Abstract: Australia and Singapore have similar standards of health care. The one major difference in the two health care systems is the cost to the patient at the point of care. The Medicare system in Australia provides partial to complete subsidy for health care delivery in the public hospitals. In Singapore, the patient has to bear the cost of their health care when needed, with some government subsidies. Studies in the variations between two health care systems, where the costs to the government and individuals are clearly dissimilar, but the health outcomes are similar, can be educational for health law specialists. The methods in which patients obtain recompense for their grievances can help both countries understand how to determine and improve standards of health care communication. Having worked in both systems, the relative values of each and their effects on medical litigation will be discussed.

Keywords: Health care delivery; medicolegal practice; Australia; Singapore

Introduction

Balancing the delivery of healthcare with patient expectations and clinical outcomes has been a problem for all countries to grapple with. This situation is further confounded by availability of healthcare resources, level of government subsidies and the medicolegal environment of the country this health care is delivered in. In this paper, two dissimilar health care systems in Australia and Singapore are described, and their effects on medicolegal issues are discussed. These differences could be used to provoke thought and action...
on provision of optimum medico-legal support for health care delivery. The comparative demographics of Australia and Singapore are shown in Table 1.

The Australian Health Care System

Australia has had, since 1984, a heavily subsidised health care system (Medicare) for all its citizens and permanent residents. The Medicare system will stay indefinitely despite its many problems because of the politically sensitive nature of health care services. Even though health care providers could charge any fee they desire, the balance has generally been in favour of patients in the large cities due to competition. In states where health professional numbers are less, the cost of health care is higher and patients are more likely to have private insurance against illness knowing the substantial costs of health care delivery. However most patients are largely subsidised by a Medicare rebate and many, especially pensioners and people from lower socio-economic groups, do not pay any medical fees even in private consultations.

In order to contain costs, the Australian government does not increase the medical consultation rebates in line with inflation. Medical practitioners have been disenchanted with their financial reimbursement, compounded by the change in the medicolegal environment triggered by a number of landmark legal judgements. The cost of delivering extra time and services to the patients has resulted in resentment by the medical profession in paying huge increases in their medical indemnity insurance bills without receiving a more significant reimbursement for services rendered. Many practitioners have either left the private sector to work full-time in the government sector which provides full indemnity for their services, or left medical practice in Australia completely. This has resulted in a manpower crisis both in rural Australia, which is a long-standing problem, as well as in the cities, which traditionally have been well populated by doctors and other health care providers.

There have been many positive off-shoots from the medicolegal changes in Australia including the production of well-designed information sheets by the Royal Australasian College of Surgeons. These are given to patients when

obtaining informed consent for their operative procedures, and has led to more
careful explanation of the nature of treatment and the potential side-effects of
invasive procedures and drugs, as well as the more thorough documentation
of clinical information in the patients’ medical records.

The Singaporean Health Care System

Singapore also has a two-tiered public and private health system4. “Singapore’s
financing system combines universal savings accounts with supplementary
programs to protect the poor. The interplay of individual incentives, targeted
subsidies, and other cost containers is an important factor in its success. The
system differs significantly from national health insurance. Employees are
required to contribute a percentage of their salary (6-8%) to individual savings
accounts. These accounts belong to the individual, accumulate over a lifetime,
and can be used at the individual’s discretion. To address the risk of severe
illness Singapore complements these accounts with catastrophic insurance.
The government also provides targeted subsidies for the poor, the elderly and
the unemployed. Both the public and private sector provide health care in
Singapore and patients can choose their provider at all levels of care”.

There are regular changes in the relative usage of both systems depending on
the state of the economy. This was affected significantly in 2003, when the
epidemic of Severe Acute Respiratory Syndrome (SARS) hit Singapore, further
affecting the economy and leading to increased utilisation of the public health
system.

While the Basic Indicators of Health as published by the World Health
Organisation (WHO) are similar in both Australia and Singapore, the National
Health Accounts Indicators are significantly different (Tables 2 and 3).
Singaporeans pay in excess of 63% of their health care expenditure on private
health care while Australians spend 32.5%. The Singaporean government
spends 4.5% of their Gross Domestic Product (GDP) on health, the lowest
among developed countries.5

4. The Singapore health system – achieving positive health outcomes with low
default.asp?ArticleID=13850&pub=HealthcareMarketReview
5. Is Singapore a model for health financing? A discussion moderated by Rob Taylor in http://
As there is both personal and family commitment for the payment of health care costs in Singapore, as per national legislation, the citizens are much more cognisant of the cost of delivery of health care. Families of patients are particularly keen on being informed of treatment options at all times not only because of their concern for the relative, but also because they are responsible for any charges that are levied after the government subsidies. Official complaints against medical practitioners are more often made than in Australia. This is because patients and their families are aware that there have been precedents when hospital and medical fees have been reduced or waived because administrators do not want the negative publicity of these complaints revealed to the media. While these are always dealt with promptly by the appropriate authorities, it is stressful for the medical practitioner. They have to produce formal medical reports on the care of the patient and await the findings of the relevant Complaints Committee. There is often the loss of rapport with that patient and their family.

Health care complaints

In Australia, patients are now using the state Health Care Complaints Commissions (HCCCs) to address issues that they are concerned with regarding their health care. In order to improve the way healthcare services manage complaints, the Australian Council for Safety and Quality in Health Care sponsored a project in 2003, the ‘Turning wrongs into rights’ project’. They found that an informal responsive complaints system, designed at the local level with an element of consumer participation, was much more successful than an externally imposed formal complaints mechanism. They found that most of the direct complaints to General Practices were due to waiting times, bills or perceived rudeness, while most of the complaints directly to the HCCCs, were about diagnosis and treatment. Singapore also has a Complaints section in the Singapore Medical Council. Similar to the Australian experience, most of the complaints made formally were about diagnosis and treatment. However complaints made in hospitals and doctors’ clinics were usually about fees, and waiting times. The main difference is how this is then followed through by the patients.


With high profile cases regularly reported in the media and with law firms aggressively marketing their interests in health care litigation, Australians tend to consider the legal option more quickly and bypass the pathways set up by the HCCCs. In Singapore, the complainants tend to use the system set up at individual hospitals and the Singapore Medical Council rather than go through the courts. The obvious reasons between these two countries, are the costs involved and the responses at administration level. In Singapore, any legal fees for cases taken up by law firms will have to be covered by the clients themselves. In Australia, it is quite common for law firms to adopt the policy of “no win, no fee” which allows more people to litigate without worrying about the cost. This is offset by the legal cases won, where the lawyers take a large percentage of the costs awarded.

In Singapore there have been incidences when complaints have been made after an unsuccessful medical outcome, despite the best of care being given. Complaints due to interpersonal differences between patients, their families and health care providers, with little substance, are not uncommon. “Complaints can also be used by patients or their relatives for selfish reasons. Doctors are aware that a patient’s death may precipitate a formal complaint if there is a background of dissatisfaction. Relatives may more readily complain to assuage feelings of guilt about not having done more for the patient when he/she was still alive. This appeared to be the reason for the attempt by a relative to malign a doctor on the unsubstantiated charge that the doctor refused to give emergency first aid to a distressed patient who died soon after. This case was reported in the SMA News in September 1996 as ‘Rashomon Redux’, an allusion to the Kurosawa’s classic movie that explored seemingly truthful yet contradictory accounts by various interested parties of a rape-cum-murder that was committed”9. “It is important that the medical profession and administrators are seen to publicly support the doctor where it is clear that a complaint is frivolous and baseless. Only with such actions, can doctors feel safe to practise cost-effective medicine and not defensive medicine”.

There have been occasional situations where cases have gone to court despite a patient not heeding the doctor’s advice and suffering a bad consequence. In Singapore, the courts are more likely to weigh the facts and come down on the

8. Legal Profesional Act Singapore Section 107(1)(b)

side of justice and equity\textsuperscript{10}. There are however no jury-based trials to arbitrate these decisions (Table 1).

**Judgments in cases of negligence: The Bolam Principle**

Courts around the world are telling lawyers on both sides to keep their hired ‘expert witnesses’ away from the witness stand unless they are more accountable for their evidence. As the courts and governments give judges more power to eliminate bias, the challenge is to provide a fair and balanced outcome for both the plaintiffs and defendants. In medicolegal cases, when every medical negligence case goes against a doctor, some other ‘expert’ medical practitioner has given evidence against that doctor.

While the adversarial legal system exists, expert evidence is intrinsic. A variation is to use expert witnesses in Alternative Dispute Resolution (ADR) outside the courtroom where the evidentiary opinions can be weighed up against each other and rebuttal can be immediate over the negotiating table. The introduction of an expert witness code of conduct into the New South Wales court system in 2000, has helped the courts deal more openly with expert witnesses and ensure they understand their obligations to the court. There are however many ways of reducing the bias that exists and this is being viewed regularly by both judicial systems. Singapore is currently training professionals in ADR methods.

However, judgements also need to be fair. As Australian High Court Judge Michael Kirby stated “Medical practitioners tend to see malpractice cases as involving a moral blight or stigma upon the practitioner concerned. From the point of view of the patient (and most lawyers) however, the issue is usually more basic. It is whether a person who has suffered in some way as a result of medical or hospital procedures will be cast upon the genteel poverty of the social security system or be entitled to recover compensatory damages from the medical practitioner’s insurance. To gain insurance, the practitioner must pay premiums. These premiums become part of the costs of medical practice. In this way, all patients bear the cost of, and contribute to, the fund from which are paid damages when things go wrong.”\textsuperscript{11}


\textsuperscript{11} Kirby, M. Patients’ Rights – Why the Australian Courts have Rejected “Bolam”, 1995 J. of Medical Ethics; 21: 5-8.
However, retired Queensland Supreme Court Justice James Thomas regretted the impact of the developments in the tort of negligence. "Judges who liked 'playing Santa Claus', were partly to blame for Australia's public liability crisis. 'Common sense' had gone from the legal system when it came to cases of negligence. Some judges have enjoyed playing Santa Claus, forgetting that someone has to pay for our generosity." Justice Thomas said. "We have allowed the tests for negligence to degenerate to such a trivial level that people can be successfully sued for ordinary human activity." Justice Thomas said society's 'lust' for compensation had been accelerating over the past 20 years as a result of increasing compensation payouts. "We now have a compensation-oriented society in which people know that a minor injury is a means of getting more money than they could possibly save in a lifetime. It is no use blaming plaintiffs' lawyers. We, the judges are the ones who have laid down the ground rules and given the judgements. The buck stops with us, not them. We are the ones who have let the quantum of damages get out of hand, and who have lowered the barriers of negligence and causation." Justice Thomas said the trend of skyrocketing compensation payouts could only be halted by High Court rulings. "I have, of course, faithfully followed precedent, but there is not a lot a judge, even at an intermediate appeal level, can do unless the High Court approves, except to bemoan the general trend."

In contrast, while recent Australian judgments have gone away from the Bolam Principle and the doctrine of precedents, Singapore still lays a great store in these two principles. In Singapore, the Bolam Principle is still held that a doctor is not liable in negligence, when it is proven that he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Judges allow doctors by law, the privilege of having their performance judged by their peers, who by the fact of being peers should be the best persons to know every matter which should or should not go onto the scales, when a particular incident is weighed and considered from the point of view of negligence.

Singaporean judges still therefore go by the evidence of expert medical witnesses and as a matter of law, evaluate their opinions against the reasons they give in support of them and make their judgments accordingly. Justice

13. Bolam v Friern Hospital Management Committee 1957. 1 WLR 583.
Lai Kew Chai in the Sreenivasan Oration in 1985 to the College of General Practitioners of Singapore reiterated the validity of the Bolam Principle in his court and discussed examples from British Law Court judgments that had exonerated doctors in cases of medical negligence\textsuperscript{14}. He concluded however that he did not like to see the law imposing a new duty of care for doctors particularly in situations where the natural history of an event could not be avoided by the doctor concerned such as in recanalisation of a vasectomy, or damage to the recurrent laryngeal nerve by operative complications. However, these measures taken by the judiciary in Singapore may be seen as a means for health care cost containment.

The Bolam Principle in Case Law

The Bolam Principle has been revisited many times in Singapore and it still generally holds provided the court is satisfied that the exponents of the expert body of opinion relied upon can demonstrate that such an opinion has a logical basis. In the case of \textit{Vasuhi d/o Ramasamypillai v Tan Tock Seng Hospital Pte Ltd}\textsuperscript{15}, disparate expert opinions required Justice Tan Lee Meng to discuss the tests for the standard of care with regard to medical diagnosis and treatment. One of the issues contended was whether a coronary angiogram should have been performed earlier on the patient (Vasuhi). The defendant's medical expert's opinion was that a patient's heart should be left to heal for two to three weeks after a heart attack before performing a coronary angiogram, whereas the plaintiff's medical expert testified that the medical professions in Australia and the United States no longer espoused that view. As the standard of care practised in Singapore at the time was followed, no negligence was found.

The Singaporean Courts also accept that medical risks and benefits are a matter of clinical judgment, which a judge would not normally be able to make without expert evidence. When a judge can be satisfied that the body of expert opinion cannot be logically supported at all, such opinion will not provide the benchmark by reference to which a defendant doctor's conduct will be assessed. In a rare case, where it can be demonstrated that professional opinion is not


\textsuperscript{15} \textit{Vasuhi d/o Ramasamypillai v Tan Tock Seng Hospital Pte Ltd.,} 2001. SLR(2) 165.
capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. In the case of *Pai Lily v Yeo Peng Hock Henry*¹⁶, the Singaporean Supreme Court reversed the judgement of the High Court. The decision was made that despite the doctor’s (Dr Yeo) breach of duty of care in failing to advise the plaintiff to seek immediate specialist attention for an infection in the eye, there was little evidence to support a full or even reasonable recovery of the eye taking into consideration the unusual nature of and severity of the infection. The patient (Lily Pai) might have suffered the same injury even if she had received the proper medical advice and acted on it promptly.

However the recent British House of Lords decision for the judgment in the cause of *Chester v Afshar*¹⁷ may have long-term ramifications for the delivery of health care in Singapore. In this case, reminiscent of the *Chappel v Hart* decision¹⁸, the Appellate Committee by a 3:2 decision dismissed the appeal of Dr Afshar, a neurosurgeon who performed lumbar canal decompressive surgery on Ms Chester. The patient developed cauda equina syndrome, a rare (1%-2%) risk of this type of surgery. As in the *Chappel v Hart* case¹⁸, the court did not find the surgeon negligent in performing the desired operation but that he had not warned the patient of the unavoidable risk of the proposed operation. If she had known of this risk, Ms Chester claimed she would have not agreed to the surgery, entrusted herself to a different surgeon or had more conservative treatment. As many Singaporean court decisions follow British law precedents, the decision will allow local courts to make judgements on the ‘duty to warn’ in the practice of medicine.

Medical practice in the past decade has had some major changes. While health care delivery has largely changed from a one-to-one relationship between an individual and the medical practitioner, current practice dictates that health is delivered by a health care team. Patients obtain information about their health care not only from doctors, but also from nurses, allied health practitioners, naturopaths and increasingly from the media and the Internet. While the quality and accuracy of the information varies depending on the source, patients are also becoming more demanding as far as knowing all the attendant risks of their treatment are. This is a good practice overall as it allows the personal

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empowerment of decision-making. In Australia, precedence has been set with the Rogers v Whitaker case to provide as much information as possible that is required by a 'reasonable person'\(^\text{19}\). In this case, the appellant (Dr Rogers) was an ophthalmic surgeon who conducted corrective surgery on the respondent’s (Mrs Whitaker) right eye. The surgeon was not found to be negligent in his performance of the surgery, conducting this with the required skill and care. The basis upon which the High Court judges found the appellant liable was that he had failed to warn the respondent that, as a result of surgery on her right eye, she might develop a condition known as sympathetic ophthalmia in her left eye. In this case, sympathetic ophthalmia did occur and the respondent ultimately lost all sight in her left eye. The respondent had "incessantly" questioned the appellant as to the possible complications. She was deemed as a ‘reasonable’ person in the nature of her questions and as no warning was given on this complication, the surgeon was deemed negligent in his duty to warn\(^\text{19}\).

However a ‘reasonable’ person is difficult to define. There are still many people who wish their health practitioners to take on a paternalistic role in their health care. This is not uncommon in Singapore. They want the practitioner to inform them of their treatment options and then advise them directly of their preferred choice. Legislation has now increasingly influenced the way medical and other health practitioners deliver health information. The two Australian cases of the 1990s, Rogers v Whitaker (1992) and Chappel v Hart (1998) have changed the way the law in Australia expects information to be delivered. These two cases have highlighted to health practitioners, especially doctors, that all attendant risks of treatment need to be mentioned to the patient and the patient has the right to choose the practitioner that they feel has the best experience to treat their individual clinical problem.

**Implications of the Australian High Court’s decision in Chappel v Hart**

The decision of the Chappel v Hart case\(^\text{18}\) has not as yet had a dramatic impact on the rate of medical negligence cases in Australia. In this case, an ENT surgeon (Dr Chappel) performed an operative procedure on a patient (Mrs Hart) with a pharyngeal pouch. The patient was warned about some risks of the procedure but developed a rare complication of mediastinitis and damage to a nerve for her vocal cords resulting in impaired speech. Her voice was important.

\(^{19}\) Rogers v Whitaker 1992. CLR (175) 479.
for her employment and she had asked specifically about this complication of surgery. Paul Donohoe QC who represented the respondent, Mrs Hart in the High Court, said that the fulcrum of the case was that the patient was not informed of a particular risk after she had expressed her concerns about it. He stated that the patient would have sought a more experienced surgeon had she known about the risk. The case did not make a ruling about the need for doctors, spontaneously and without inquiry, to inform each and every patient about more experienced practitioners.

While the implications of the case have been discussed in relation to the judgments, the immediate concern that medical practitioners have to be aware of, is the articulation of risks in term of the skills of the surgeon. In this case, the Courts did not find the surgeon, Dr Chappel negligent in the performance of the procedure nor was he negligent in informing this patient of the risk of perforation of the oesophagus. He was however found negligent about not answering the specific question that the patient had in regards to her voice. It would therefore appear that patients should not only be given as much information about any treatment and procedures they may find helpful in an elective setting, but they appear to be expected to produce theoretical risks if specifically questioned about these. Hence if a patient, once told of all the inherent risks of a particular treatment or procedure, then asks how they can reduce this, it would appear to be the legal duty of the doctor to inform them of the most experienced practitioner available for this treatment. The attendant problem for this is twofold. Patients would have to wait for months in order to see particular doctors who are deemed to be specifically skilled in particular procedures in view of the excessive demands on their opinions and skills. Then less experienced doctors, who need to treat and operate on patients to gain more experience, would not be referred these patients.

A middle-of-the-road solution for this may be that more senior and junior practitioners be paired off so that the junior practitioner is supervised in carrying out the procedures by the senior experienced practitioner. This would have the additional benefit in that patients may be seen earlier by the practice and more complex cases discussed by both medical practitioners. General practitioners and doctors who have had expertise in specific fields would need to assess their capabilities in comparison to their peer group. Referring doctors would also be responsible for making reasonable efforts to assess the specialists' or surgeons' skills before referring their patients. The emphasis in the future may purely be on the ability of the medical practitioner rather than on other
attributes like affability, accessibility, affordability and availability of the practitioner which currently ranks as important for both doctors and their patients. As discussed in the case, generalisations have to be tempered in specific situations. While doctors have a duty to inform patients of the risks of a procedure and their experience and skills in performing this procedure, what a particular patient may wish to know, may be different from what an ordinary and 'reasonable' patient would want to know.

The High Court decision in the *Chappel v Hart* case also highlights the use of expert witnesses in cases of medical negligence. In this case, the expert witness for the respondent, Mrs Hart, was Professor Benjamin. Despite being an experienced surgeon, he was unable to present figures suggesting the frequency of the complications suffered by Mrs Hart. This was because, while theoretically possible, the final effect on her voice was extremely rare. In any medico-legal case, lawyers from both sides will find expert medical witnesses who are capable of stating positions that are favourable to their clients. Recollections of individual experiences are inevitably flawed and flawed in a non-random direction. Meadow and Lantos correctly contend that "medical care is not a single behaviour that conforms to or deviates from an idiosyncratic and retrospectively determined standard, but rather a distribution of behaviours in response to a variety of medical circumstances". "For a given scenario, each of several possible responses can be ascribed a relative frequency based on empirical data, and the consequent normal curve depicts the totality of medical care."20.

In Singapore, patient care is affected by the way many people seek their treatment. It is not uncommon for patients to go to both western and eastern-trained physicians to seek 'cures' for their ailments. In these situations, late diagnosis or failure to take western medication, has had negative long-term impacts on patient outcomes particularly organ damage and death with cardiovascular diseases, malignancies and autoimmune diseases. The Singaporean Ministry of Health issued a statement on this in 2004. "We would like to take the opportunity to clarify certain issues. Science-based (western) medicine is the main form of health care in Singapore. Many Singaporeans also turn to Traditional Chinese Medicine (TCM) and other types of natural and herbal treatments as a complementary form of health care. The practice of

western medicine is evidence-based in which the efficacy of medical treatments is tested and supported by scientific research and clinical trials that are subject to peer review and international scrutiny. TCM and other complementary or alternative medicine therapies have not been studied in the same scientific manner. We would advise that consumers exercise discretion in evaluating the information available on the efficacy of TCM/alternative medicine products and therapies.”21

Regulation of medical practitioners in Singapore, includes a separate Register for alternative practitioners. It is however difficult to legislate against failed diagnosis and complications of treatment in the community setting by these alternative practitioners. However hospital-related errors of diagnosis and management are more transparent and therefore can be identified and litigated against.

At this point in time medical injury litigation is not perceived as a financially lucrative area of practice among the Singaporean legal fraternity. Hence cases are few and far between. However both the medical system and its legal advisors are constantly reviewing and setting up guidelines for ideal clinical practice. Hence preventive care is more prevalent and patients and their families are constantly kept in the loop as to the treatment and updated research on medical conditions. Good communication skills and appropriate checks and balances therefore stave off potential litigation in many situations.

Information overload

Giving patients information is the fundamental basis of a medical consultation. However the way in which this information is presented can significantly influence the choices that patients make and consent to treatment. Therapeutic privilege allows doctors to withhold information when they think a patient may be unable to cope with the information or may be harmed by it. The degree to which therapeutic privilege is applied depends on the patient’s condition, how well the doctor knows the patient and the quality of their relationship. In Singapore, most people do not have a Family Practitioner. As such they see a number of health professionals from their various specialists to natural health practitioners. There is often little opportunity to develop a

professional bond with a doctor that can result in mutual confidence and trust in their relationship. There are efforts to change this situation by having government-run Polyclinics and partially subsidising private Family Physicians for delivery of health care. Hence therapeutic privilege is rarely taken and decisions are left to patients and family members for treatment. Medical intervention can sometimes be delayed as various members argue on the risks and benefits of the treatment options.

In Australia, all residents are encouraged to have a Primary Family Physician, even medical practitioners. Communication between other health practitioners on patient care is passed on to this physician so that coordination of care can be conducted with the patient. This is better done in areas where the doctor to patient ratio is low, as patients are less likely to ‘doctor-shop’ and change doctors when they are dissatisfied with their care.

With the advent of evidence-based medicine (EBM), there is a real threat of information overload. Patients would have to be told that the alternative treatments are based on research and are then given the option of reviewing this for themselves. While this to some extent abrogates the doctor of some responsibility for making the clinical decisions and allows more patient autonomy, it can also make the patient so confused that they choose not to have any treatment. In some self-limiting conditions this may actually be a blessing as the patient will not have short-term and sometimes unnecessary treatment. In aggressive diseases like rheumatoid arthritis and cancer, this may actually be a detriment as the studies that are needed to confirm therapeutic benefit may take years to complete, to satisfy the best trial designs. However, experiences that clinicians may have in treating a small number of their own patients, may be just as useful in determining ongoing management for a particular patient.22

In Singapore, EBM has been embraced whole-heartedly and sometimes aggressively. One concern with legislation influencing the type and amount of information that is conveyed to a patient is that, this may encourage a didactic approach where doctors feel pressurised to follow research evidence rather than their clinical judgment. Clinical pathways, that are developed with combined specialist expertise in the management of conditions like asthma, diabetes mellitus and breast cancer, will be helpful to guide doctors on current

available evidence. Nevertheless, this has to be combined with data-driven clinical practice. The impact of computerised data bases like the Cochrane Collaboration, may in the future affect court decisions on medical negligence if a health practitioner is perceived to have digressed from evidence-based clinical practice. One of the concerns is that this will replace the multifactorial interaction between clinical, psychosocial and environmental factors that currently govern best clinical practice.

Standards of Medical Care

Brennan and colleagues studied 31,000 medical records of adult patients in New York in the 1980s. Using independent reviewers to assess the relationship of malpractice allegations to true medical negligence, these researchers found that one in six allegations of malpractice was justified and one in six episodes of true malpractice was actually sued. Following a subset of patients through discovery of their files and trial proceedings, these same authors determined that the likelihood of pay-out bore no relation to any identifiable negligent behaviour and correlated only with the degree of disability of the plaintiff. This does lead to scepticism in the Australian medical fraternity about decisions like that in the Chappel v Hart case. While medical practitioners should be wise to take heed of the decision, and modify their consulting and communication skills if needed, there are still concerns that the recollections of individual experiences are inevitably flawed and that people often underestimated large numbers, overestimated small numbers and skewed responses in favour of outcomes deemed more appropriate or desirable. The standard of care is often created anew by expert testimony in each individual case. In future medical negligence cases, the Chappel v Hart case will set case-law precedents. Whether this will set a standard that is appropriate to modern clinical practice is left to be seen.

In clinical practice, if the aim of the health professional is only to diagnose and offer advice, and the patient is then left with the responsibility of obtaining all the advice they can get to base their decisions, there will be many individuals who are unable to make their own decisions based on their level of education, complexity of the clinical problem and ability to sieve through the relevant information. There are concerns in the medical profession that judges appear

to view plaintiffs as victims. There are also concerns that the unrealistic expectations that judges place on medical practitioners, in deciding what actually constitutes negligence. In a strongly worded assessment of the judgment into the High Court case of *Chappel v Hart*, a Brisbane ENT surgeon, Dr Bill Coman, searched the literature and had not turned up any cases of a vocal cord palsy following the Dohlman's procedure performed by Dr Chappel on Mrs Hart. He was highly critical of the assessment of the case including the failure to properly assess the current state of Mrs Hart's voice from a speech pathologist or an independent ENT surgeon.

In Singapore, doctors are often frustrated that patients do not follow their advice and seek medical attention from their family and friends rather than listen to the information given by trained professionals. This is also important as there are now patients, as in other parts of the world, who download information from the internet and treat this as accurate rather than checking the validity of this information. Doctors who are well-trained in communication skills, may be able to systematically and pro-actively counsel their patients to absorb the information and decide treatment options according to their condition, desired quality of life and financial situation.

**Future directions:**

Medical schools now have in their curriculum a major emphasis on communication skills. Simulated patient-doctor sessions are organised to cover many aspects of communication that a practising doctor may face in their professional lifetime. Risk management is the way doctors must now practice after the judgments in cases like *Rogers v Whitaker* and *Chappel v Hart*. Good risk management is trying to form some understanding of the patient, their culture and expectations, a rapport and some measure of empathy. Failure to communicate can often become the source of disaffection ending in litigation.

Australian medical practitioners need to work out at the start of their career, how they are going to approach their patients. Doctors must be prepared to recognise and treat individuals like Mrs Hart, who place an extraordinary emphasis on certain parts of their bodies. Any procedure that leads to the loss of function or deformity of that part is usually devastating to the patient. Doctors must also be sensitive to the needs of individual patients and provide as much

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information to the person as they can absorb. In a more complex medical setting, it may be useful if the doctor arranged a time for another consultation to revise issues already covered. If a patient asks a question, this should be answered by any means within the training, knowledge-base and clinical experience of the doctor. Any issues that are beyond the scope of an individual doctor, should be referred on to a specialist who can provide the patient with his/her expertise. Any concerns that the patient may have should be addressed by the treating doctor. The Australian medical profession’s response with risk management both at the professional and government levels, is a reaction to cost containment in order to prevent a further escalation of the medico-legal costs.

Singapore is marginally ahead of Australia in its pro-active development of directives both in clinical care and communication to its medical fraternity. The medical profession in both countries consider risk management both at the professional and government levels in order to reduce medico-legal problems. Postgraduate training in Singapore has just introduced compulsory courses in Medical Ethics and Law for all Specialist trainees. Australia currently has voluntary risk management courses run by Professional Indemnity Associations with input from both doctors and lawyers.

The community however needs to understand that despite all modern-day advances, medical practice has its limitations. Singaporeans have been brought up to believe that their government can take care of all their problems. Hence the pressure placed by patients and relatives on health professionals especially Western-trained doctors needs to be monitored and addressed. If this does not happen, disillusioned doctors will leave medical practice in Singapore to the extent that the government will have to recruit more doctors at all levels from overseas. This is not an ideal situation as the stress levels of both the doctors and patients increase as they try to understand and deal with different cultural expectations. We already know that the national medical workforce provision is inadequate for their needs (Table 3).

Comparative studies on health care systems and medico-legal practice patterns can identify areas of strength and validate these with professional and consumer satisfaction outcome measures.

TABLE 1: DEMOGRAPHICS (2005) *

<table>
<thead>
<tr>
<th>Country</th>
<th>Area</th>
<th>Population</th>
</tr>
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<tbody>
<tr>
<td>AUSTRALIA</td>
<td>7,686,850 sq km</td>
<td>20.3 million</td>
</tr>
<tr>
<td>SINGAPORE</td>
<td>640 sq km</td>
<td>4.3 million</td>
</tr>
</tbody>
</table>

- Based on British judicial system- adversarial with High Court/Supreme Court/ District and Magistrate’s courts
- Public and private medicine
- Co-payment system exists but high level of subsidised care without any need for co-payment
- Societal choices on use of services e.g. with feedback to government for drug subsidies
- Individual responsibility for health care expenses
- State-of-the art facilities available but long-waiting times and reduced expectations by doctors and patients
- Slow uptake of latest therapeutic advances because of societal expectations of subsidies and government desire for cost containment.

- Also adversarial with Supreme Court/High Court/ Court of Appeal with District and Magistrate’s courts
- Public and private medicine
- Compulsory co-payment system for services rendered
- Individual choices on use of services
- Extended family support expected for health care expenses
- State-of-the art facilities with blood and radiological investigations available as to the latest research and evidence-based practice
- Rapid uptake of latest therapeutic advances at cost prices as patients are expected to pay for this.
- Singapore has no jury trials dealing with medical malpractice and the judge acts as an arbiter of both the facts and the law.

* Important differences in italics
### TABLE 2: BASIC INDICATORS OF HEALTH (WHO figures 2003)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>AUSTRALIA</th>
<th>SINGAPORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population greater than 60 years of age</td>
<td>16.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Life expectancy at birth (Average for Male and Females)</td>
<td>81.0 years</td>
<td>80.0 years</td>
</tr>
<tr>
<td>Fertility rate (children per woman)</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Infant Mortality Rates (per 1000 live births)</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Indicator</th>
<th>AUSTRALIA</th>
<th>SINGAPORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>9.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Expenditure on health:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>67.5%</td>
<td>36.1%</td>
</tr>
<tr>
<td>Private</td>
<td>32.5%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Patient out-of-pocket expenditure as % of private expenditure</td>
<td>67.8%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Per capita total expenditure on health at International Dollar rate</td>
<td>2874</td>
<td>1156</td>
</tr>
<tr>
<td>Per capita government expenditure on health at International Dollar rate</td>
<td>1939</td>
<td>417</td>
</tr>
<tr>
<td>Physicians density per 1000 Population</td>
<td>2.47</td>
<td>1.40</td>
</tr>
</tbody>
</table>