2007] DCPI 1255	5.6
<i>Tung Ka Chun and others v Hospital Authority</i> [2014] DCPI 398	5.4
<i>Turner v The Minister of Defence</i> [1969] 113 SJ 585	2.4
<i>Watt v Hertfordshire County Council</i> [1954] 1 WLR 835	2.2
<i>Whitehouse v Jordan</i> [1981] 1 WLR 246, [1980] UKHL 12, [1981] 1 All ER 267	2.2, 5.6
<i>Wilsher v Essex Area Health Authority</i> [1988] AC 1074	1.2, 2.2

<i>Wong Ieok Hei v Kwok Kwan Ho</i> [2014] HCPI 22/2012	5.7
<i>Wong Kim Ying v Hospital Authority</i> [2006] HCPI 265/2004, HKEC 1182	5.7
<i>Wong Wai Ming v Hospital Authority</i> [2001] 3 HKLRD 209	2.2
<i>Wong Yiu Ming v To Chark Wah</i> [1993] 1 HKC 510	1.3
<i>Wu Yim Kwong Kindwind v Manhood Development Limited</i> [2012] DCCJ 3839	6.2
<i>Yu Yu Kai v Chan Chi Keung</i> [2004] CACV 433	3.10, 5.3
<i>Yuen Kun Yeu v Attorney General of Hong Kong</i> AC 175, [1987] 2 All E R 705, (1987) 3 WLR 776, [1987] UKPC 16	1.2

List of Statutes

Note: The numbers refer to sections / page numbers.

Apology Ordinance (Cap 631)	4.6.2.1 / 128
Application of English Law Ordinance 1966 (Cap 88), Section 3(1)	1.1.2 / 4
Arbitration Ordinance (Cap 609)	6.2.3 / 177
Basic Law, Article 8	1.1.2 / 4
Civil Evidence Act in 1972	5.6.2 / 161
Coal Mines Act 1911, section 49	1.2.1 / 8
Coroners Ordinance (Cap 504)	5.5.3 / 159
Dentists Registration Ordinance (Chapter 156 of the Laws of Hong Kong)	1.5.1 / 20
Dangerous Drugs Ordinance (Cap 134)	2.7 / 61
Emergency Medical Treatment and Labor Act (EMTALA)	2.1.3.1 / 30
Fatal Accidents Ordinance (Cap 22)	2.4.1.1 / 44–45
High Court Ordinance (Cap 4). Section 56A	2.4.2 / 47
Hospital Authority Ordinance (Cap 113).	2.1.1.1 / 26
Law Amendment and Reform (Consolidation) Ordinance (Cap 23)	2.4.1.1 / 45, 5.7.2 / 164
Limitation Ordinance (Cap 347), section 27	5.7.1 / 163; 5.7.2 / 164
Limitation Ordinance (Chapter 347), section 22(1), section 27(5),	1.4.5 / 20
Mediation Ordinance (Cap 620),	6.2.2 / 177, 6.3.2 / 179
Medical Registration Ordinance (Cap 161)	5.1 / 140
Personal Data (Privacy) Ordinance (Cap 486)	4.2 / 111, 4.2.1 / 113
Practical Direction 18.1 (PD 18.1)	1.5.2 / 20, 5.6.3 / 162
Practical Direction (PD) 31	6.3.1 / 179
Theft Ordinance (Cap 210), section 2	2.6.3 / 60
UNCITRAL Model Law	6.2.3 / 177

Part I

The Development of the Law of Medical Negligence

Part I looks at the development of negligence in common law. Negligence arose as part of English tort law. It is a relatively recent concept. Only two centuries ago, any injury caused by medical malpractice was a matter for prosecution in the English criminal courts. However, owing to a lack of criminal intent, it evolved into a civil matter.

Over the years, tort law has developed dramatically. So too, however, has medical science. In fact, in recent decades the growth of medical technology has far outstripped developments in the legal sphere. Moreover, progress in the fields of mass communications and insurance, coupled with an increasing awareness among the general public of their legal rights, has left many medical practitioners playing catch-up.

The Hong Kong Special Administrative Region (HKSAR) features a common-law legal system. Over the last 30 years, there have been a number of important court cases related to medical negligence here, and these decisions have developed the law. The most significant cases will be discussed in Chapter 3.

1

Negligence in Common Law

Objectives

By the end of this chapter, you should be able to:

- Explain the concept of negligence
- Identify the four elements in an actionable negligence case
- Understand some of the approaches used to establish liability
- List the most commonly used defenses to negligence
- Outline the procedure for medical negligence claims in Hong Kong

1.1: Negligence as a Concept

1.1.1: Historical background

Negligence is a tort arising from old English law after the Norman Conquest. A tort is a wrongful act, and under the Normans the punishment was the payment of a fine to either the courts or the king. As a result, a division arose between civil pleas and pleas of the crown, marking the origins of the common law and the law of equity in the English legal system.

Tort derives from an Old French word meaning wrong, injustice or crime. It implies a civil wrongdoing. *Negligence* comes from the Latin *neg-legere*, which literally means not to pick up something. The tortfeasor, or wrongdoer, is the defendant in a tort case. The person who suffered is the plaintiff or claimant.

1.1.1.1: Rationale

“A ship stranded and passengers drowned; pedestrian killed in a car crashed because the driver is playing with his cell-phone; an estate agent sells property with incomplete legal title lacking proper investigation; a patient dies because of a drug overdose.”¹ All these events happen all the time, and the victims are likely to seek justice and compensation.

1. Glofcheski, *Tort Law in Hong Kong*, 1.

A tort is a form of wrongful conduct resulting in harmful consequences, and the law may award compensation for such consequences as personal injury or damage to property. While tort law requires the wrongdoers to pay compensation, it awards compensation only if the tortfeasor was at fault for the harm caused. Fault generally means either a failure to take reasonable care or an intention to cause unwanted contact or interference with a person or property.

1.1.1.2: Scope

Tort law covers a diverse group of legal principles: trespass to the person, negligence, employer's liability, occupier's liability, product liability, liability for animals, land torts, statements harming reputation (defamation), interference with chattels, nuisance and the rule in *Rylands v Fletcher* [1868]. The scope is so wide that, for the purposes of this book, we will limit it to the law of negligence only.

1.1.2: Status in Hong Kong

Hong Kong tort law comes from case law and legislation. The decisions of the courts are the major source of tort law in Hong Kong and provide the basis for most of the principles presented in this book. English law is also a source of tort law in Hong Kong, as a result of Hong Kong's previous status as a British colony. Section 3(1) of the Application of English Law Ordinance 1966 (Cap 88) provided: "The common law and the rules of equity shall be in force in Hong Kong . . . so far as they are applicable."

The application of English Law continues following the transfer of sovereignty to the People's Republic of China on July 1, 1997. Article 8 of the Basic Law, the mini-constitution that governs the Hong Kong Special Administrative Region (HKSAR), states: "The laws previously in force in Hong Kong, that is, the common law, rules of equity, ordinances, subordinate legislation and customary law shall be maintained." As a result, Hong Kong courts are able to make references to English case law. According to Article 84 of the Basic Law, references can also occasionally be made to other common-law jurisdictions, such as the United States of America, Canada, Australia, New Zealand, Malaysia and India. However, even important cases from the highest courts of these jurisdictions are of persuasive value only.

Hong Kong currently lags behind other common-law jurisdictions in terms of statutory reforms. In England, the Defective Premises Act 1972, the Consumer Protection Act 1987, the Occupier's Liability Act 1984 and the Torts (Interference with Goods) Act 1977 were all reformed, yet there are no equivalent statutes in Hong Kong. Moreover, law enacted in the United Kingdom after the handover, such as The Protection from Harassment Act

1997, has no counterpart in Hong Kong. Most English case law interpreting UK legislation (if there is an equivalent law in Hong Kong) is, however, still relevant in Hong Kong courts.

1.1.3: Law of negligence

1.1.3.1: Legal definition

The court in *Blyth v Birmingham Waterworks Co* [1850] defined negligence in English common law as follows: “Negligence is the omission to do something which a reasonable man . . . would do, or doing something which a prudent and reasonable man would not do.” An alternative definition is provided in the textbook as follows: *Winfield & Jolowicz on Tort*: “Negligence as a tort is a breach of a legal duty to take care which results in damage to the claimant.” Legal negligence does not take into account the state of mind of the tortfeasor.

The law of negligence is based on the House of Lords decision of *Donoghue v Stevenson* [1932]. Mrs. McAlister Donoghue went to a cafe with a friend, who bought her a bottle of ginger beer and an ice cream. The ginger beer came in an opaque bottle, so the contents could not be seen. Mrs. Donoghue poured half the contents of the bottle over her ice cream and also drank some from the bottle. After eating part of the ice cream, she then poured the remaining contents of the bottle over the ice cream and a decomposed snail fell from the bottle. Mrs. Donoghue suffered personal injury in the form of psychological harm and gastroenteritis as a result and brought a claim against the manufacturer of the ginger beer.

The issue underpinning the case was whether the manufacturer of a product had a legal duty to the consumer to take reasonable care that the product was free from defects likely to cause injury. Lord Atkin established the “neighborhood principle” in response: “The rule that you are to love your neighbour becomes in law you must not injure your neighbour; and the lawyer’s question ‘Who is my neighbour?’ receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.”

Donoghue v Stevenson established the principle that a defendant owes a claimant a duty of care if there is a relationship of neighborhood in the sense that it can reasonably be foreseen that the claimant is likely to be affected by an act or omission. The manufacturer made the product, the cafe served it,

and Mrs. Donoghue's friend purchased it. The challenge, then, is to identify the person who owes a duty.

1.1.3.2: Statutory law

The system of statutory laws, which ceased to operate in Hong Kong following the handover in 1997, continues in the United Kingdom, and many statutes relating to medical negligence have been introduced in England and Wales in recent years. Since most medical services in England and Wales are provided by the National Health Service (NHS), a program has been set up to cover medical negligence in the NHS. Medical liability for staff employed by the NHS in England is addressed through the tort principle of vicarious liability. Where claims for negligence arise against employees of the NHS, a program known as the Clinical Negligence Scheme for Trusts addresses the issues. The program is funded through contributions by NHS Trusts that are members and operates on a "pay-as-you-go" basis, funding claims out of the monies it raises. The NHS Litigation Authority administers the program.

The application of vicarious liability has resulted in a government policy known as NHS indemnification, which arises when an employee of the NHS is responsible in the course of their work for a negligent act or omission (commonly referred to as "clinical negligence") which results in harm to an NHS patient or volunteer. The NHS has provided guidance in a document entitled *NHS Indemnity* stating that when it is vicariously liable for the negligent healthcare professional, it should "accept full financial liability where negligent harm has occurred, and not seek to recover costs from the health care professional involved."

When negligence is alleged, the NHS is responsible for meeting "the legal and administrative costs of defending the claim or, if appropriate, of reaching a settlement," "the plaintiff's costs, as agreed by the two parties or as awarded by the court" and "the damages awarded either as a one-off payment or as a structured settlement." NHS indemnity covers only the financial consequences of a clinical negligence program, not complaints or disciplinary or regulatory hearings, and does not extend to General Practitioners (primary care physicians) or to "general dental practitioners, family dentists, pharmacists or optometrists," "other self-employed health care professionals eg independent midwives," "employees of NHS practices," "employees of private hospitals," "local education authorities" or "voluntary agencies." General Practitioners typically belong to a medical defense society or union which will provide advice and may undertake the defense and settlement of the case.

In Hong Kong, a similar system of vicarious liability operates within the Hospital Authority. However, there are no guidelines stating when the authority is vicariously liable for the negligent healthcare professional, and

no litigation authority with independent funding. Instead, the Hospital Authority buys insurance for coverage.

1.1.3.3: The Koo test

A common-law rule which is used in Hong Kong to decide whether a doctor has been negligent is commonly known as the “*Koo test*.” This refers to *Koo Kwok Ho v The Medical Council of Hong Kong* [1988], a case which resulted in the defendant being removed from the register of medical practitioners for three months for professional misconduct.

The test is not very specific, as it applies to “misconduct in any professional respect,” as stated in section 21(1)(b) of Chapter 161 of the Medical Registration Ordinance. It was reaffirmed in a recent case, *Chan Po Sum v The Medical Council of Hong Kong* [2015]. Both cases will be discussed in detail in Chapter 3.

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1.2: Elements of Negligence

1.2.1: Statutory negligence

The term “statutory negligence” was coined by Lord Wright in *Lochgelly Iron and Coal Co v McMullan* [1933], a case in which the claimant alleged that his son, a coal miner in the employment of the defendant, had been killed due to “fault and negligence” on the part of the defendant. The claimant’s case was that his son had been set to work at a place of danger, as the roof adjacent to his place of work was unsupported and fell, bringing down part of the roof

nearly and killing him. The claimant alleged that he had suffered damage, and that the accident was the result of a breach by the defendant of the statutory obligations imposed upon him by section 49 of the Coal Mines Act 1911, which stated that: "The roof and sides of every travelling road and working place shall be made secure, and a person shall not, unless appointed for the purpose of exploring or repairing, travel on or work in any travelling road or working place which is not so made secure."

In his judgment on the case, Lord Wright stated that these provisions in the Coal Mines Act imposed a special duty upon the employer towards those for whose safety they were designed. He therefore dismissed the defendant's argument that the employer could not be liable unless he himself was guilty of the act or omission complained of, or had ordered it or in some way was privy to it. He concluded that, "In strict legal analysis, negligence means more than heedless or careless conduct, whether in omission or commission; it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing."

The duties were imposed under statute and also a common law duty of care in the tort of negligence. Two different approaches can be found. The first approach is the "statutory negligence" when the court complies with the intention of the law-makers from the statute. The second approach is to apply the common law as "common law duty" by precedent unless there is exemption from the statutes. Both approaches become to the three elements with minor differences (depends on situations).

These three elements—the duty of care, the breach of duty, and the damage—together with a link of causation between the breach and the damage, have become the essential components of an actionable negligence claim.

1.2.2: Duty of care

The concept of a duty of care was established in *Donoghue v Stephenson* [1932], with Lord Atkin asserting the "neighborhood principle," whereby a defendant owes a claimant a duty of care if it can reasonably be foreseen that the claimant is likely to be affected by an act or omission. Lord Buckmaster dissented from the majority in the ruling, asserting that the neighborhood principle should only apply in two circumstances: where the article was dangerous in itself, and where it had a defect known to the manufacturer. However, his attempt to narrow the scope of the duty of care was unsuccessful, and in a later case, *Dorset Yacht Co Ltd v Home Office* [1970], omission liability was established by Lord Reid. Ruling on a claim for damage caused by seven borstal trainees, Lord Reid judged that the borstal officers responsible for the trainees ought to have foreseen the damage as "likely to occur

if they failed to exercise proper control or supervision,” and therefore concluded that the officers owed a duty of care to the claimant.

The neighborhood principle was modified in *Anns v Merton London Borough Council* [1977], in which Lord Wilberforce used a two-stage test to determine the existence of a duty of care. First, one has to ask whether there is a sufficient relationship of proximity between the alleged wrongdoer and the person who has suffered damage, based on the foreseeability of the damage occurring. Secondly, if the first question is answered in the affirmative, it is necessary to “consider whether there are any considerations which ought to negate, or to reduce or limit the scope of the duty or the class of person to whom it is owed or the damage to which a breach of it may give rise.”

Further confusion arose from the decision made by Lord Bridge in *Caparo Industries PLC v Dickman* [1990], which introduced a singular composite test stating that for a duty of care to exist, three conditions had to be satisfied: harm must be reasonably foreseeable as a result of the defendant’s conduct; the parties must be in a relationship of proximity; and it must be fair, just and reasonable to impose the liability. However, the test failed to really clarify the issue. Indeed, as David Howarth commented in his textbook *Tort Law*, the word *proximity* had “begun to float in a sea of meaninglessness.”

In *Bank of Credit and Commerce International (Overseas) Ltd v Price Waterhouse (No. 2)* [1998], the English Court of Appeal tried to search for a principle or test for establishing a duty of care by following four separate but parallel paths: the threefold *Caparo* test, the assumption of responsibility test, the *Hedley Byrne* principle (which recognizes liability for pure economic loss arising from a non-contractual relationship) and the incremental approach. At this point the law becomes too complicated for a layperson to fully grasp.

In Hong Kong, there was an important Privy Council decision before the handover. In *Yuen Kun Yeu v Attorney General of Hong Kong* [1987], Lord Keith held that the Commissioner of Deposit-taking Companies owed no duty of care to depositors who lost their money to registered companies. The commissioner, therefore, was not liable for failing to revoke the registration of a company with which the claimant had deposited money that was subsequently lost. Foreseeable harm is a necessary ingredient of a duty of care, but it is not the only one. Otherwise, liability would arise whenever anyone neglected to shout out a warning to a person who was about to walk off a cliff. The issue is clear-cut in most situations, however, because there is a presumed duty of care as common sense. It is a social norm that we are expected to save lives if possible. However, it cannot be extended to others’ properties. Duties of care may have difference in definition by applying difference case laws. (*Donoghue, Anns, and Caparo are good laws but applied differently.*)

1.2.2.1: Medical-related cases

In *Cassidy v Ministry of Health* [1951], the Court of Appeal asserted that when a patient chooses a doctor, the doctor owes him or her a duty of care. However, since the doctor in the case was employed by a hospital, he was essentially integrated into the health service, and the Ministry of Health was therefore vicariously liable for his actions.

In *Nettleship v Weston* [1971], the Court of Appeal ruled that the standard of care expected of a learner driver should be the same as that applicable to an experienced driver. Lord Denning held that applying a lower standard to a learner driver would have unwelcome implications, for example that an inexperienced doctor owed his patient a lower standard of care if the patient was aware of his lack of experience. Thus, in *Wilsher v Essex Area Health Authority* [1988], Lord Mustill rejected the doctor's inexperience as a consideration in determining the standard of care owed to the plaintiff.

The establishment of a doctor-patient relationship, and hence a duty of care, will be discussed further in Chapter 2.

1.2.3: Breach of duty

The standard of care expected in law is defined by the "reasonable man rule," a general rule in common law that is used to determine liability. A "reasonable" man is a hypothetical person who exercises average care, skill and judgment in his actions. The reasonable man rule was applied in *Blyth v Birmingham Waterworks Company* [1856], with Baron Alderson stating: "Negligence is the omission to do something that a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."

There are two questions that need to be asked when assessing whether a breach of duty has occurred:

1. What is the standard of care required in law?
2. Has the defendant fallen below the standard?

The first is a question of law and is mostly objective. The second is a question of the facts of the individual case and is more subjective.

Breach of duty in medical negligence will be discussed in Chapter 2.

1.2.4: Causation of damage

The basic approach to establishing causation of damage is the "but for" test. The test simply asks whether, but for the negligence of the defendant, the claimant would have suffered a loss. In this test, the claimant bears the burden of proof. In relatively straightforward cases, the "but for" test is

easily satisfied, as the inquiry is simply technical or evidentiary. It is simple when cause-in-fact is determined by the but-for test. If the driver did not go cross the intersection in red light, the collision should not have occurred. However, in more complex cases, there may be a probabilistic cause or two separate causes for the same damage, or the claimant may have broken the chain of causation that links the negligence and the damage.

In *McKew v Holland* [1969], the claimant was judged to have broken the chain of causation. The claimant had been injured at work due to his employer's breach of duty, after attempting to climb down a steep concrete staircase without a handrail. Part of the way down, the claimant's leg had given way, so he had jumped 10 steps to the bottom, fracturing his ankle and causing a permanent disability. However, the claimant suffered from pre-existing morbidities in his back, hips and leg, so his action in attempting to climb down the steps unaided was held to be a *novus actus interveniens* (an act that breaks the causal link between the wrongdoing and the damage). The defendant was therefore not liable for the injuries resulting from the incident.

McGhee v National Coal Board [1972] was an important case in terms of causation, with the House of Lords ruling in favour of the claimant, a kiln worker who had sued his employer for failing to provide proper washing facilities. The claimant had developed dermatitis, and although there was no medical proof that the washing facilities would have prevented this, it was held that the defendant had materially increased the risk of the worker developing the condition by failing to provide the facilities. The ruling was significant in that the claimant had not passed the "but for" test. Instead of demonstrating that the defendant's actions were the cause of the injury, he had merely established that they had materially increased the risk of injury. The implication was that the burden of proof in cases of negligence had shifted onto the defendant.

The ruling in *McGhee v National Coal Board* was reinforced by *Fairchild v Glenhaven Funeral Services Ltd* [2002], where the House of Lords, rather than applying a "balance of probabilities" test under the "but for" standard, considered whether the defendant had materially increased the risk of harm towards the claimant. The case involved a worker who had died of mesothelioma as a result of inhaling substantial quantities of asbestos dust while working for a number of different employers. Since a single asbestos fibre can trigger mesothelioma, and since it can take anywhere from 25 to 50 years for symptoms of the disease to appear, it was impossible for the claimant to prove that any one employer was to blame. However, it was held that it was wrong to deny the claimant any remedy, and the employers were found to be jointly liable. The impact of the decision was huge, as about a dozen people in Britain were dying every day as a result of asbestos-related disease during that period.

Causation in medical negligence will be discussed in Chapter 2.

1.2.4.1: Remoteness of damage

The principle of remoteness of damage was laid down in *Re Polemis & Furness, Withy & Co Ltd* [1921] and *Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd* [1961]—or *Wagon Mound (No 1)*, as it is more commonly known. However, the decisions are somewhat conflicting. In the former case, a ship was destroyed by fire after a plank dropped by an employee of the defendant, who was loading cargo, caused a spark which ignited some petrol vapour in the hold of the ship. The Court of Appeal held that the defendant was liable for the damage caused by the fire, since the fire was a direct, though highly unforeseeable, consequence of the negligent act (the dropping of the plank).

In *Wagon Mound (No 1)*, a House of Lords ruling, the claimant's wharf suffered substantial damage when oil discharged from the defendant's ship caught fire after hot metal produced by welders on the wharf had fallen on some floating cotton waste. The judicial committee held that the defendant was not liable for the fire damage, because the oil had only caught fire as a result of the cotton waste, so the fire could not have been reasonably foreseen.

The remoteness of damage is not usually an issue in medical negligence, because a patient's loss cannot be remote if a doctor-patient relationship has been established. However, there are some exceptions, and these will be discussed in Chapter 2.

1.2.5: Status in Hong Kong

The courts in Hong Kong follow the same principles concerning duty of care, breach of duty, causation and damage in cases involving medical negligence. For a medical negligence claim to be successful, all four elements need to be proven. However, duty of care is not a difficult issue in healthcare cases and identifying damage after an unsatisfactory medical treatment is usually fairly straightforward, so any disputes tend to focus on the medical standard and whether the treatment has been substandard.

In *Lee Fai v Tung Wah Group of Hospitals* [1997], a case involving an infant born with cerebral palsy, which left him with a 100% disability for the rest of his life, the claimant was able to establish a duty of care and prove that the disability had resulted from the illness. However, although she alleged that "optimal therapy in the early periods of such a condition can help to improve the condition" and that "the treatment actually provided . . . fell far short of the desired treatment," she was unable to establish the two other elements necessary for an actionable claim, namely breach of duty and causation. As a

court, not their respective parties. A joint report is very helpful in settling a conflict. It sets out what the experts agree and disagree on and why, and it helps to identify if an additional expert report is required—for example, a report from a psychiatrist for damage assessment.

It is common for a settlement to be reached once all the expert reports have been submitted. If no settlement is reached, however, the case will go to trial.

1.5.3.2: Trial

Medical negligence cases are judged by a single judge without a jury. It may take years to resolve legal proceedings from their initiation through to judgment.

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1.6: Chapter Summary

Negligence is a tort. It derives from the principle that a defendant owes a claimant a duty of care if it can reasonably be foreseen that the claimant is likely to be affected by the defendant's act or omission. The four elements in an actionable negligence case are duty of care, breach of duty, causation and damage.

In cases where the claimant has difficulty in meeting the burden of proof, he or she can use *res ipsa loquitur*, a rule of evidence used to infer that the harm suffered was due to the defendant's negligence. The defendant's state of mind, i.e. intention, is not considered in most negligence cases, but in certain cases strict liability may be applied, making the defendant liable regardless of culpability. The thin skull rule imposes a similarly high standard of care, since the duty of care is the same irrespective of whether the claimant has a pre-existing physical, mental or emotional condition.

The defenses to negligence are *volenti non fit injuria*; contributory / comparative negligence; *novus actus interveniens*; *ex turpi causa non oritur actio*; and the Limitation Ordinance. The best defense is informed consent, which comes under the umbrella of *volenti non fit injuria*.

Medical negligence claims in Hong Kong usually start with complaints to the Medical Council of Hong Kong or the Dental Council of Hong Kong.

If a settlement cannot be reached, legal action commences in either the Small Claims Tribunal (for claims of HK\$50,000 or below), the District Court (for claims of between HK\$50,000 and HK\$1 million) or the Court of First Instance (for claims of over HK\$1 million). The legal process can be lengthy, costly and inefficient.

Part II

Practical Issues in Medical Negligence

Part II looks at the law of medical negligence from a practical perspective. Chapter 4 highlights the main areas where the medical profession is at risk of accusations of negligence and offers some tips to help practitioners avoid any difficulties. As James Badenoch QC commented in a lecture delivered at the Hong Kong Academy of Medicine, part of the University of Hong Kong, in 2015: “People love doctors and hate lawyers when they don’t need them, and they hate doctors and love lawyers when they need them.”

Chapter 5 deals with how an allegation of medical negligence is processed in Hong Kong. The problems of justice and delay are scrutinized, and the roles of important players—such as the Medical Council, insurance providers, coroners, expert witnesses and lawyers—are outlined.

Chapter 6 focuses on alternative dispute resolution (ADR), which offers a humane and economical alternative to litigation. Mediation is one form of ADR that is becoming increasingly popular in medical negligence cases in Hong Kong.

Risk Management

Mistakes are inevitable in medical practice. However, it is essential to avoid them whenever possible, and to face the consequences whenever they occur. Good record keeping is at the heart of risk management for medical professionals, and a good doctor-patient relationship is the best shield against negligence litigation. Even when a good relationship exists between a doctor and patient, however, the doctor must be sure to gain adequate consent before any course of treatment is embarked on. The new concept of informed consent is now in force, and all doctors should act accordingly.

The handling of complaints is not an exact science. However, the skillful disclosure of errors and a careful apology may help to alleviate any problems and stop “fires” from spreading. An awareness of the laws surrounding “Good Samaritan” acts and dealings with the media will also help in this regard. If doctors can master the art of handling complaints, it will help them to avoid the pitfall of defensive medicine, where the provision of treatment is determined less by the needs of the patient than by the desire for self-protection on the part of the doctor.

Professional bodies and insurance companies provide regular lectures, seminars and workshops to help doctors with risk management. They may also provide legal assistance if necessary.

4.1: Medical Records

According to the Medical Council of Hong Kong’s Code of Professional Conduct: “The medical record is the formal documentation maintained by a doctor on his patients’ history, physical findings, investigations, treatment, and clinical progress. It may be handwritten, printed, or electronically generated. Special medical records include audio and visual recording.”

Medical records should be as comprehensive as possible, for as the saying goes, “if it isn’t in the medical notes, it didn’t happen.” The Medical Defence Union (MDU) recommends that, in order to fulfill its primary purpose of supporting patient care, a medical record should include the relevant clinical findings, a differential diagnosis and details of the information disclosed to

the patient. It also recommends that the record include details of any drugs or other treatment prescribed, along with the date of each entry and the identity of the person making the record. Telephone consultations, handwritten notes, test results and general correspondence should all form part of the record. However, correspondence concerning complaints should be filed separately.

The content of a good medical record was suggested in a fact sheet published by the Medical Protection Society in 2013:

1. Relevant details of the history, including important negatives
2. Examination findings, including important negatives
3. Differential diagnosis
4. Details of any investigations requested and any treatment provided
5. Follow-up arrangements
6. What you have discussed with the patient

The presence of chaperones and any instances in which the patient fails to cooperate (such as refusing examination or not complying with treatment) should also be recorded. On subsequent follow-up notes, the patient's progress, findings on examination, monitoring and follow-up arrangements, and details of telephone consultations should all be entered.

It is not possible to include every conversation in the medical record, and for this reason there will never be a flawless medical note. Nevertheless, medical professionals should try their best to keep clear and detailed records, as the records will determine how they will look in the eyes of the expert witnesses and judge in court. As another popular saying goes: "Good records, good defense. Poor records, poor defense. No records, no defense. False records, worse than no defense." The importance of keeping good medical records is illustrated in the cases of *Atzori v Chan King Pan* [1998] (see section 3.1) and *Nip Mun Wing v The Medical Council of Hong Kong* [2014] (see section 3.7). The inadequacy of the medical record was severely criticized in the former case, while credit was given in the latter case for good record keeping.

4.1.1: Clinical findings

Clinical findings include history and physical examination. Only relevant clinical findings should be included in the medical record, and since relevancy varies from case to case, doctors must use their professional judgment to determine which findings are important and which are not.

In a successfully defended case published by the MDU as a case study on December 4, 2013, a football player was suffering from a missed testicular torsion, which resulted in an orchiectomy four days after the original injury. At the initial consultation, the family doctor wrote in the medical record: "Both testicles were normal in size and position. The right testicle was tender

in the lower half." She also noted that there was no evidence of a torsion, and that she suspected the pain was a result of the original injury. Moreover, she advised the patient to seek urgent medical assistance if the pain got worse. As one of the expert witnesses remarked, this advice provided the doctor with a good defense against the claim that was subsequently brought against her. The expert for the defendant put forward the theory that the torsion might have occurred after the consultation. As a result, the MDU solicitor proposed to the claimant that if he discontinued his claim, the MDU would not seek legal costs from him. The proposal was accepted. Both expert witnesses commented that this was a difficult case. However, the excellent medical records, which included examination findings and follow-up arrangements, assisted them in supporting the defendant's position.

In another successfully defended case, a 25-year-old man was treated for a respiratory tract infection which turned out to be empyema thoracis, requiring a left thoracotomy with decortication to drain the pus. The defendant was the family doctor, and the basis for the claim was the alleged presence of hemoptysis during the first consultation. The symptom was recorded in subsequent consultations with other doctors, and the expert evidence supported the claim that if it had been reported to the defendant in the first consultation as the claimant alleged, further investigation would have been required. However, no such symptoms were recorded in the consultation notes, even though the defendant had made very careful notes. The MDU experts therefore concluded that the doctor would have recorded hemoptysis as an important symptom if the patient had reported it. The experts were supportive of the doctor's overall management of the case, and a response was submitted to the claimant's solicitors denying liability on behalf of the doctor on the basis that he had made a comprehensive contemporaneous record, as well as providing prompt and correct safety-net advice. The report of hemoptysis was therefore denied, and the claim was not pursued, thanks in large part to the comprehensive clinical record kept by the defendant.

These two cases explain how settlement negotiation works, and how litigation can be avoided. Keeping a record of the relevant symptoms and signs helped the doctor in the first case. In the second, a detailed record excluded the possibility of omitting relevant information from the consultation. Both cases show how keeping good medical records can help a doctor avoid problems in the future.

4.1.2: Differential diagnosis

Differential diagnosis is also a matter requiring doctors to exercise their professional judgment. How many differential diagnoses are required and what the order of ranking should be is an issue that varies from case to case.

It is very difficult to define liability in terms of which diagnoses ought not to have been missed. If a doctor missed a diagnosis and he or she had a reasonable explanation, there may not be a case to answer. However, if the diagnosis missed was more likely than the one that was followed up on, it is better to be able to show that other possibilities were considered. The essential component of the differential diagnosis is the use of reasonable medical judgment. If a doctor eliminates a possibility simply because a condition is rare, that is not enough. The judgment must be reasonable, and it must be based on the information available. This does not mean, however, that doctors have to order every possible test to eliminate every possible disease.

4.1.3: Disclosure

The doctor's decision in respect of the most likely diagnosis should be discussed and recorded in the medical record. It should also be communicated to the patient, with a record made of all the information that is shared. In the old days, a relative of the patient could request the doctor not to inform the patient of his or her condition, or to even lie to the patient. However, today this will constitute a legal offense if you lie to your patient, even if you are only complying to his/her relative. There might be a conspiracy and you are abetting and aiding crime.

The process of clarifying the medical record can include mentioning "negative" information, such as the patient's denial of a history of injury. The aim of the process is for the doctor to gain informed consent for the chosen course of treatment. Duty of disclosure and consent were discussed in detail in section 2.5.

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4.4: Informed Consent

The nature and importance of consent in medical practice was been discussed in section 2.5. This section focuses on the concept of informed consent. The key question here is how much information must be shared with the patient in order to obtain informed consent.

4.4.1: Definition

Informed consent is not the same as consent. Consent is a unidirectional process in which the information flows from the doctor to the patient, who gives his or her approval (written, verbal or implied) for the treatment recommended based on the information that has been made available to him or her. Informed consent, on the other hand, involves a process of interactive communication between patient and clinician which results in the patient's voluntary authorization for a specific medical treatment or intervention after he or she has been informed of all the relevant aspects of the treatment, including its general nature, effect and risks.

Doctors are required to obtain informed consent before embarking on a course of treatment. There are four components of informed consent:

1. the patient must have the capacity to make the decision;
2. the medical provider must disclose all the relevant information about the treatment, test or procedure in question, including the expected benefits and risks, and the likelihood of these benefits and risks occurring;
3. the patient must understand the relevant information;
4. the patient must grant consent without coercion.

In October 2011, the Medical Council of Hong Kong revised section 2 of its Code of Professional Conduct to include the stipulation that a doctor's explanation of a proposed treatment "should cover not only significant risks, but also risks of serious consequences even though the probability is low." This looks like a reaction to the ruling in *Chester v Afshar* [2004] (section 2.5), where a surgeon was found to have been negligent after failing to inform a patient of a 1–2 percent risk of paralysis as a result of surgery. In December 2012, the Medical Council further revised section 2.5 of the Code, stipulating: "Express and specific consent is required for major treatments, invasive procedures, and any treatment which may have significant risks." As a result of the revision, consent for surgical procedures involving general or regional anesthesia must now be given in writing, with a clear and succinct record of the explanation given to the patient included on the consent form. The patient, the doctor and the witness (if any) should sign the form at the same time, with each signatory specifying his or her name and the date of signing.

However, a properly signed consent form does not necessarily mean that informed consent has been obtained. The question is still how much information is enough for consent to be informed.

4.4.2: Required information

The essential information for informed consent is as follows:

1. the nature of the decision or procedure;
2. reasonable alternatives to the proposed intervention;
3. the relevant risks, benefits and uncertainties related to each possible treatment;
4. an assessment of the patient's understanding;
5. the patient's acceptance of the proposed treatment.

A medical professional should have no problem in explaining the likely diagnosis and differential diagnosis in any given case. A management plan can then be formulated with the patient, with alternatives to the proposed plan also outlined. The relevant discussions can easily be documented in the medical record, along with a description of the patient's understanding and acceptance of the proposed treatment. The most difficult part, then, is outlining the relevant risks and probabilities, as the list of potential complications resulting from a medical intervention can never be exhaustive.

In a case that went to the Medical Protection Society (MPS), a patient suffering from post-operative uveitis after intra-ocular lens surgery made a claim against her ophthalmologist for medical negligence, alleging that the doctor had failed to obtain informed consent prior to the surgery. Even though the final outcome of the surgery was excellent, the patient suffered a period of reduced visual acuity. The MPS identified the case as indefensible, as there was no record in the patient's note of any possibility of complications due to the surgery, and a settlement was made.

This case shows the importance of providing an adequate amount of information when seeking a patient's consent. However, what constitutes "adequate" here? That depends on which of three common "standards" is applied:

1. the reasonable doctor standard
2. the reasonable patient standard
3. the subjective standard

According to the reasonable doctor standard, the adequate amount of information is determined by what a typical doctor would deem appropriate in the given circumstances. However, this standard is often inadequate, since most research shows that the typical doctor tells the patient very little. The

standard is also generally considered inconsistent with the goals of informed consent, as the focus is on the doctor rather than the patient.

According to the reasonable patient standard, the adequate amount of information is determined by what the average patient would need to know in order to be an informed participant in the decision regarding the proposed treatment. The reasonable patient standard focuses on what a typical patient would need to know in order to understand the decision at hand. The subjective standard, by contrast, focuses on what the individual patient would need to know and understand in order to make an informed decision.

The subjective standard is the most challenging of the three standards to incorporate into practice, since it requires tailoring information to each patient. Nevertheless, it is the standard that the Hospital Authority seems to have adopted. In a circular dated August 2015, the Authority suggested that the following information be included when seeking informed consent from a patient:

1. Information particular to the patient
(the nature of the patient's medical condition; the consequences if the condition is not treated; any uncertainties on the part of the doctor in his or her diagnosis; the options available, including the option not to treat, and the likely outcomes; the risks representing known concerns, e.g. the risk of a recurrence of the pathology; and any other information that may be important or relevant to that particular patient)
2. Information particular to the procedure
(the nature of the procedure; significant risks and complications, even if the possibility is low; common risks and complications, even if insignificant; and what to expect before and after the procedure)
3. Additional information
(questions raised by the patient, and explanations given by the doctor)

Clearly, the standard of practice is rising, and the time required to obtain consent from a patient is increasing. Although it continues to be publicly funded, the Hong Kong medical system is becoming a high-cost, patient-centered system as the previous high-quality but cost-effective system gradually fades out. However, high-cost does not necessarily mean high-quality. An MRI scan can be performed for each and every patient with back pain, for instance, but it is unlikely to be very useful in everyone. An adversarial medical system is, therefore, not necessarily beneficial to all parties.

4.4.3: Recent cases

Two recent cases of particular importance in respect of informed consent are *Jacqueline Stewart v Nicholas Wright* [2006] and *Montgomery v Lanarkshire Health Board* [2015]. Both cases are discussed in detail in section 2.5. Another

case, which was reported by the Medical Protection Society in September 2016, is also discussed here, as it raises some relevant learning points.

4.4.3.1: *Jacqueline Stewart v Nicholas Wright*

Jacqueline Stewart v Nicholas Wright [2006] was a court case in Northern Ireland arising from surgery performed by Mr. Wright, a dentist, to remove Mrs. Stewart's right lower wisdom tooth. As a result of the surgery, Mrs. Stewart suffered damage to her inferior dental nerve and lingual nerve. The key issue in the case was that Mr. Wright had not used a standardized consent form before the operation, although one was provided by the clinic. However, he was held to be not negligent, because it was common practice for the form not to be used in the clinic. The court considered his actions a failure to follow best practice, rather than negligence.

The underlying issue in the case was whether sufficient warning had been given of the possible complication. Although there was only verbal consent for the operation, Mr. Wright had provided good documentation in the medical record, using a different color ink to note that he had warned Mrs. Stewart verbally of the risk of numbness in relation to the removal of the wisdom tooth. Mr. Wright's claim was supported by his dental nurse, and both the trial judge and the appeal judge believed that he had given the patient a warning in respect of the risks involved in the operation. However, the trial judge wrote that "the defendant has failed to persuade me that he explained the risks involved in the extraction of the right hand lower wisdom tooth to Mrs. Stewart, and she was therefore prevented from making an informed decision as to whether she would undergo this procedure." The appeal court agreed, as an appropriate explanation of the risks involved in the operation would have been sufficient to make the patient reject the option of surgery.

One very important factor in the ruling was that the burden of proof was reversed. Under normal circumstances, the claimant would be required to prove that a warning had not been given, particularly when the medical notes indicated that it had. However, in this case it was enough for the claimant to establish that in light of the potential risks of the surgery, she would not have had the wisdom tooth removed if she had been given a proper warning, and that the fact that she had gone ahead with the surgery therefore proved that no such warning had been given.

This case tells us that it is better to use a standardized written consent form. It also tells us that a patient should be warned of any severe risks associated with an operation. The warning should be highlighted, and the patient should be given the option of refusing the surgery.

4.4.3.2: *Montgomery v Lanarkshire Health Board*

The practical implications of *Montgomery v Lanarkshire Health Board* [2015] are reflected in the latest interpretation of informed consent. It does not mean that the patient should be informed of everything under the sun, which is impossible. However, it does mean that the doctor's advisory role should involve a dialogue with the patient, the aim of which is to ensure that the patient is aware of the seriousness of the condition, as well as the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that he or she can make an "informed" decision. A doctor is still entitled to withhold information in respect of a risk if he or she reasonably considers that its disclosure would be seriously detrimental to the patient's health. However, this is just a theoretical condition, and in reality a justifiable condition is hard to find. In the case of a life-threatening illness in an unconscious patient, though, the condition does not apply, and with good justification.

The Medical Council of Hong Kong reacted to the ruling in *Montgomery v Lanarkshire* by issuing a newsletter in December 2015. The newsletter emphasized that doctors in Hong Kong could no longer rely on the *Bolam* test (see section 2.2) when facing a professional negligence claim for breach of their duty of disclosure in advising a patient about the risks associated with a course of treatment. However, it stressed that the *Bolam* test was still a good standard to apply when assessing other aspects of a potential breach of duty. Whether doctors could still rely on the test when being disciplined for professional misconduct, though, was open to debate.

4.4.3.3: A case report

In a case reported by the Medical Protection Society in September 2016, a patient who developed an infected hematoma in a post-vasectomy wound alleged that he had not been warned by the surgeon of the possible complication before consenting to the operation. The signed consent form was the key piece of evidence in this case. The surgeon had used a standard consent form which did not mention all the possible complications of the operation, and had therefore handwritten the complications of pain, bleeding, bruising, hematoma and infection at the bottom of the form. The patient alleged that this had been done after the claim had been filed. However, the surgeon had made a photocopy of the consent form and sent it to the patient's family doctor on the same day as the consultation. Moreover, a nurse who had been sitting in during the consent procedure confirmed that the procedure had been thorough and complete. The claim was therefore discontinued, and costs were recovered from the claimant.

The patient's claim that the consent form had been amended after the consent procedure is a serious allegation, as doctoring evidence is a criminal

offense. Medical professionals need to be extremely careful, therefore, when adding information by hand to a standardized consent form. In this case, the surgeon protected himself by having a nurse sit in during the consent procedure, and by making a photocopy of the consent form and sending it to the patient's family doctor. However, this is not a common practice in Hong Kong.

Another point arising from this case is the importance of good communication following the initial consent procedure. To pre-empt any problems, the surgeon should have left his contact details with the patient. When surgeons operate on patients in the private sector and their complications are then managed by doctors in the public sector, the patients can often feel aggrieved at the operating surgeon, who is now "nowhere to be seen." Effective communication among the various parties can help to remove any misunderstandings and minimize the risk of litigation.

4.4.4: Checklist

When seeking to obtain informed consent from a patient, medical professionals should:

1. use standardized consent forms;
2. spend sufficient time in dialogue with the patient;
3. use language that is understandable to the patient;
4. try to understand the patient's particular circumstances;
5. tell the patient that he or she needs to make the final decision as to whether or not to receive the proposed treatment, based on the material risk and the available alternatives;
6. use information leaflets, supplemented by an explanation of the essential points;
7. provide good documentation of advice on the consent form, with appropriate highlights and annotations;
8. sign the consent form at the same time as the patient and witness.

References and further reading

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4.5: Disclosure of Errors

Errors in healthcare are inevitable. However, doctors have traditionally shied away from discussing them with patients. This is partly due to the fear of a possible malpractice lawsuit, although the desire to avoid embarrassment and discomfort may well be a more common reason. Attitudes have changed in recent years, though, and the obligation to disclose errors is now considered part of a doctor’s overall responsibility to act in the best interests of his or her patients. The disclosure of errors not only helps to respect a patient’s autonomy, it also ensures that the patient can access timely and appropriate interventions for the harm that he or she has suffered.

4.5.1: Requirements

There are no clear legal rules in respect of the disclosure of errors. However, in October 2007, the Hospital Authority established the Sentinel Event Policy, which mandates reporting of incidents and a standard process not only in reporting but also in investigation, documentation and the implementation of recommendations. In 2010, the Authority further improved the reporting mechanism by mandating the reporting of two more categories of Serious Untoward Events. Through these initiatives, the Authority hopes that its staff will apply the principles of open disclosure in incident management.

In an article in the September 2013 issue of *Casebook*, Dr. H Bill Chan, Chief of Service for Paediatric and Adolescent Medicine at United Christian Hospital, commented: “Open disclosure in the event of medical incidents is the prerequisite of regaining trust of our patients and their carers. Barriers to open disclosure include concerns about personal, professional and legal consequences, as well as adequacy of communication skills.” In the same article, Dr. KM Li, Chief of Service for the Accident & Emergency Department at United Christian Hospital, admitted: “To disclose an incident to patients and/or their family is one of the most difficult tasks for doctors, especially

when it is associated with severe adverse outcomes or the death of patients. Not much has been taught in medical school.”

The disclosure process should incorporate a “no blame” approach. The administration needs to be consistent, and there should be no changes of opinion during the course of disclosure.

4.5.2: Planning a disclosure

Open disclosure of errors involves communication in a challenging setting where one might expect to find denial, distancing, defensiveness, guilt, blame, mistrust, anger and confrontation, as well as demands for compensation and the threat of lawsuits. It is essential, therefore, to plan any disclosure of errors very carefully.

In the event of an incident necessitating the disclosure of an error, there are a number of things that care providers and relevant parties can do to ensure that the disclosure meeting goes as smoothly as possible:

1. make sure that the relevant records are accurate and complete;
2. identify all the harmful errors;
3. agree on an explanation as to why the errors occurred;
4. consider how the effects of the errors will be minimized;
5. finalize steps to prevent a recurrence of the errors;
6. formulate a contingency plan.

Before the meeting, all those involved should work as a team to role-play the disclosure dialogue, as some doctors may not understand the real purpose of open disclosure and the real needs of the clients. They may also be uncertain of the dos and don'ts of open disclosure, in particular what they should and should not say to the patient and his or her relatives. If the role play of the disclosure meeting proves unsatisfactory, legal representation should be considered.

References and further reading

“Open disclosure: The road to success” (2013) 21(3) Casebook 12–13.

Robert Francis, “Disclosure of Mistakes and Errors” (Hospital Authority Convention 2014).

4.6: Apologies

No one likes to apologize. However, making an apology is especially difficult for doctors because of the fear that it might be taken as an admission of guilt and, by extension, liability. Physicians in Hong Kong are currently not afforded any legal protection if they decide to apologize to their patients, so they are commonly advised against making an apology. However, the

conventional wisdom that it is dangerous to issue an apology may well be incorrect. In fact, declining to apologize may actually make a lawsuit more likely, as in the absence of an apology the injured party (or his or her family) might be less willing to explore alternative modes of dispute resolution.

There is a lot of research to suggest that by simply saying “I’m sorry,” doctors can help to cut costs and increase efficiency in their healthcare systems. This was the case with the University of Michigan Health System, where a policy of “saying sorry” was implemented in 2001. As part of an Apology and Disclosure Agreement, healthcare professionals were encouraged to engage in open discussion with their patients whenever clinical care had not gone according to plan. The mantra was: “Apologize and learn when we’re wrong, explain and vigorously defend when we’re right, and view court as a last resort.” Accordingly, a six-month “cooling-off” period was put into place for all malpractice lawsuits, while doctors were required to take out their own insurance for professional negligence.

The “Michigan Model” has been an unqualified success. The number of medical malpractice claims has dropped every year, and attorney fees have declined significantly. The university has also reduced its claims by more than 47 percent per case payment, while the average settlement time has dropped from 20 months to six months.

4.6.1: Apology in law

From a legal perspective, there are three types of apology: a full apology, a partial apology and an implied full apology. A full apology includes an explicit admission of fault or responsibility, an explanation of the cause of the problem, and some form of redress (e.g. a proposal to put things right). A partial apology consists merely of an expression of sympathy without any admission of liability, while an implied full apology is a statement that acknowledges fault implicitly.

To protect themselves against the possible adverse effects of an apology, medical professionals can include one of three elements in their defense:

1. a declaratory element
(where an apology is not an admission of fault because it was preceded by a statement declaring that it could not be taken as an acceptance of liability)
2. a relevance element
(where an apology cannot be taken into account in determining fault—for example, because it was made under duress)
3. a procedural element
(where an apology is not admissible as evidence of fault due to a statutory exception)

4.6.2: Apology legislation

Apology legislation exists in several common-law jurisdictions. The legislation is designed to make it easier for politicians, professionals and executives, among others, to make apologies, by making the apologies inadmissible in lawsuits, even if they include an admission of fault.

4.6.2.1: The situation in Hong Kong

In 2017, an apology law was introduced in Hong Kong. Before its introduction, the situation had been influenced by the ruling in *Robert Hung Yuen Chan v Sing Tao Ltd* [1996], where the judge adopted the definition: “An apology could be a sincere expression of regret or mere admission of guilt.” The definition gave rise to the possibility that an apology might adversely affect the legal position of the person making the apology, although it was unclear whether it would apply in non-defamation cases. Given that an apology might also have a significant effect on quantum of damages, it was evident that a clear legal definition of what constitutes an apology would be welcome not only to healthcare providers but also to all those working in other areas where tort law is commonly used in civil litigation—for example, government, construction and engineering.

In a session at the Mediation Conference 2014 in Hong Kong entitled “*Sorry* is the hardest word to say—How an apology legislation will assist in resolution of disputes,” the participants discussed whether legal protection against liabilities should be available to people making apologies, and whether apology legislation would enhance dispute resolution. The prevailing view was that in the absence of an apology law, people were held back from making an apology by the fear that it would have legal consequences, and that this prevented the “softening” effect typically produced by a timely and sincere apology, an effect which might incline the victims of a wrongdoing to consider alternatives to litigation, such as negotiation or settlement.

The Apology Ordinance

The Apology Ordinance (Cap 631) was passed on July 13, 2017 and became effective on December 1, 2017, making Hong Kong the first jurisdiction in Asia to have legislation of this kind. Australia, the United States, Canada and Scotland had already enacted similar legislation, but the scope of protection given to apologies under the Hong Kong ordinance is probably the widest yet.

The Apology Ordinance defines an apology as “an expression of the person’s regret, sympathy or benevolence in connection with the matter.” An apology may be either oral or written and may occur in the form of an

electronic record such as an email, SMS message or social media post. It may also be made through a person's conduct—for example, offering to pay the other party's medical expenses, sending flowers, taking bows of apology, and so on. The apology may include an admission of fault, either expressed or implied, or it may just consist of a statement of fact concerning the mistake.

The Apology Ordinance is applicable to all civil proceedings, including judicial, arbitral, administrative, disciplinary and regulatory actions. However, it does not apply to apologies made in documents filed or submitted during these proceedings, or to apologies made during hearings that are part of the proceedings. Moreover, in exceptional cases “decision makers” (e.g. courts, tribunals and arbitrators) may exercise their discretion to admit a statement of fact contained in an apology as evidence in the proceedings if they are satisfied that it is just and equitable to do so. No further explanation is provided in the ordinance, however, as to what exactly constitutes an exceptional case.

The Apology Ordinance does not affect the operation of the Mediation Ordinance (see section 6.3), the Defamation Ordinance or the Limitation Ordinance (see section 5.7). It also has no effect on the discovery process in civil proceedings (see section 5.3). Section 10 of the ordinance, meanwhile, expressly states that an apology will not render any insurance coverage void.

The ordinance does not apply to criminal proceedings, and there are exemptions for civil proceedings conducted under:

- the Commissions of Inquiry Ordinance;
- the Control of Obscene and Indecent Articles Ordinance; and
- the Coroners Ordinance.

The exemption for proceedings under the Coroners Ordinance is a potential weak spot in the new legislation, as there is a scenario in which an apology made by a doctor to relatives after the death of a patient could be included in the judgment of the Coroner's Court (see section 5.5), making it admissible in a subsequent legal case. Unless this is rectified, therefore, an apology related to the death of a patient may not always be protected.

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4.7: The Good Samaritan Doctrine

The Good Samaritan doctrine is a common-law principle relieving first responders of any civil liability arising from an issue of negligence. The doctrine is named after the Parable of the Good Samaritan, which was told by Jesus in the Gospel of Luke. The parable, which tells the story of a traveler from Samaria who helps a Jewish man in need even though Samaritans and Jews were traditionally enemies, teaches a universal moral principle (that you should love your neighbor irrespective of his or her ethnicity). However, the application of the principle in law is not the same in all jurisdictions.

4.7.1: The legal principle

The Good Samaritan doctrine is a principle in tort law. For the principle to apply, three conditions must be satisfied:

1. the care provided must be the initial treatment in an emergency;
2. the person involved in the provision of the treatment must not have caused the emergency;
3. the care provided must not constitute gross negligence.

4.7.1.1: The initial treatment

The Good Samaritan doctrine applies only to the first responder in an emergency. If a person has already been attended to, a bystander’s actions are not protected, as the injured person is judged not to be in imminent danger anymore. If the bystander’s intervention is inappropriate, therefore, he or she may be liable for any harm caused. This principle was established in the USA and may also apply in other common law jurisdictions.

4.7.1.2: The person involved

If the person involved in the provision of the initial treatment in an emergency actually caused the emergency, he or she has a duty to rescue the injured person and the Good Samaritan doctrine cannot be applied. For example, if someone accidentally falls into a hole in the road when construction work is in progress, the person responsible for the roadworks owes a duty of care to the person who suffers the accident.

Case law

Khoo James v Gunapathy d/o Muniandy [2002] SGCA 25

R v Sellu [2016] EWCA Crim 1716, [2016] All ER (D) 114

4.10: Chapter Summary

Mistakes are inevitable in medical practice, so risk management is an important skill for medical professionals. Good medical records are essential for effective risk management. A medical record should be as comprehensive as possible and must be kept confidential. The cultivation of good doctor-patient relationships is also an important part of risk management. To establish consistently good relationships with patients, a doctor must master the basics of good communication. He or she must also be sure to obtain informed consent before embarking on any course of treatment.

The obligation to disclose errors is now considered part of a doctor's overall responsibility. The disclosure of errors may include an apology, which cannot be used as evidence of liability in legal proceedings. There is currently no "Good Samaritan" law, but the courts may give extra latitude to rescuers accused of negligence. Legal redress is available to doctors, however, when information that is factually incorrect appears in the media.

Effective risk management skills can prevent doctors from falling into the trap of defensive medicine, the provision of treatment by a doctor that is determined by the need to protect the doctor him- or herself against potential charges of negligence. Defensive medicine can, paradoxically, make medical practice more perilous. It almost certainly raises healthcare costs as well. To lower these costs, tort reform may be needed.

Afterword

To err is human, and doctors are human beings like everyone else. So it is only natural that errors should occur from time to time in medical practice. However, many people die as a result of medical errors, and when financial costs are added to the human tragedy, it is understandable that these are very serious matters.

Nevertheless, it is a fact that most mishaps in medical treatment do not turn into complaints. Indeed, as a general rule, victims of medical malpractice only tend to complain if they think that something “unjust” has occurred.

Medicine is a psychosocial practice, rather than a purely evidence-based science. In other words, it is an art. In medical school, doctors receive a lot of instruction about the scientific part of medicine, and we go deeper and deeper into the technical aspects in postgraduate training. However, in everyday practice, we need to take care of the feelings and expectations of patients and their families. We need to listen actively to what they say and show them empathy and understanding. In short, we need to communicate effectively with them at all times.

When we are under stress or in anger, therefore, it is essential that we “go to the balcony.” In these moments, we should pause and say nothing. We should look back and see what went wrong, and we should think how we can break the impasse and rectify the situation.

The law of tort is constantly evolving, and with it the mindset of medical practitioners. The cases of *Lee Fai v Tung Wah Group of Hospitals* [1997] (see section 1.5) and *Chan Chun Chau v Hospital Authority* [2011] (see section 3.4) show that litigation nowadays can go too far. The “reasonableness” of *Bolam* and *Bolitho* is being eroded further and further, and although the *Bolam* principle can be somewhat unfair to the patient, the cases of *Khoo James v Gunapathy d/o Muniandy* [2002] (see section 4.9) and *R v Sellu* [2016] (see section 2.7) clearly illustrate the dangers of having a system that places too much emphasis on patients’ expectations. The era of “defensive medicine” is upon us, with doctors increasingly choosing the safest practice over the best care in order to prevent themselves from being sued.

To avoid the pitfall of defensive medicine, doctors must perfect their interpersonal skills. Anger management, communication and empathy are just some of the things that need to be mastered. We also need to learn about risk management. For only then can we be sure of avoiding all the stress and unhappiness that arise from complaints of medical negligence.

About the Author

Dr. Cheong Peng Meng graduated from the University of Hong Kong in 1989 and has been working as a frontline doctor in Queen Mary Hospital, Princess Margaret Hospital, and Yan Chai Hospital for thirty years. Trained as a specialist in orthopedic surgery, he became a fellow of the Royal College of Surgeons in Edinburgh in 1995 and has been awarded fellowships from the Hong Kong College of Surgery, the Hong Kong College of Orthopaedic Surgery and the Hong Kong Academy of Medicine. In 2000, he went for overseas training at the Massachusetts General Hospital (Harvard Medical School) and the Mayo Clinic (Mayo Foundation). He remains in public service and is currently developing his subspecialties in foot and ankle surgery and rehabilitative medicine.

Dr. Cheong is an associate consultant in orthopaedics and traumatology of Hospital Authority. He is also an honorary clinical assistant professor at both the University of Hong Kong and the Chinese University of Hong Kong. His clinical work is highly appreciated, especially in the area of patient care, and he received the Outstanding Staff Award at Yan Chai Hospital for the year 2014–2015. Despite a heavy clinical load and long working hours, he finds time for research, and has three articles published in medical journals (two case reports and one randomized clinical control trial).

Dr. Cheong devotes his leisure time to other forms of public service. He is currently chairman of the Doctors' Welfare Association at Yan Chai Hospital and is also an assistant superintendent of Hong Kong St. John Ambulance.

Dr. Cheong is interested in law, having obtained his Bachelor of Laws degree in 2010 from the University of London. He also has a special interest in risk management and is currently a member of the Yan Chai Hospital–Hong Kong Baptist University Chinese Medicine Centre (YCH–BUH CMC) Operational and Risk Management Committee. Additionally, he is a member of the Hospital Authority Chinese Medicine Quality and Safety (HA CM Q&S) Working Group and the Tender Assessment Panel for Selection of NGO Operations for the Provision of Chinese Medicine Services (CMS) for the Integrated Chinese-Western Medicine (ICWM) Project and is active in the Communication Training Work Group of the Hospital Authority Kowloon West Cluster (HA KWC).

Index

- abandonment, patient, 31, 55, 56, 57, 58
- admission, hospital, 116
- admission, of guilt, fault, liability, 126, 127, 128, 129, 138
- adversarial, 121, 137
- agent of hospital, 89
- alternative dispute resolution, 172
- American bystander rule, 132
- apologies, 126
- arbitration, 177
- awards, 4, 44, 170

- Basic Law, 4, 68
- battery, 49, 55, 59
- best interest, 125, 138
- Bolam principle, 34, 35, 36, 50, 51, 61, 77
- breach of duty, 8, 10, 11, 12, 19, 22, 31, 34, 36, 39, 40, 41, 42, 49, 62, 87, 112, 123, 131, 151, 152, 153
- burden of Proof, 10, 11, 14, 61, 122, 132, 151
- but for, 10, 11, 37, 39, 40, 42, 50

- causation, 8, 10, 11, 12, 19, 21, 37, 39, 40, 43, 50, 51, 151, 152, 153, 156
 - break in chain of, 15, 19
 - multiple, 41
- chaperone, 108, 151
- charges, 44, 49, 61, 132, 136, 144, 145
- civil negligence, 61, 62, 63
- civil proceedings, 129
- code of professional conduct, 26, 93, 107, 111, 113, 119, 135
- common law, 3, 4, 5, 8, 10, 20, 53, 68, 111, 130, 132, 152, 161
- compensation, 3, 4, 21, 22, 43, 44, 46, 48, 62, 116, 132, 141, 166, 173, 174, 182

- labor, 114
- complaints, 6, 20, 48, 57, 107, 108, 114, 135, 138, 141–45, 165, 167, 168, 182
- confidentiality, 111–15, 135, 143, 180, 182
 - guideline, 111
- conflict of interest, 83
- consent, 107, 111–18, 143
 - implied, 48
 - informed, 119–24, 138
- coroner, 129, 140, 157–59
- coroner's inquest, court, 157
- cost, 44, 121, 165, 170, 174
- criminal negligence, 61–63
- cross-examination, 68, 82–83, 155

- damage, 4, 5–12, 15–19, 22–23, 32–33, 40–47, 164, 150, 169–70, 173
 - assessment of, 43
- defamation, 4
- data protection, 113
- defense, 17–19, 36, 41, 108–9
 - abandonment, 58
 - apology, 127
- defensive medicine, 136
- delegation, 93
- disclosure, 48, 110
 - of errors, 125
- disciplinary proceeding, 143
- dishonesty, 60
- doctor-patient relationship, 107, 116, 117
 - abandonment, 55–59
 - establishment, 10, 12, 28–30, 132, 177
 - models of, 25–27
 - termination, 31, 59
- documentation, 107, 122, 124–25, 168
- duty of care, 8–10, 12, 14–19, 22, 25–29, 32, 61–62, 133, 153

- determine, 131
- establishing, 5, 25, 151–12
- termination, 56
- duty of disclosure, 37, 49–50, 110, 123
- equity, 3–4
- evidence, 154
 - documentary, 171
 - oral, 171
- examination, 30, 108–9, 154–55
- expert opinion, 21–22, 46, 143, 145, 154–55, 158, 160, 162, 175
- expert witness, 159, 169
- ex turpi causa non oritur action*, 19
- fees, 29
- fiduciary, 26–27, 111
- General Medical Council, 113, 162
- Good Samaritan doctrine, 130–33
- gross negligence, 131
- guidelines
 - comparative negligence, 18
 - confidentiality, 111
 - disclosure, 112–13
 - utility conduct, 37
- indemnity, 6, 146, 167, 150, 166
- informed consent, 17, 51–52, 107, 110, 119–24, 138
- insurance, 145
 - claim-based, 165
 - occurrence-based, 165
 - providers, 146
- intentional wrongs, 55
- interdepartmental consultation, 27
- journalist, 135
- jurisdiction, 152
 - common law, 4
- jury, 23, 29, 62
- legal action, 21
- legal aid, 172
- legal costs, 48, 72, 79, 109, 166, 177
- legal duty, 5, 30
- liability, 147
- limitation, 163
- litigation, 177
- magnitude of risk, 37
- material risk, 54
- media, 135
- mediation, 176, 178
 - development, 179
 - medical negligence, for, 181
 - ordinance, 179
 - popularity, 180
- medical record, 35, 56, 107–10, 113–14, 120, 138, 143, 158, 169
- medical report, 22, 111, 114, 154, 156, 158, 165
- mental disorder, 46
- minor, 166
- misconduct, 7, 20, 123, 140, 142–43, 182
- mistake, 107, 129, 133
- murder, 17, 160
- negligence
 - claims, 20
 - comparative, 18
 - concept, 3
 - contributory, 18
 - criminal, 61
 - element of, 7
 - gross, 131
 - law of, 5
- negotiation, 176
- neighborhood principle, 9
- novus actus interveniens*, 19
- occurrence-based, 147, 165
- offence, 15, 55
- omission, 5–10, 20
- personal injury, 59
- post-mortem, 65
- practicability of precautions, 37
- practical direction, 20, 179
- pre-action protocol, 20
- presumption of negligence, 15
- pre-trial procedure, 22
- prima facie, 51, 79, 140, 143, 151–53
- privacy, 67, 111–15
- professional, 107–9, 116, 119–25
- prosecution, 61–62, 151
- protective medicine, 136
- public interest, 111, 173
- publication, 136

- reasonable man rule, 32
- redress, 136
- refusing treatment, 30
- registration, 9, 20, 140, 142
- remoteness of damage, 12
- rescuers, 132
- res ipsa loquitur*, 13
 - rebutting, 15
- responsibility, 9, 14, 18, 30, 34, 61–62, 77, 141
- risk management, 109

- settlement, 168, 172
- sexual
 - offenses, 57, 154, 182
 - partner, 112
- sick leave doctors, 94
- signature, 54–55
- standard of care, 31
- state of knowledge, 33
- statutory law, 6
- strict liability, 15
- submission, 158

- test
 - informal consent, 51
 - materiality, 54
 - medical standard, 51
- theft, 60
- thin skull rule, 16
- third-party consultation, 30
- tortfeasors, 18
- tort law, 3, 4
- treatment, 12, 19, 26–29
- trial, 23, 151–53, 162, 168–69

- ultimate-issue rule, 161
- utility of conduct, 33, 37

- viability of claim, 155
- vicarious liability, 6, 147
- volenti non fit injuria, 17
- volunteer, 131, 133, 145

- witness, 153–55, 158–62, 164, 168–69