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ASSESSING THE STANDARD OF CARE OF DOCTORS IN EMERGENCY DEPARTMENTS

Haniwarda Yaakob
Faculty of Law, Universiti Kebangsaan Malaysia, Malaysia

hani75@ukm.edu.my

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ABSTRACT

Working in emergency departments appears to be challenging as the doctors stationed here encounter obstacles that may not be faced by other doctors. This includes the need to attend to a high number of patients, the lack of manpower and resources, as well as the pressing situation of being in an emergency. This condition may be more apparent in public hospitals that are usually overcrowded with patients with various illnesses that require urgent treatment. Occasionally, claims of medical negligence have been filed against doctors and hospitals by patients seeking medical treatment in emergency departments. An issue, therefore, arises on the standard of care required of doctors as has been imposed by the law on working in emergency departments. The question is whether the calamitous situation that doctors in emergency departments encounter is acknowledged by the law as a possible defence against the allegation of negligence in Malaysia. From the cases analysed, it is concluded that doctors in emergency departments are expected to exercise the skill of any other reasonable competent doctor in similar circumstances. As such, doctors and hospitals should strive to provide the best medical treatments according to the situations of each case in order to avoid liability in negligence. It is hoped that the findings of this research would assist doctors working in emergency departments in discharging their daily duties according to the standards imposed by law. To fulfil its objective, this research employs legal and doctrinal methods in which the analysis and arguments have been based on the written literature, which has been mainly case laws from Malaysia and the United Kingdom, as well as textbooks and journals.

Keywords: Medical negligence, accident and emergency department, duty of care, standard of care.

INTRODUCTION

Doctors working in emergency departments face several obstacles that may not be encountered by their colleagues in other departments. Treating a high number of patients, lack of manpower and resources, as well as the pressing situation of an emergency are among the hurdles that must be overcome by such doctors. Consequently, the heavy workload faced by these doctors and other healthcare workers leads to the risks of burn out or exhaustion among them (Emin Bilge et al., 2019). This situation is more apparent in public hospitals that are usually overcrowded with patients with various illnesses that require urgent attention (Syed Jamal Zahiid, 2023). No official statistics on the number of patients visiting emergency departments in hospitals are available. However, a public hospital in Selangor estimates that around 100,000 patients came to its emergency department per year, or 250-300 patients each day (Official Website of Hospital Selayang). It was also reported that patients may have to wait for six hours to receive treatment in the emergency department of public hospitals and this might lead to accusations of negligence, on some occasions.

This delay is allegedly caused by the rising numbers of patients which has exceeded the accepted capacity of the hospital and also the problem of the lack of medical staff in the emergency department (Badrul Hizar, 2019). For example, in 2023, a public hospital has been accused of causing the death of a child who was brought to the emergency department for treatment (Bernama, 2023). In this case, it was alleged that the patient had to wait for more than 40 minutes to receive medical attention, the said patient had suffered from shortness of breath and was declared dead (Norzamira Che Noh, 2023). Another incident was reported in early 2024 when it was alleged that a teenager had died from an error of diagnosis and treatment by medical officers in the hospital's emergency department (Johari Indan, 2024).

Thus, the question arises on the standard of care required by law of doctors working in emergency departments. It needs to be ascertained whether the calamitous situation that doctors in emergency departments encounter is acknowledged by the relevant laws as a possible defence against the allegation of negligence. Herring (2008), for example, argues that the court should consider the circumstances in which the doctor was treating the patient. In an emergency, doctors may not be expected to show the same skill as required of doctors who have the benefit of time to diagnose and treat the patient. Jackson (2010: 136) also argues that:

> *"Once a doctor has undertaken to offer care to an injured person, she undoubtedly assumes a duty of care. But since what is expected of doctors is 'reasonable care,' it is appropriate to take into account the situation in which the doctor who has been called out to the site of a train crash to provide the level of care that would be available in a well-equipped intensive unit."*

This issue forms the crux of this paper where the standard of care applicable to emergency departments is analysed through the decisions of reported and unreported case laws in Malaysia and the United Kingdom. To achieve this objective, the present paper uses legal and doctrinal methods to scrutinize primary and secondary sources which included text books, journal articles and particularly case laws from Malaysia and the United Kingdom. This analysis begins by establishing doctors' duty of care in emergency departments.

DUTY OF CARE IN EMERGENCY DEPARTMENTS

It is trite law that to succeed in a claim of medical negligence, the plaintiff needs to prove the following elements, as cited in *Shalini a/p Kanagaratnam v Pusat Perubatan Universiti Malaya (formerly known as University Hospital) & Anor* [2016] 3 MLJ 742, p. 753:

(i) there is a duty of care owed by the doctor to the patient;
(ii) there is a breach of standard of care by the doctor;
(iii) there is a breach of duty care by the doctor; and
(iv) the said breach of duty and standard of care has caused damages to the patient.

Doctors' duty of care towards their patients is derived from the doctor-patient relationship that has been formed between them. As stated in *R v Bateman [1925] 19 Cr App R8*:

> *"If a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge by a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his discretion and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment…"*

Without a doctor-patient relationship, there is no duty on the part of the doctor to treat the patient. Siti Norma Yaakob FCJ *in Foo Fio Na v Dr. Soo Fook Mun & Anor [2007] 1 MLJ 593* states:

> *"At common law, the duty of care owed by a doctor arises out of his relationship with his patient. Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advise and treat his patient."*

It follows that doctors may refuse to treat strangers who are not their patient. However, if the doctor undertakes the duty to treat a patient, s/he is said to owe a duty of care to that patient. In *Ang Yew Meng & Anor v Dr. Sashikannan a/l Arunasalam & Ors [2011] 9 MLJ 153*, it was held that:

> *"The law did not impose a general duty of care to be a Good Samaritan unless a special relationship existed between the parties. However, when the first defendant relented and rendered treatment to the child, he had taken control of the situation and accepted responsibility. Therefore, he had to be regarded as entering voluntarily into a relationship of doctor and patient and hence as owing a duty to the child and his parents, the plaintiffs, to use due diligence, care, knowledge, skill and caution in administering treatment."*

This position is arguably different for doctors working in emergency departments. Doctors in emergency departments owe a duty of care towards patients who come to the emergency department for treatment and they cannot refuse to treat them. This proposition finds support from the English case *Barnett v Chelsea and Kensington Hospital Management Committee [1968] 1 All E.R. 1068.* Here, three men started vomiting after drinking tea. They then went to the defendant's hospital emergency department that was open. Upon seeing them, the nurse at the emergency department telephoned the doctor in charged to inform him of the men's symptoms. The doctor, however, did not see the men and told them to consult their own doctors. The men then left and later, one them died due to arsenic poisoning. His widow sued the hospital for breach of duty for failing to diagnose and treat the deceased.

The court held that the doctor was negligent and failed to discharge his duty of care to the patients by failing to see, admit and treat them. Neild, J. in *Barnett v Chelsea and Kensington Hospital Management Committee [1968] 1 All E.R. 1068* held that "there was here a close and direct relationship between the hospital and the watchmen that there was imposed on the hospital a duty of care which they owed to the watchmen". This duty is presumed since the emergency department was open to patients to walk in and was not one which had closed its door and not wanting to receive patients.

The court however, cautions that there may be situations where doctors in emergency departments need not see patients who comes in. The court gave this example:

> *"It is not, in my judgment, the case that a casualty officer must always see the caller at his department. Casualty departments are misused from time to time. If the receptionist, for example, discovers that the visitor is already attending his own doctor and merely wants a second opinion, or if the caller has a small cut which the nurse can perfectly dress herself, then the casualty officer need not be called." (p. 1073).*

Nonetheless, the situation in Barnett's case clearly places a duty on the doctor to see, diagnose and treat the three men. The court agreed with what the expert witness had tendered: "I cannot conceive that after a history of vomiting for three hours a doctor would leave the matter to a nurse, however experienced the nurse." (p. 1073). Hence, Nield, J. (*Barnett v Chelsea and Kensington Hospital Management Committee [1968] 1 All E.R. 1068,* p. 1073) reiterated that: "Without doubt Dr. Banarjee should have seen and examined the deceased. His failure to do either cannot be described as an excusable error as has been submitted, it was negligence."

Therefore, it is concluded that doctors in emergency departments generally owe a duty to attend and treat patients who come in for treatment and that failure to do so, may amount to negligence. Reference is also made to the Malaysian Medical Council Good Medical Practice 2019 which places an ethical duty on doctors to provide emergency treatment. Section 4.2.3 states:

> *"4.2.3. Treatment in Emergency: Professional, ethical and humane considerations dictate that doctors render emergency or lifesaving treatment to patients irrespective of their social and financial status or suspicion of being afflicted with serious communicable disease (when standard or universal precautions should be taken by the doctor and his staff). Refusing to provide emergency treatment for such reasons is considered unprofessional and unethical."*

Having established the duty of care owed by doctors in emergency departments to see and treat patients, the next question to be decided is the standard of care required in emergency departments.

STANDARD OF CARE IN EMERGENCY DEPARTMENTS

The Federal Court in *Zulhasnimar bt Hasan Basri v Dr. Kuppu Velumani P & Ors [2017] 5 MlJ 461* has clarified the test to be applied on the standard of care required of doctors in their duty to diagnose, advise, and treat patients. In summary, on the issue of doctors' duty to diagnose and treat patients, Malaysian courts now adopt the test propounded in the English case of *Bolam v Frien Hospital Management Committee [1957] 1 WLR 582*. Here, the plaintiff, a patient suffering from mental illness has been advised to undergo electro-convulsive therapy at the defendant's hospital. However, the patient

claimed that he was not told of the risks associated with the said therapy. He further alleged that he was not given relaxant drugs or manual control when undergoing the therapy. Consequently, he suffered some injuries and brought a claim for negligence for the doctor's failure to adequately inform him of the risks involved. He also claimed that the doctor was negligent for failing to administer relaxant drugs or provide some form of restraint during the therapy. At the trial, two different expert opinions on the use of relaxant drugs were tendered; the first expert opinion had supported the practice of administering relaxant drugs or providing some form of restraint during the therapy. In contrast, the second opinion rejected the use of such drugs on the grounds that it might cause death and should, therefore only be used in exceptional circumstances. In addition, the second expert opinion indicated that the plaintiff's condition did not justify the use of such drugs. Two differing views were also received from experts on whether the plaintiff should be informed of the risk of fracture associated with the therapy. The court, in finding that the defendant was not negligent, introduced what is commonly known as the Bolam's test. This test evaluates doctors' action by referring to reasonable medical opinion. A doctor is not negligent if s/he has acted according to what another reasonable doctor would have done in that situation. Quoting the judgment by McNair J:

> *"A doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view."*

In summary, in order to find a doctor liable for negligence according to the Bolam's test, the plaintiff must prove that the doctor has not acted according to what another reasonable competent doctor would have done in that situation. For example, in *Ahmad Zubir bin Zahid (suing on behalf of himself and as the administrator of the estate of Fatimah binti Samat, deceased) v Datuk Dr Zainal Abidin Abdul Hamid & Ors [2018] MLJU,* the court applied the Bolam's test in that, the plaintiff must prove that the defendant has not acted according to the practice required from the defendant as a consultant cardiologist.

This test is, however, subject to the qualification introduced in *Bolitho v City & Hackney HA [1997] 4 All ER 771*. The facts of the Bolitho case are as follows: Patrick Bolitho, a two-year-old child, was admitted to the hospital as he was having difficulties in breathing. However, he later suffered cardiac arrest which then caused brain damage and his subsequent death. During the emergency call, the doctor in charged had failed to attend to him. During trial, the said doctor testified that even if she had attended to the plaintiff when he was suffering cardiac arrest, she would not have intubated him. Although intubation was the only appropriate procedure, it was risky in that situation. During trial, conflicting medical opinions on the issue of intubation were produced in court by both parties. At the trial, the doctor admitted breach of duty in failing to attend to the patient but the plaintiff's claim was dismissed on the grounds of causation. The Court of Appeal affirmed the decision by the trial judge that even if the doctor had attended and not intubated the patient, that would suffice to demonstrate a reasonable level of skill and competence. Furthermore, it had not been proven that the admitted breach of duty had caused the injury. On appeal to the House of Lords, the approach to the negligence claims as decided in Bolam's case was raised for determination, where it was held that:

> *"A doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a*

> *rare case, if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible."*

Adopting the findings of the Bolitho case allows the court to reject the medical evidence tendered by the defendant doctor if they are not "capable of withstanding logical analysis." Thus, the standard of care demanded from doctors are ultimately decided by the courts, by its weighing of the medical evidence tendered by both the doctor and the patient. Bolitho's case has been applied in Malaysia as seen in *Airis Nurhana Alfian v Darul Aiman Sdn Bhd & Anor* [2023] MLJU 214, where the High Court stated that: "In medical science, experts do not always agree. The court having considered the evidence of the experts is entitled to come to its own conclusion upon considering the reasonableness of the medical opinion."

With regards to the duty of doctors to advise patients of the nature and risks of the proposed treatment, the Federal Court in Zulhasnimar's case *[2017] 5 MLJ 461* has affirmed the adoption of the test expounded in the Australian case of *Rogers v Whitaker* [1992] 16 BMLR 148. The question of what information to disclose to the patients is not decided by referring to reasonable medical opinion as in Bolam's test. On the contrary, the court will investigate the specific needs of the patient where doctors are required to inform patients of the "material risks" inherent to the suggested treatment. Materials risks, according to *Rogers v Whitaker* [1992] 16 BMLR 148, are defined as the risks that any reasonable person in the patient's position would regard as significant or those which the doctor is aware or should reasonably be aware that the patient would want to know.

In *Rogers v Whitaker* [1992] 16 BMLR 148, the respondent had a surgery on her right eye intended to remove scar tissue and enhanced her vision. Her left eye was, nevertheless, unaffected. After the surgery, the respondent suffered from sympathetic ophthalmia in her left eye and as a result, her left eye went blind. The respondent then commenced an action for negligence against the surgeon claiming that the surgeon had failed to adequately advised her on the risks to her left eye. At the trial, it was proven the patient has on various occasions shared her worries to the surgeon about the outcome of the surgery. She had also asked questions about the risks of the surgery to her left eye before she consented to the surgery. The court at the first instance held the surgeon liable for failure to warn the patient of the risks and this decision was upheld by the court of appeal. The surgeon had appealed, but the appeal was dismissed as the court had held that:

> *"Medical practitioners have a duty to warn of material risks which are inherent in the proposed treatment. A material risk is one to which a reasonable person, in the position of the plaintiff, would be likely to attach significance, or one which the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be probably find significant. This duty is, however, subject to therapeutic privilege, in that the doctor has the opportunity to prove that he or she believed on reasonable grounds that disclosure of certain risk would be damaging to the particular patient."*

However, the question now is whether the same standard of care is applicable in emergency departments where doctors are confronted with various challenges including lack of manpower, resources and are often overburdened with a high number of patients. In what follows, the standard of care placed on doctors in emergency departments is analysed by referring to case laws from Malaysia and the United Kingdom. Case laws from the United Kingdom are chosen as section 3(1) of the Civil Law Act 1956

allows for the adoption of English case laws in Malaysia, but subject to certain qualifications contained therein.[1]

Duty to Diagnose

The standard of care on the duty to diagnose for doctors in emergency department was considered by the Supreme Court in *Wong Choon Mei & Anor v Dr. Kuldeep Singh & Anor. [1985] 2 MLJ 373.* The facts of the case are as follows. A man was assaulted and consequently suffered multiple injuries. He was taken to the Casualty Department of the General Hospital and was examined by the first respondent. X-Rays were taken and the result showed two fractures of the elbow and the clavicle. The first respondent did not find any fracture on the man's rib or the presence of any fluid in the chest or abdomen. The man was then discharged the same evening. Unfortunately, he died 15 hours later and post-mortem results revealed that his death was caused by an internal bleeding from a ruptured spleen caused by fractures to his 8th, 9th and 10th left ribs. Following this discovery, a legal suit was filed by the appellant for negligence against the respondents for, inter alia, breach of duty to diagnose the severity of the deceased's injuries. The trial accepted the respondent's defence that the deceased's injuries were not shown by the X-Rays taken and dismissed the claim. The appellants then appealed which was subsequently dismissed by the Supreme Court. In addressing the claim of *res ipso loquitur* that was considered by the trial judge, Lee Hun Hoe C.J. (Borneo) held:

> *"The learned judge apparently considered that the doctrine of res ipso loquitur did not apply to the facts in this case. Res ipso loquitur does not mean that merely because a person is assaulted by a group of ruffians and hurt this implies negligence on the part of the doctor who,* ***in an emergency,*** *examined and treated him.* ***If that is the law, then a stage would be reached when no doctor would care to render assistance to a victim of an accident or assault."*** (p. 375) (Emphasis added).

The above judgment arguably implies the consideration placed by the court on doctors rendering emergency treatment. The court will not easily apply the doctrine of *res ipsa loquitur* as to do so would be prejudicial to the interest of doctors and patients in general. If the doctrine of *res ipsa loquitur* is easily applied in cases where doctors provide emergency treatment, it is feared that doctors may be hesitant in rendering emergency treatment for fear of being liable for negligence.

The judgment in *Wong Choon Mei & Anor v Dr. Kuldeep Singh & Anor. [1985] 2 MLJ 373* is parallel with the judgment in the English case of *Mulholland v Medway NHS Foundation Trust [2015] EWCA 268 QB.* In the latter case, *[2015] EWCA 268 QB,* Green J dismissed the claim and criticism against the accident and emergency doctor who failed to arrive at a proper diagnosis when the patient came to the Accident and Emergency (A&E) Department of Medway Maritime Hospital on 11 and 12 January 2010, complaining of a stroke. Upon arrival at the A&E, the patient was attended by two ambulance teams, two nurses, a general practitioner in emergency medicine, a specialist stroke team and then a doctor in

[1] According to section 3(1)(a) of the Civil Law Act 1956, English common law and equity administered in England as on 7 April 1956 are binding on the Malaysian courts in Peninsular Malaysia. While for Sabah and Sarawak, the cut-off dates for the application of English common law, equity and statutes of general application are 1 December 1951 and 12 December 1949 [see section 3(1)(b) & (c)]. English common law decided after the said dates are only persuasive on the Malaysian courts as seen in *Jamil bin Harun v Yang Kamsiah [1984] 1 MLJ 217.* In addition, English common law is only binding in Malaysia in the absence of local statutes, and if such application suits local custom and culture as stated in the proviso to section 3(1) of the Civil Law Act 1956.

A&E. Nonetheless, no one had reached a diagnosis that required him to undergo an immediate CT scan until several months after he first came to the hospital. Subsequently, it was discovered that the claimant had a tumour that led to an emergency surgery. The claimant then filed a claim in negligence based on the conduct of Dr. C who had attended to and assessed the claimant's condition on 12 January 2010 at the A&E and had arranged for his care path. It was argued that Dr. C was negligent in reaching a diagnosis that the claimant's symptoms were likely caused by his use of cannabis. The issue in question is whether any reasonable doctor in the position of Dr. C would have failed to refer the claimant to a specialist neurological clinic or direct a CT scan when he came to the A&E on 12 January 2010. In other words, the issue in this case focused on the standard of care placed on nurses and doctors working in "highly pressurised environment of a busy A&E."

Green J in *Mulholland v Medway NHS Foundation Trust [2015] EWCA 268 QB* delivered judgment in favour of the defendant and concluded that Dr. C's reliance on the previous assessments by the specialist and other team members in the A&E was appropriate. His Lordship further held that Dr. C's initial diagnosis was not negligent as:

> *"Doctors in A&E do not have the luxury of long and mature consideration. They took decisions at short notice in a pressurised environment. The standard of care owed by an A&E doctor had to be calibrated in a manner reflecting reality... All that was required was to form a view of possible causes, any requirement over and above that was imposing a near-impossible task and not one which should be required of a reasonable doctor within an A&E environment."*

The English court in *Mulholland v Medway NHS Foundation Trust* appears to place consideration on the situation that doctors in an accident and emergency department faced when deciding on whether there was a breach of standard of care in diagnosing patients. Given the circumstances in emergency departments, the court was of the view that the doctor in the emergency department was not negligent in making the initial diagnosis, as all that is required from a reasonable doctor in an emergency department was to diagnose the possible causes of the symptoms and take the necessary action. In doing this, doctors in emergency departments are justified in relying on the previous findings of other healthcare professionals unless those findings appear to be clearly erroneous. Doctors in emergency departments are not expected to form an extensive diagnosis on the patient's illness. To impose a higher expectation on doctors in emergency departments falls beyond the standard required of a reasonable competent doctor in an emergency department.

Be that as it may, it is also worth mentioning another English case decided in 1951, namely *Wood v Thurston (1951)* Times, 25 May (Herring, 2008). In this case, a doctor in an emergency department was found negligent for failing to diagnose the broken ribs of a drunken man who was brought to the casualty department after being involved in an accident. It was decided that the doctor should have anticipated that due to the patient's drunken state, the pain that he was in may be dulled and he was not able to mention the pain to the doctor. Since the doctor was aware that the patient was seen under a moving lorry, he should have conducted a proper examination and used X-Ray to diagnose the patient's injuries.

Both the cases discussed above, namely *Wong Choon Mei & Anor v Dr. Kuldeep Singh & Anor. [1985] 2 MLJ 373* and *Mulholland v Medway NHS Foundation Trust [2015] EWCA 268 QB* arguably imply the imposition of a lesser standard of care on doctors in an emergency department to reach an accurate and extensive diagnosis. The immediate and dire circumstances faced by doctors in emergency departments are considered by the courts as a possible mitigating factor or defence against the claim of

negligence or a breach of the duty of care in carrying out a diagnosis. Nevertheless, it is still crucial for doctors in emergency units to give their best efforts in diagnosing the patient's condition according to what is reasonably expected from a doctor in that similar position as seen in *Wood v Thurston (1951)* Times, 25 May (Herring, 2008). Although doctors in emergency departments are not expected to reach an extensive diagnosis, they are obligated to take all reasonable measures to inquire into the patient's signs and symptoms.

Duty to Advise Risks

It has been established earlier that Malaysian courts adopt the test stated in *Rogers v Whitaker [1992]16 BMLR 148* in determining the material risks that need to be informed to patients. Gaudron J. in *Rogers v Whitaker* nonetheless, provides an exception to the duty to advise patients of the risks in emergency or in cases of special circumstances involving the patient. According to His Lordship:

> *"[U]nless there is some medical emergency or something special about the circumstances of the patient, there is simply no occasion to consider the practice or practices of medical practitioners what information should be supplied. However, there is some scope for consideration of those practices where the question is whether, by reason of emergency or the special circumstances of the patient, there is no immediate duty or its content is different from what which would ordinarily be the case." (p. 159)*

The judgment by Gaudron J quoted above in *Rogers v Whitaker* seems to provide exceptions to the duty to disclose material risks establish in the case. Such an exception includes medical emergencies and this exception was applied by the Malaysian Court in *Hasan bin Datolah v Kerajaan Malaysia [2010] 2 MLJ 646.* Here, the Court of Appeal was of the view that the information given to the patient about the first operation was sufficient as it was an emergency surgery. Delivering the judgment of the court, Sulaiman Daud JCA stated on page 659 that:

> *"In our view whether or not there was sufficient disclosure of the risk of the operation must be decided in relation to the peculiar circumstances of the present case. We agree with the aforesaid observation made in Rogers v Whitaker, that there was a need to give different consideration in the case of an emergency. Having considered that the appellant had already shown sign of progressing paralysis with bladder dysfunction before first surgery, and the surgery carried out was an emergency operation which if not carried would result in paralysis, we are of the view that the information given by DW1 to the appellant in respect of the first operation was sufficient in the circumstances of the present case."*

More recently, in *Noor Azukee bin Mohd Noor lwn Md Sayuti bin Md Yunus [2021] MLJU 1748*, the issue on the standard of care to be applied when administering emergency treatment in a clinic arises. This is an appeal to the High Court by the appellant (defendant doctor) from the decision of the Sessions Court that ruled in favour of the plaintiff (respondent) in his suit for medical negligence against the appellant. In 2017, the respondent went to the appellant's clinic to seek treatment for the injury he suffered on his wrist as a result of an accident at his workplace. The appellant had attended to and treated the respondent's injury by suturing his wound. However, when the respondent went to the appellant's clinic again to remove the sutures, he discovered that his fingers could not function normally and were numb. He was informed by the appellant that the said condition was a normal effect of his injury. The respondent's condition continued to persist for the next couple of days and he therefore, decided to seek treatment at the Hospital Pakar Perdana KPJ. He was then informed by the specialist

who examined him that his injury was not properly treated previously and this has resulted in his inability to fully recover. The respondent then sued the doctor at the clinic for breach of standard of care in treating his injury and the Sessions Court found in his favour.

On appeal by the appellant to the High Court, the findings of liability against the appellant were affirmed. One of the issues considered by the High Court was the standard of care to be applied to the appellant/doctor when he was giving emergency treatment to the patient/respondent. It was alleged that the appellant/doctor has failed to provide sufficient information to the appellant on his injury and the treatment that was given, including the possible consequences of this injury. On this issue, the High Court agreed with the arguments of the appellant's solicitor that the standard of care applied with regard to the duty to warn patients of the risks that was applied in *Dr. Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim [2018] 3 MLJ 281,* was not applicable in the present case as the surgery performed in Dr. Hari Krishnan's case was an elective surgery which requires informed consent from the patient. In the said case, the treatment rendered by the appellant doctor when the respondent first came to the clinic was an emergency treatment. As such, the High Court ruled that:

> *Situasi di dalam kes tersebut (Dr. Hari Krishnan) bukanlah situasi di mana pesakitnya berhadapan dengan keadaan yang mengancam nyawa atau pun di dalam keadaan kecemasan. Mahkamah bersetuju bahawa dari segi amalan dan standard kewajipan berhati-hati di dalam kedua-dua situasi iaitu situasi rawatan yang biasa dan rawatan kecemasan hendaklah berbeza. Adalah menjadi prinsip perundangan bahawa kewajipan berhati-hati adalah berbeza-beza bergantung kepada situasi rawatan. (para 15)*

The High Court further referred to the Malaysian Medical Council Guideline: Consent for Treatment of Patients by Registered Medical Practitioner. Section 2 of which excludes the requirement to obtain consent from the patient in emergency situations:

> *"2. Necessity for Obtaining Consent*
> *Generally, no procedure, examination, surgery or treatment - may be undertaken on a patient without the consent of the patient, if he or she is a competent person. Such consent may be expressed or implied and may be verbal or in writing.*
>
> *Obtaining a patient's consent is an important component of good medical practice, and also carries specific legal requirements to do so.* ***Except in an emergency*** *where the need to save life is of paramount importance, the consent of the patient must be obtained before the proposed procedure, examination, surgery, or treatment is undertaken. Failure to do so may result in disciplinary inquiry for transgression of ethical professional codes and/or legal action for assault and battery instituted against the medical practitioner."* (Emphasis added)

The High Court in Noor *Azukee bin Mohd Noor lwn Md Sayuti bin Md Yunus* reiterates the exception to the general duty to warn patients on materials risks inherent to a treatment in an emergency situation. The High Court distinguished the present case with the earlier decision of the Federal Court in *Dr. Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim* in that the surgery performed in the latter case was an elective surgery and not an emergency and thus, the duty is placed upon the surgeons to disclose all material risks involved in the surgery. In summary, it is arguable that the law places a lower threshold on doctors' duty to advise patients of the risk involved in an emergency medical treatment or surgeries.

The amount of information that is expected to be disclosed to the patients may be not the same due to the urgency of the treatment required.

Duty to Treat

Bolam's test places an expectation on doctors to act according to what other reasonable doctors skilled in the art would do in that situation that the doctor is facing or the post that he is holding. Nevertheless, it is likely for the courts to take into consideration the special situation that the doctor was acting in (Poole, 2020). In an emergency department, doctors confronted with a dire situation is expected to demonstrate the standard of care that is required of a reasonable competent doctor in that situation of emergency. This principle is applied in *Ang Yew Meng & Anor v Dr. Sashikannan a/l Arunasalam & Ors [2011] 9 MLJ 153* where the High Court held that:

> *"I found that in that emergency case scenario, the treatment that the first defendant provided to the deceased child was appropriate and in accordance with the standard of care required of a medical doctor in the circumstances of the case." (p. 182)*

Hence, in Ang Yew Meng's case, the defendant doctor was held not liable for the death of the patient as the court found that he has acted according to the standard required of a reasonable doctor rendering emergency treatment. Another case on this point is *Siow Ching Yee v Dr. Megat Shiraz & Ors [civil suit no: 23NCVC-27-10/2017]* (High Court Shah Alam) where the plaintiff suffered permanent brain damage due to the negligence of the anaesthetist in delaying intubation after general anaesthesia was administered in an emergency surgery. The High Court found the anaesthetist liable and this was affirmed by the Court of Appeal. One of the defences raised is one of public policy wherein the anaesthetist argued that her intention was to alleviate the patient's suffering and save his life as it was an emergency situation. The High Court, however, rejected the said defence on the basis that she had failed to consider other acceptable treatments or options that were reasonable in the said emergency situation. As such, the anaesthetist had failed to discharge the required standard of care of a reasonable competent doctor in that particular situation.

Another issue that has reached the court in several cases is the issue of delay in providing emergency treatment to patients. This issue should not be taken lightly by doctors as there have been a number of cases that have imposed liability on doctors and hospitals for negligence caused by such a delay. For example, in the case of *Ahmad Thaqif Amzar bin Ahmad Huzairi (Claiming through his mother and legal representative, Majdah bt. Mohd Yusof) v Kuala Terengganu Specialist Hospital Sdn. Bhd. & Ors [2021] 9 MLJ 10*. Here, the plaintiff was only seen by a specialist almost 14 hours after he arrived at the emergency department of Hospital Sultanah Nur Zahirah (HSNZ). The doctors also failed to act with urgency to ensure that there was no blockage on the plaintiff's airway. The High Court found this as a breach of duty of care to the plaintiff. Abdul Wahab J remarked: "It is in my considered opinion that the lack of urgency on the part of the defendants was very starking" (p. 38).

Furthermore, in *Lim Zi Hong v Pengarah Hospital Selayang & Ors* [2013] MLJU 1613, the court found the doctors and hospital liable for failure to provide timely emergency C-section on the plaintiff's mother. The court dismissed the defendants' argument of lack of resources as a defence against the negligence claim when the court held that:

> "*It is reasonable to infer that a safe obstetric system would require an emergency lower segment caesarean particularly to a high-risk patient, such as the plaintiff's mother, to be*

> *attended to promptly, anticipate difficulties and have a specialist to conduct the delivery or to be immediately available to prevent any injury to the baby. In this case there was an unexplained delay from the time of decision to conduct an emergency caesarean section to the time of delivery of the plaintiff which was 54 minutes and such delay was fatal."* (Para 53)

Again, in *Nur Arissa Naura Noor Afrizal & Anor v. Dr. Abirami Kunaseelan & Ors [2023] 5 CLJ 793,* consent judgment was recorded when the defendants had admitted liability for their negligence in treating the second plaintiff. In this case, there was an inordinate delay on the part of the defendants in providing emergency C-section in ensuring the safe birth of the first plaintiff, which caused the first plaintiff to suffer from spastic quadriplegic cerebral palsy.

From the cases discussed above, it has become clear that allegations of unreasonable delay in giving treatment to patients have been accepted by the court in imposing liability on doctors and hospitals. Commenting on the chaotic situation caused by the Covid-19 pandemic, Sokol (2020) rightly pointed out that "Even in challenging circumstances, there are mistakes that no reasonably competent doctor would make." Likewise, Jackson (2010: 125) appropriately stipulates that:

> *"Let us take the common example of having to wait to be seen in a busy accident and emergency department. It would not be negligent to expect people with minor injuries to wait a few hours, but a similar failure to attend to someone who had a heart attack would fail to meet this basic minimum standard of care, and the fact that the hospital was operating with limited resources would offer no excuse."*

CONCLUSION

Working in a busy emergency department particularly in public hospitals where the number of patients daily are high is indisputably challenging for doctors and other healthcare workers. Claims of long waiting hours and delay in receiving treatment are among the qualms expressed by patients which have, on some occasions, led to unfortunate consequences. Thus, the question arises on the duty and standard of care that the law places on doctors who have to face challenges such as the lack of manpower and resources working in emergency departments. Does the law consider the special circumstances in which doctors at emergency departments encounter in performing their duties that are not faced by other doctors as a defence against a negligence claim? To address these concerns has been the objective of the present paper. The case laws of Malaysia and the United Kingdom were analysed with the view to determining the standard of care required by law in emergency departments.

From the decisions of the courts examined, the following observations have been arrived at with regard to doctors' duty to diagnose, advise and treat patients in emergency departments. First, on duty to diagnose, it can be argued from the cases discussed earlier, namely *Wong Choon Mei & Anor v Dr. Kuldeep Singh & Anor. [1985] 2 MLJ 373* and *Mulholland v Medway NHS Foundation Trust [2015] EWCA 268 QB,* that doctors in emergency departments are not expected to reach an accurate and extensive initial diagnosis due to the time constraint that they face in dealing with the medical emergency presented to them. However, emergency department doctors are still expected to exercise the reasonable skills expected in the situation in reaching a proper diagnosis by conducting the required examination, given the fact of the case presented as has been illustrated in the English case of *Wood v Thurston (1951)* Times, 25 May.

Further, in performing emergency medical treatments or surgeries, the amount of information that are expected to be disclosed by doctors to their patients is different from what is expected in other elective treatments or surgeries. This analysis is derived from the cases of *Rogers v Whitaker [1992]16 BMLR 148, Hasan bin Datolah v Kerajaan Malaysia [2010] 2 MLJ 646* and *Noor Azukee bin Mohd Noor lwn Md Sayuti bin Md Yunus [2021] MLJU 1748.*

However, greater caution must be exercised by doctors when discharging their duties to treat patients even in emergency departments, where it is held that the law does not accord a lesser standard of care required of doctors. What is required of doctors is to act according to what other reasonable competent doctors would have done in a similar situation, as has been decided in *Ang Yew Meng & Anor v Dr. Sashikannan a/l Arunasalam & Ors [2011] 9 MLJ 153* and *Siow Ching Yee v Dr. Megat Shiraz & Ors [civil suit no: 23NCVC-27-10/2017]* (High Court Shah Alam). There is, however, a "flexibility for the standard of care to the tailored to specific circumstances, such as with emergency or other disaster" (Vanderpool, 2021). Finally, on the issue of delay in providing emergency treatment, the list of cases discussed above, namely *Ahmad Thaqif Amzar bin Ahmad Huzairi (claiming through his mother and legal representative, Majdah bt. Mohd Yusof) v Kuala Terengganu Specialist Hospital Sdn. Bhd. & Ors [2021] 9 MLJ 10; Lim Zi Hong v Pengarah Hospital Selayang & Ors* [2013] MLJU 1613; and *Nur Arissa Naura Noor Afrizal & Anor v. Dr. Abirami Kunaseelan & Ors [2023] 5 CLJ 793)* have clearly placed liability on doctors and hospitals for their failure to provide timely emergency treatments. Reasons such as the lack of resources or system failure were not accepted by the courts as a defence to a claim of negligence. As such, doctors and hospitals should strive to provide the best medical treatments according to the circumstances of each case to avoid liability in negligence. Proper facilities and qualified medical staff should be adequately placed in every healthcare setting so as to ensure a timely and effective patient management system. Quoting the words of Poole (2020: 97): *"The expected standards of care will reflect the stresses imposed on the particular healthcare providers and professionals, but those standards may yet be breached by unacceptably poor care."*

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