Legal Update: Delayed detection of lung cancer – a patient's suit against a hospital and its doctors

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Key implications of the Court of Appeal's judgment of 26 February 2019 in the case of *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd and others* [2019] SGCA 13 on medical practice and public sector hospital work systems

I. Brief background to the litigation

The patient, Ms Noor Azlin binte Abdul Rahman, was diagnosed with lung cancer in 2012. Two years later, she suffered a relapse, and in 2015, she sued Changi General Hospital (the Hospital) and three of its doctors – a respiratory medicine specialist (Dr X) and two medical officers working in the Hospital's Accident & Emergency (A&E) Department (Dr Y and Dr Z) (collectively the 3 Doctors) for negligently delaying the diagnosis of her disease. The 3 Doctors each faced distinct claims in medical negligence. The Hospital faced two types of claims in negligence, the first by way of primary liability for negligence because of the system which it had in place at the material time, and the second by way of secondary (vicarious) liability for the negligence of each of the 3 Doctors.

After a trial and hearing the testimony of various witnesses of fact and expert witnesses, the High Court in February 2018 dismissed the patient's negligence claim against all four defendants, with costs awarded against her. The patient appealed the High Court's decision. In a landmark decision delivered on 26 February 2019, the Court of Appeal allowed the patient's claim against the Hospital, found the Hospital liable in negligence and remitted the issue of loss and damage, including the quantum of damages to be awarded (if any), back to the trial judge for decision. The patient's appeal in respect of all of the 3 Doctors failed.

The Dentons Rodyk & Davidson LLP team led by Lek Siang Pheng and Vanessa Lim successfully defended the 3 Doctors both in the High Court and in the Court of Appeal.

II. Summary of the case and key findings by the Court of Appeal

Key Facts

The crux of the patient's case was that the 3 Doctors who saw her on separate occasions from 2007 to 2011, and the Hospital where they worked, had negligently delayed the diagnosis of a malignant lung nodule, which resulted in the loss of a better medical outcome and/or loss of chance to cure her cancer. There were distinct allegations of breach of duty made by the patient against each of the 3 Doctors and the Hospital.

The patient had seen Dr X in November 2007 for a lung opacity that had been incidentally detected on a chest X-ray

when she attended at the Hospital's A&E Department two weeks earlier. Dr X examined the patient in his specialist outpatient clinic (SOC) and found her well and asymptomatic. He ordered a further chest X-ray in two views, and upon reviewing the X-ray films, concluded that the lung opacity was infective. Since it appeared to be resolved or resolving, he gave her an open date to return to his clinic.

In 2010, the patient was seen in the Hospital's A&E Department by Dr Y, a locum A&E medical officer, complaining of right lower chest pain which worsened with deep inhalation, but had no respiratory symptoms. An ECG and chest X-ray were ordered, and a stable opacity with no malignant features was noted in the right mid-zone of the patient's lung. The patient informed Dr Y that she had previously seen Dr X, a respiratory medicine specialist, and was told that she was fine. Dr Y did not have access to the respiratory medicine department's SOC notes. After discussing the case with his supervising A&E consultant, Dr Y diagnosed the patient with musculoskeletal pain, and sent the chest X-ray for reporting, noting that the patient would be recalled if necessary. She was then discharged with medication. Dr Y did not have to follow up on the X-ray report personally, as the Hospital had a system by which X-ray reports would be sent to the A&E Department, where they would be reviewed by a senior A&E doctor on duty. This senior doctor would then determine what follow-up, if any, was required. Hence, Dr Y was not aware of the 2010 chest X-ray radiological report or its contents.

The 2010 chest X-ray radiological report states:

"A rounded opacity measuring approximately 2.2cm is seen in the (R) mid zone, which appears stable since the previous chest radiograph dated 15/11/2007. This is non-specific and is indeterminate in nature. A follow-up radiograph may be performed for assessment of interval stability. The rest of the visualised lung parenchyma shows no significant abnormality. No gross consolidation is seen."

In 2011, the patient was seen in the Hospital's A&E Department by Dr Z, an A&E medical officer. This time, she presented with left lower rib cage pain which had persisted for one month and was previously diagnosed by a general practitioner as rib-cage inflammation. Dr Z ordered an ECG and a chest X-ray in two views (erect and left oblique). In view of the patient's complaint, Dr Z adopted a targeted approach and focused on the left side of the patient's chest. He did not notice the opacity in the right mid-zone of the patient's lung, which was only visible in the erect view of the X-ray. Dr Z cleared his diagnosis of costochondritis with his supervising consultant. The chest X-ray was sent for reporting. Again, Dr Z did not receive the 2011 chest X-ray radiological report, and he was unaware that a lung nodule had been detected.

The 2011 chest X-ray radiological report states:

"The opacity in the (R) midzone is again noted, measuring 2.6x2.2cm compared to 2.5x2.0cm in the previous study dated 29 April 2010. It is non-specific in nature and largely stable since the previous study. No new mass lesion is noted in the rest of the lungs. There is also no pleural effusion or pneumothorax. Follow up of this lesion is suggested."

Key findings of the Court of Appeal

We summarise below the main allegations made by the patient against the Hospital and the 3 Doctors, and the key findings by the Court of Appeal:

The Hospital

The patient alleged that the Hospital failed to put in place a reasonable system of management to ensure proper follow-up on her medical condition. In its defence, the Hospital had argued that the 2010 and 2011 chest X-ray radiological reports were sent to the A&E Department, and the senior doctor on duty had reviewed the reports and determined that no follow-up was required on each occasion. However, the Court of Appeal found that there was no evidence that the Hospital had in fact taken any action on the patient's radiological reports in 2010 and 2011. The Court went on to identify three systemic failures by the Hospital.

- First, the standard of care required the Hospital to ensure that radiological reports were properly followed up and given appropriate attention. The Court of Appeal expressed the view that such reports should not have been sent to the A&E Department, but rather to the SOCs, which are better equipped and have more time to deal with them. As to which SOC ought to receive the radiological report, the Court's view was that the Radiology Department should decide this. Only if the radiologist was unable to ascertain the appropriate department for follow-up, should the radiological report be sent to the A&E Department for follow-up. In the present case, the Court held that the 2010 and 2011 chest X-ray radiological reports should have been assessed by a respiratory physician rather than an A&E doctor.
- Second, the Hospital's [then] system for review of radiological reports did not allow for comprehensive management of a patient, namely, a means for consolidating known information about the patient. The Court cited in particular, Dr Y's inability to access Dr X's clinic notes.
- Third, the Hospital did not have a system [then] for recording decisions made by the A&E senior doctors who reviewed the patient's 2010 and 2011 X-ray radiological reports. This meant that the patient would not know the decision made, and doctors treating the patient down the line would not know the reasons for the decision.

Thus, the Hospital was held by the Court of Appeal to have been negligent in that it breached its duty of care owed to the patient for failing to have in place a proper system to ensure adequate follow-up of the patient's case and that this resulted in a delay in diagnosing her with lung cancer. This is a finding of primary liability against the Hospital.

As none of the 3 Doctors were found to have been negligent (see below), there was no finding of vicarious liability on the part of the Hospital in this regard.

The 3 Doctors

The patient had alleged that Dr X ought not to have discharged her with an open date without being sure that the patient's lung opacity had resolved. The Court of Appeal agreed with the patient on this point but found that Dr X was not liable to her in negligence because she did not have lung cancer in 2007. [In other words, while there was a breach of duty by Dr X, there was no causation of loss. Hence, there was no liability in negligence.]

Among the key allegations by the patient against Drs Y and Z were that they should have either referred the patient to a specialist or ordered a CT scan to diagnose her lung nodule. However, the Court of Appeal, accepting the expert opinion of the doctors' Emergency Medicine expert witness, held that standard of care applicable to A&E doctors must be informed by the reality of their working conditions and calibrated accordingly. A&E doctors work under immense time pressure and cannot be expected to review patients in the same manner as a GP or in a SOC. They are permitted to adopt a targeted approach to prioritise the patient's presenting symptoms and rule out life-threatening conditions. However, incidental findings should not be ignored, and the standard of care for incidental findings would depend on factors such as its characteristics, the patient's history, whether the finding had been detected previously.

Dr Y was not in breach of his duty of care to the patient. It was sufficient for him to defer the diagnosis of the lung opacity, send the chest X-ray for reporting and provide instructions to recall the patient if necessary. There was also no duty on the A&E medical officer to order a CT scan at first instance on an incidental finding of a known nodule that was stable. However, the Court of Appeal also cautioned that the fact that the A&E medical officer is aware that a specialist had seen the patient in the past cannot of itself justify a lack of follow-up. Also, simply because a patient says that a specialist had told her that "she was fine" would not be sufficient reason by itself, for the medical officer not to investigate further.

As for Dr Z, the Court of Appeal accepted that he had not seen the lung opacity on the 2011 chest X-ray image. However, there was no breach of duty on the part of Dr Z, as he was entitled, as an A&E doctor to adopt a targeted

approach to address the patient's presenting condition in an A&E setting.

III. Implications of the Court of Appeal's judgment

We highlight four key implications of the decision which are likely to affect medical practice, particularly in the public sector healthcare setting:

1. The Court of Appeal did not address the part of the High Court's decision that the patient should be notified of the results of radiological reports and of the clinical decision on the patient's condition as part of the doctor's communication of his/her diagnosis. Given that this part of the High Court's decision remains in place, hospitals may need to consider putting in place a system to ensure that radiological findings are communicated to the patient even if no further intervention is assessed to be required, so as to allow the patient to evaluate the information to decide how, if at all, they want their care to be followed up on. If the radiological findings are related to or have some impact on the patient's presenting complaint, the hospital may have to recall the patient to explain the findings to him/her, even if no further intervention is thought necessary. If the findings are not related to his/her presenting complaint, such communication can be made by e-mail.

Our comments

It is plausible that the High Court's ruling can extend to all investigation findings and reports which are not immediately available at the time of the patient's consultation, or prior to the patient's discharge (if he or she was admitted).

2. The Court of Appeal accepted the expert evidence adduced on behalf of Drs Y and Z that the A&E Department is meant to adopt a targeted approach focusing primarily on the acute episode concerned and the patients' presenting symptoms in view of the constraints of time and resources. Following from this, the Court of Appeal's view is that the radiological reports should be routed by the radiologists (rather than the A&E doctors) to the appropriate SOC, and it is only where the radiologist is unable to ascertain the appropriate specialty that the report is sent to the A&E Department for a consultant to decide upon.

Our comments

a. The import of this aspect of the Court of Appeal's ruling is that public hospitals with an A&E Department should now consider implementing processes for all radiological reports, which would ordinarily be sent to the A&E Department, to be directed instead to the appropriate outpatient SOCs. In addition, the receiving SOCs would have to devise a system for these radiological reports to be reviewed and followed up on if necessary. Decisions on whether to follow-up and what the follow-up is would also have to be documented.
b. The aspect of the Court of Appeal's view that radiological reports should be routed by radiologists (rather than the ordering A&E Department) to the relevant SOC bears a closer look. The Court's view seems to be based on the premise that the reviewing senior doctor in the A&E Department is subject to the same time constraints as the medical officers working on the ground and attending to patients at the frontline. However, we think that this may not necessarily be the case in every A&E Department: if there is a separate system or roster in place for such a review to be undertaken, this would possibly ameliorate these constraints. Also, given that the A&E Department had ordered the radiological investigation and that the doctors there had taken the patient's history and seen the patient, the A&E Department would perhaps be better placed, rather than the Radiology Department, to correlate the radiological findings with the patient's presentation, and make the call as to whether a referral to the SOC is required and also which specialty the patient should be referred to.

3. The Court of Appeal's decision suggests that hospitals ought to have a system to consolidate known information

about a patient.

Our comments

With electronic medical records system now prevalent in public sector hospitals and more accessible to doctors, the problem that arose in the case of *Noor Azlin bte Abdul Rahman* (that is, an A&E doctor's inability to access SOC clinical notes) is unlikely to arise now in the public sector. There remains the separate and distinct problem of how to sieve through the mass of available medical history in the records.

4. Of particular interest to doctors would be the Court of Appeal's observation that the mere fact that a patient says that she had previously seen a specialist and had been told she was fine, does not by itself excuse the doctor from investigating further. In other words, this suggests that the medical history given by a patient should not be taken entirely at face value. This gives rise to several interesting questions: how far must a doctor investigate medical history narrated by a patient or care-giver, and what must he/she do to satisfy his/her duty of care? Would mere verification against previous medical records suffice, and if so, how far back must he/she look? Or must the doctor take further steps such as initiating a referral or performing clinical investigations where previous records are old or not available?

Our comments

The likely answer is that the extent of further investigation required depends on the context of the consultation, e.g. how important that piece of medical history is to the doctor's treatment plan, whether verification against previous records is practicable, and the cost vs benefit of putting the patient through further rounds of clinical investigation (such as MRI or CT scans, which are costly) or referrals to verify the medical history. Going forward, doctors of all specialties may need to think twice, before simply accepting a patient's medical history at face value.

IV. Conclusion

The Court of Appeal's decision in *Noor Azlin bte Abdul Rahman* is the first time a public sector hospital in Singapore has been found to have been negligent for its system. The decision, particularly on the aspects of the case relating to the hospital work systems impacts on how a healthcare institution ought to collate and consider the relevant medical information in its possession for the purpose of patient care. Accordingly, healthcare institutions may wish to review their processes and protocols, particularly with regard to radiological investigations and also the handling of incidental findings.

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