Legal Update: High Court dismisses suit against neurosurgeon and hospital

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The Dentons Rodyk & Davidson LLP team led by Mr Lek Siang Pheng and Ms Mar Seow Hwei successfully defended Dr Y, a neurosurgeon and the head of the Division of Neurosurgery at the National University Hospital (NUH), in one of the longer medical negligence trials seen locally in recent years.

The Plaintiff patient (suing by way of her litigation representation) canvassed a broad array of allegations against Dr Y at the start of the trial: these ranged from his failing to personally advise the Plaintiff of the risks of the surgery to alleged negligent management of the Plaintiff's post-operative complications. The Plaintiff also argued that since she opted for an elective procedure and paid private class rates in a public hospital, she was entitled to personalised treatment from Dr Y (in more instances than what Dr Y had provided).

After a 32-day trial, the High Court dismissed all of the Plaintiff's claims and also awarded to Dr Y and NUH the costs of defending the suit. In its written judgment (in the case of *Goh Guan Sin (by her litigation representative Chiam Yu Zhu v Yeo Tseng Tsai and National University Hospital (Singapore) Pte Ltd* [2019] SGHC 274), the High Court also sought to reiterate and clarify some legal principles governing the area of medical negligence. In our article below, we have set out the background to this case and some of the key takeaways from the judgment.

I. Background to the litigation

In June 2014, the Plaintiff underwent a surgery to remove an acoustic neuroma - a benign brain tumour. The surgery was successfully performed by Dr Y.

A few hours after the surgery, the Plaintiff's condition unexpectedly deteriorated while she was in the High Dependency Unit. An urgent CT scan was immediately done which showed the presence of a significant haematoma (blood clot) in the Plaintiff's head. The Plaintiff was then in a critical condition due to the high pressure in her head and a decision had to be made urgently on the treatment to be provided to the Plaintiff. Dr Y and two other neurosurgeons (who were involved in the tumour removal surgery) interpreted the Plaintiff's urgent CT brain scan and diagnosed the Plaintiff with a significant haematoma within her brainstem, as well as a haematoma in the surgical tract.

As the presence of bleeding within the brainstem on its own already connoted a very poor prognosis, and the Plaintiff was by then in a very poor neurological condition, any attempt to surgically remove the brainstem haematoma was a very high-risk surgery. Such a surgery, in Dr Y's view, would not only be very likely futile but also carried a high risk of death. So, Dr Y determined that the only reasonable treatment at that stage, and the immediate treatment that was necessary to save the Plaintiff's life, was to quickly drain the accumulation of cerebrospinal fluid in her head (a condition known as obstructive hydrocephalus) by way of an insertion of an external ventricular drain (EVD). The surgery to insert an EVD was successfully performed, and a second CT brain scan was immediately performed thereafter which confirmed that there was a significant haematoma in the brainstem. The drainage of the Plaintiff's

obstructive hydrocephalus saved her life, but she has remained in a persistent vegetative state since then.

The Plaintiff commenced a civil suit in the High Court through her daughter and litigation representative against both Dr Y and NUH (the Defendants). The Plaintiff alleged, among others, that:

a. At the pre-operative stage, Dr Y had been negligent for failing to obtain the Plaintiff's informed consent for the tumour removal surgery, failing to personally review the Plaintiff, and for failing to first insert an EVD (in a separate surgery) to treat the Plaintiff's existing hydrocephalus prior to the surgical removal of the tumour;
b. At the intra-operative stage (during the tumour removal surgery), Dr Y had been negligent for failing to insert an EVD at the start of the surgery, and for sacrificing the Plaintiff's superior petrosal vein during the surgery;
c. At the post-operative stage, Dr Y had been negligent for misdiagnosing the Plaintiff with a significant brainstem haematoma, for failing to evacuate the Plaintiff's haematoma that was in the surgical tract, for failing to be personally involved in the post-operative care of the Plaintiff, and for failing to ensure that the Plaintiff was adequately monitored post-operatively. Further, NUH's medical and nursing staff had been negligent for failing to adequately monitor the Plaintiff's condition after the tumour removal surgery, and in particular, for failing to record all of the Plaintiff's neurological parameters in a single document; and
d. NUH was vicariously liable for the negligence of Dr Y and its staff.

II. Three key takeaways from the High Court's judgment

We highlight below three key findings by the High Court with implications for clinical practice and the law of medical negligence in Singapore.

1. Team-based care is accepted but it would be good clinical practice for the lead surgeon/doctor to provide personal attention in elective, high-risk cases

The High Court noted that the practice of team-based care has been endorsed by the medical community in Singapore, as evidenced by paragraph A4(1) and C6(8) of the Singapore Medical Council Ethical Code and Ethical Guidelines (SMC ECEG) (2016 Edition), and paragraph 4.1.1.4 of the SMC ECEG (2002 Edition).

The High Court also elaborated that:

a. at the pre-operative/consent stage: it is permissible for the other members of the treating team (such as registrars and medical officers) to provide the patient with the necessary advice and to obtain the patient's consent on behalf of the operating surgeon; and
b. at the post-operative stage: it is appropriate for the lead surgeon to hand over the post-management care of the patient to the other members of the team. At this stage, the lead surgeon still retains overall responsibility for the patient but he must take reasonable care to ensure that the other team members are capable of providing care to the required quality and standards.

However, the High Court commented that it would be good clinical practice for the lead surgeon/doctor to personally review the patient before the surgery/procedure (i.e., a few days before the surgery, instead of immediately before the surgery or in the operating theatre). The Court highlighted two factors which moved him towards this stance: (a) the fact that the surgery was an elective one; and (b) that the surgery was one with significant risks including death. However, this does not mean that there was necessarily negligence if a personal review was not done.

In Dr Y's case, the High Court found that there was a clinic consultation arranged for Dr Y to meet the Plaintiff prior to the surgery. However, the Plaintiff failed to attend this consultation. In light of this, and Dr Y's schedule which did not

allow him to meet the Plaintiff in the intervening period, the High Court stated that Dr Y could not be found to be in breach of his duty of care for only personally reviewing the Plaintiff on the morning of the surgery.

In the authors' view, the High Court's endorsement of the team-based approach would offer some measure of comfort for doctors practising in public healthcare institutions. The consultant in charge would not be legally required to personally undertake all aspects of the patient's care. Trained and qualified members of the medical team can assist in reviewing the patient, advising, taking informed consent from the patient. However, when it comes to a situation involving high-risk elective surgeries/procedures, it is clearly advisable for the lead surgeon/doctor and proceduralist to review the patient (and meet his/her family) at least once before the surgery/procedure to ensure that all the risks have been communicated adequately and the surgery is appropriate for the patient.

2. The lead surgeon does not owe a non-delegable duty of care to ensure that the post-operative monitoring of the patient by the medical team is adequate

The High Court expressed the view that it was highly doubtful that a lead surgeon in the position of Dr Y would owe a non-delegable duty of care to ensure that the patient was adequately monitored by his team of doctors and nurses after the surgery. Although this was not specifically pleaded, the Plaintiff's counsel had argued that a lead surgeon owed such a non-delegable duty of care to his patients, which if found, would mean that the lead surgeon would be strictly liable for the negligence (if any) of the other members of his team in the post-operative monitoring of the patient, notwithstanding that he does not have full control over the actions of his team members at the time.

In its judgment, the High Court reminded that it was important and necessary to first determine the scope of the lead surgeon's duty of care to the patient, and thereafter, to ask whether the duty/duties in issue were non-delegable. In expressing doubts that Dr Y would owe a non-delegable duty of care to the Plaintiff to ensure that her post-operative management was adequately performed by the team of doctors and nurses at NUH, it was implicit in the High Court's judgment that, in a hospital which practises team-based care, it would be reasonable for the lead surgeon to rely on his colleagues to render post-operative care to the patient. Further, the imposition of such a non-delegable duty would fracture the practice of team-based care and would be excessively onerous, and disregard the reality on the ground where a consultant in a public healthcare institution may have to attend to many patients in a single day.

It should be pointed out that as the High Court found no negligence on Dr Y or his team's part for the post-operative care provided to the Plaintiff, its ruling on this non-delegable duty issue is obiter dicta, i.e. made in passing and not binding authority. Regardless, it is the authors' view that the High Court's conclusion on this point is a principled, reasoned and logical one, and represents a balanced view of the duties of care that may be realistically expected of healthcare providers in a public hospital setting.

3. Medical practitioners who are witnesses of fact may give opinion evidence

The High Court had, in what appears to be the first reported case in Singapore on this point, affirmed that the opinion evidence of doctors who are witnesses of fact may in some instances be admissible in a medical negligence claim where the opinion evidence is relevant to the issues in the trial.
In general, a witness of fact (including the defendant) may only give evidence of facts which he perceived, and not his inferences and interpretations of the facts, i.e. opinion, which is for an expert witness to make. However, a witness of fact may give evidence of his opinion if he is adducing that evidence (of his opinion) to explain his conduct.

In medical negligence lawsuits, the defendant doctor is routinely allowed to give evidence on his thoughts, theories and rationale, if this is relevant to his defence. This is because, as a matter of natural justice, the defendant doctor must be afforded the opportunity to explain why he managed the plaintiff patient in the way he did, and why in his opinion he considers that his conduct did not fall below the standard of care reasonably expected of him.

In this case, Dr Y and Dr P (one of the assisting neurosurgeons in the tumour removal surgery, and who joined in

making the diagnosis of the Plaintiff and the decision for the treatment plan after the first CT brain scan) had relied on their medical opinions and expertise when they diagnosed the Plaintiff with a significant brainstem haematoma and opined (both at the material time and at the trial) that an evacuation of the haematoma in the surgical tract need not be done as it would not have made a difference to the Plaintiff's clinical outcome.

The Plaintiff's counsel had argued that Dr Y and Dr P should not be allowed to give evidence of their opinion because they were witnesses of fact. The High Court rejected the Plaintiff's counsel's arguments, noting that Dr Y and Dr P were themselves experienced neurosurgeons, and whose opinions were relevant evidence which formed an integral part of the defence; to disallow Dr Y to give evidence of his medical opinion would be a miscarriage of justice and unfairly prejudicial to him.

Conclusion

The High Court's rulings in this case helped clarify some of the boundaries in which a doctor is able to supervise and delegate care of a patient in a public healthcare institution setting. It also acknowledges the right of a defendant doctor to provide opinion evidence on his treatment and management of a patient where relevant, and the Court's discretion to admit and rely on the defendant doctor's own opinion evidence and also the opinion evidence from other witnesses of fact qualified to provide such opinions.

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