Pai Lily v Yeo Peng Hock Henry
[2001] SGHC 58

Case Number : Suit 600030/2000

Decision Date : 26 March 2001

Tribunal/Court : High Court

Coram : Lee Seiu Kin JC

Counsel Name(s) : Edmund Kronenburg and Kalyani Rajendran (Drew & Napier) for the plaintiff; David Wee and Maurice Cheong (Donaldson & Burkinshaw) for the defendant

Parties : Pai Lily — Yeo Peng Hock Henry

Limitation of Actions – When time begins to run – Whether medical negligence claim time-barred – s 24A Limitation Act (Cap 163, 1996 Ed)

Tort – Negligence – Medical negligence – Whether doctor negligent in failing to conduct test for urinary tract infection – Whether conducting test would have resulted in plaintiff not suffering eye infection and subsequent loss of her eye

Tort – Negligence – Medical negligence – Whether doctor negligent in failing to stress urgency of seeking treatment at hospital's Accident and Emergency department – Whether plaintiff's eye could have been saved if doctor had so advised her

Tort – Negligence – Medical negligence – Causation – Whether doctor's negligence caused damage suffered by plaintiff

: The plaintiff is a single female and runs a translation service business. She holds a Bachelor of Arts degree from the National University of Singapore (`NUS`). At the material time, ie in December 1996, she was 38 years old.

The defendant is a doctor who, at the material time, had more than 20 years` experience as a general medical practitioner. He practised, and still practises, at the Bedok Medical Centre at Block 18 Bedok South Road. After graduating from the University of Singapore with an MBBS in 1969, he served as a medical officer at the Accident and Emergency (`A&E`) Unit of the Singapore General Hospital (`SGH`) for a year. He has been in general practice since 1973. In 1978, he was admitted as a member of the College of General Practitioners, Singapore, and was subsequently conferred a Fellow of the College of Family Practitioners, Singapore. Since 1979, he was a clinical tutor for undergraduate medical students of the NUS. And from 1996, he was a clinical tutor as well as examiner for the Master of Medicine (Family Medicine) degree at the NUS. He is the co-author of a monograph entitled `Medical Records`.

The plaintiff had been consulting the defendant in respect of her general medical problems since February 1992. On three occasions in December 1996, the plaintiff saw the defendant for treatment of an infection which worsened and eventually resulted in the loss of her left eye. The plaintiff claims that the defendant had, in respect of those consultations, failed to exercise due care and skill as a medical practitioner in breach of his contractual duties, alternatively, that he had negligently treated and advised her, and that such breaches had caused her loss.

Background facts

On the afternoon of 18 December 1996, the plaintiff consulted the defendant at his clinic. According to the plaintiff, she was running a fever and felt aches and pain in her bones and all over her body. The defendant kept a record of this consultation in his medical record card. It is in the usual doctor`s

short-hand and he explained that they meant the following:

(a) The plaintiff complained that she had a fever, backache and giddiness for the preceding two days.

(b) On examination, the defendant found that she had a temperature of 100[ordm]F and blood pressure of 100/70. He found her general condition to be satisfactory.

(c) The defendant prescribed the following medication:

(i) Transgesic for fever;

(ii) Ponstan for body pain/backache;

(iii) Dramamine for giddiness; and

(iv) Decodine for running nose.

(d) The defendant gave her a certificate for two days` sick leave.

The plaintiff went home, took the medicines and rested for the remainder of the day. However, when she got up the following day, 19 December, she felt no improvement in her condition. In addition to the continuing symptoms of aching bones and fever, she had nausea. So she returned to the defendant at his clinic. This session is recorded by the defendant in his medical record card as follows:

(a) The plaintiff complained she still had fever, backache and giddiness.

(b) She had developed a cough.

(c) On examination, she was afebrile, ie had no fever. Her blood pressure was 110/70 and her lungs were clear.

(d) The defendant prescribed the following medication in replacement of the previous day`s prescription:

(i) Apo-Naproxen for body pain/backache;

(ii) Merlislon; and

(iii) Phenexcept CD for giddiness.

(e) The defendant gave her a certificate for a further two days` sick leave.

The plaintiff returned home and took the medication as advised. However, at about 8 pm that night, she felt her heart beating very quickly, was breathless and `quivering`. By that last description, I take it that she meant that she was shivering. Knowing that the defendant`s clinic would be closed at that hour, she went to another clinic, the Bedok Family Clinic, where she was seen by Dr Teng Shi Chong. The plaintiff said that she described her symptoms and gave him details of her two prior consultations with the defendant. She also showed Dr Teng the medication prescribed by the defendant. In the clinic`s medical record card, Dr Teng recorded that the plaintiff had complained of fever and running nose. Dr Teng noted that the plaintiff`s temperature was 37[ordm]C, her general

condition was well and her heart and lungs were clear. The plaintiff said that Dr Teng had told her that the medicine prescribed by the defendant was `too strong` and it is recorded in the medical record card that he prescribed Beserol and Clarityne.

Over the next three days, the plaintiff took the medication prescribed by Dr Teng. However, she felt the fever subsiding and returning at intervals. By the morning of 23 December 1996, she had completed the course of medicine but still felt feverish. She decided to return to the defendant`s clinic as he was her regular physician. Although she got there at 11am, it was not until past 2pm that she was able to be seen by the defendant because of the large number of patients.

This is the plaintiff`s account in her affidavit evidence-in-chief of the consultation of 23 December 1996:

> *8 When I saw the Defendant, I told him about my fever, which I said had not subsided. I also informed him of the pain in my right knee joint and that a thin film had formed over the lower portion of my left eye.*
>
> *9 The Defendant examined me as he had done previously, but this time, he also conducted a urine test on me. After testing the sample I provided, he told me that there was blood in my urine. He mumbled something like he would not give me anything for my eye, and that he did not know what to do about it. The Defendant then mentioned various options that might be open for me to consider:*
>
> *(a) treatment at the Singapore National Eye Centre (`SNEC`);*
>
> *(b) consultation with, and treatment by, an eye specialist; or*
>
> *(c) treatment at the Accident & Emergency Unit of a hospital.*
>
> *10 The Defendant did not inform me that there was any infection in my body. Neither did he tell me that I needed treatment through any of the above options* ***immediately*** *ie without further delay. Neither did the Defendant inform me that my condition was serious or that I required immediate medical treatment above and beyond the medical treatment that he could provide in his own skill and expertise, at his clinic.*
>
> *11 Instead, the Defendant simply prescribed me some medication and wrote a note for me to undergo a blood test at a polyclinic after Christmas, ie 25 December 1996.*
>
> *12 The Defendant`s actions and advice led me to believe that my condition was not serious or life-threatening and only if necessary, I could avail myself of any of the options after the Christmas public holiday without endangering myself. It was because of this that I simply went home and continued to take the Defendant`s medication, looking to see if my symptoms would go away, or whether my condition would persist, or get worse. I recall my distinct impression from what the Defendant said to me, and the manner in which he said it, was that the options were* ***just in case*** *I did not feel better after Christmas. I recall that the note he wrote to the polyclinic simply re-inforced this impression. If the Defendant had really wanted me to seek urgent and*

immediate medical treatment at a hospital, or with a specialist, or the SNEC, he would have made arrangements for me to see someone, or at least write me a referral note. All he had given me was a note to a polyclinic, to use after Christmas. ...

Her evidence in cross-examination did not materially depart from this version in her evidence-in-chief.

This is the defendant`s account in his affidavit evidence-in-chief of the consultation of 23 December 1996:

6 The Plaintiff came to consult me again on 23 December 1996. The Plaintiff complained of fever with chills, giddiness and pain over the right kneecap, as well as blurring of vision and seeing spots in the left eye. This was the first time that the Plaintiff mentioned any complaints about her left eye.

7 On examination, the Plaintiff was afebrile. Her right knee joint was not swollen and her throat was not inflammed. I further examined her pupils and found both pupils to be equal and reactive to light. Both her left and right corneas were clear. There was no evidence of eye infection at the time of examination.

8 I specifically asked the Plaintiff for symptoms of vomitting, diarrhoea and of pain and/or increased frequency of urination. The Plaintiff denied having any of these symptoms. Although she said these symptoms were absent, I proceeded to examine her urine to complete the examination. I observed that there were leucocytes (white blood cells) and blood present in the urine. There was no protein or sugar in the urine. Based on the urine dipstick and the clinical picture so far, my diagnosis was that she had a urinary tract infection.

9 At the end of the consultation on the afternoon of 23 December 1996, I told the Plaintiff that I suspect that she had:

(i) a detached retina, which is a serious eye condition that required urgent specialist treatment, and

(ii) a urinary tract infection that required treatment and follow-up urine tests.

10 I informed her that she required an urgent referral to see an Eye Specialist and that she had to go to the Accident and Emergency (`A&E`) Unit of Singapore General Hospital (`SGH`) where there is an eye specialist on duty after the SNEC closes.

11 At the end of the consultation, it was already past 1600 hours. Therefore, it was not possible to refer her to the SNEC`s specialist outpatient clinic or any private eye specialist clinic on that day as the clinics would probably be closed by the time she reached them. Hence, the earliest appointment could only be the next day on 24 December 1996 and that, in my opinion, would have been inadvisable.

12 As a result, I explained to the Plaintiff that she had no choice but to go to

the A&E Unit of SGH immediately. I wrote her a referral letter to bring to the A&E Unit of SGH. I did not keep a copy as it is not my clinic`s practice to keep copies of referral letters. However, annexed hereto and marked as "YPHH-2" is a copy of the standard format that I use for my referral letters. In my 27 years as a General Practitioner, I always write a referral letter for all my patients that I refer to:

(a) A&E Unit;

(b) specialists;

(c) Government Polyclinics; and

(d) other doctors who co-jointly manage the patient so the case can be coordinated.

I write 2 to 3 such letters a day. Many of my general practitioner colleagues also do not make it a clinic practice to keep copies of referral letters.

13 I further stressed to the Plaintiff that my clinic would be closed after lunch on 24 December 1996 and Christmas Day 25 December 1996. I also informed her that the SNEC specialist outpatient clinic and the private eye specialists` clinics would probably also be closed then. Therefore, in view of the circumstances, I advised her to go to the A&E Unit of SGH or even the A&E Unit of any other hospital instead, without further delay.

14 I also informed the Plaintiff that at the A&E Unit, if admitted, she would have her blood and urine tested. In the event that she was not admitted by the doctor at the A&E Unit, she should proceed to do her blood and urine tests at the Bedok Polyclinic. The laboratory form issued to the Plaintiff was to have the blood and urine done on 26 December 1996 if she was not admitted to hospital so that her response to treatment for the urinary tract infection can be monitored. A copy of the said form is annexed hereto and marked as `YPHH-3`.

...

18 I also recall that when I informed the Plaintiff on 23 December 1996 of the urgent need to go to the A&E Unit of the SGH immediately, the Plaintiff was reluctant to go and had pleaded with me not to refer her. I insisted that she went immediately to the A&E Unit as a detached retina is a serious condition. She got up from her chair and with her gestures, pleaded with me not to send her to hospital.

...

27 In my 27 years of practice as a general practitioner, inevitably whenever I refer any patient to a hospital, the patient, whether educated or uneducated, will always question me for the reason for referral. The Plaintiff is educated. I explained to the Plaintiff that she had a serious eye condition a `detached retina`, and that she needed to go to the A&E Unit of SGH. She was not keen to

do so as she had a Christmas Eve lunch function to attend the next day (24 December 1996). It is always a doctor`s duty to explain the reason for the referral and the need for urgency, which I did. I have discharged this duty accordingly.

In cross-examination, the defendant did not materially depart from the version in his evidence-in-chief. In support of his testimony, Grace Ng Lay Hong (`Ng`), his clinical assistant was called to give evidence. She said that she was present in the consultation room that day and stood next to doctor`s table where she was able to hear the conversation between the doctor and patient. In her affidavit evidence-in-chief, she related the following:

4 I recalled distinctly the Defendant advising the Plaintiff that he suspected the Plaintiff of having a detached retina, and that this is a serious condition and which will need to be treated. The Defendant further advised the Plaintiff that she should go to the Singapore National Eye Centre or the Accident and Emergency of a hospital to have her left eye attended to.

5 The Defendant also informed that Plaintiff that as it is the festive period, the Plaintiff should try and have her left eye attended to as soon as possible, rather than wait as the eye clinics/specialists will not be available over the festive period.

However, upon cross-examination, Ng revealed that she was unable to recall a lot of the details of that consultation because it had been four years since the events took place. Significantly, Ng did not say in her affidavit that the plaintiff had refused to go immediately to the hospital as the defendant had asserted. When questioned about this, Ng said as follows:

Q:	Do you recall Plaintiff ever mentioning a lunch appointment?
A:	Cannot remember.
Court:	Can you rule it out?
A:	No. I cannot remember.
Q:	Did Plaintiff refuse to go to A&E or SNEC?
A:	I really cannot remember that.
Q:	Would it be unusual for a patient to refuse to go?
A:	Yes.

More significantly, Ng`s evidence in cross-examination was somewhat contradictory to her evidence-in-chief. Although she had stated in para 4 of her affidavit that she recalled distinctly that the defendant had told the plaintiff that he suspected she had a detached retina, her recollection of this exchange seemed to fade on the stand as the following extract from the notes of evidence suggests:

Q: Did Defendant ever mention to Plaintiff the words `detached retina` during the consultation?

A: Cannot remember.

Q: What about `retinal detachment`?

A: Cannot remember.

Q: Affidavit paragraph 4. `I recalled distinctly ...` What do you mean by `distinctly`?

A: `Clearly`.

Q: Affidavit paragraph 4. `I recalled "clearly" the Defendant advising the Plaintiff that he suspected the Plaintiff of having a detached retina ...` What exactly did Defendant say to inform Plaintiff that he suspected Plaintiff of having a detached retina?

A: Cannot remember what words he used.

Q: You said that Defendant told Plaintiff that this was a serious condition which will need to be treated. What exactly did Defendant say to Plaintiff in respect of this?

A: Cannot remember what exactly he said, but I recall he told Plaintiff that her eye problem needed to be treated by an eye specialist.

Q: Did he use the word `serious`?

A: Cannot remember.

Sole disputed fact

This then is the sole issue of fact in respect of which the plaintiff and the defendant gave very different versions. The plaintiff said that the defendant did not advise her that her eye condition was serious or that she had to go immediately to the A&E unit of a hospital to seek treatment for it. The plaintiff also said that the defendant did not tell her that he suspected she had a detached retina. On the other hand, the defendant asserted that he did tell her so and that it was a serious eye condition and to go immediately to the A&E unit of SGH. The defendant further said that the plaintiff was not keen to do so as she had a lunch function the following day which was Christmas Eve.

try to have her left eye attended to as soon as possible, rather than wait as the eye clinics/specialists will not be available over the festive period In so far as demeanour of the plaintiff and defendant as witnesses is concerned, I am unable to say that I found anything that would, of itself, lead me to conclude that one or the other was not telling the truth. Generally, they were both co-operative witnesses and answered questions posed to them in a forthright manner. I therefore have to examine these two versions in the context of the surrounding circumstances and the subsequent behaviour of the parties. In respect of the first factor, ie the surrounding circumstances, the relevant considerations are the following:

(i) The evidence of the clinical assistant, Ng at para 5 of her affidavit was that the defendant told the plaintiff that she should ``. Firstly, this does not sound like unequivocal advice to go immediately as suggested by the defendant in his evidence. Secondly, there is no reason for the defendant to make any mention about the festive period if his advice was for her to go immediately from his clinic for treatment, whether to an A&E unit or to an eye specialist.

(ii) The defendant himself said (at para 13 of his affidavit) that he mentioned that the following day, his clinic would be closed after lunch and that most eye specialists would also close early on Christmas eve. Again, this does not accord with the notion of urgency. If it were urgent that she sought treatment immediately, there should be no need to consider the availability of treatment options the following day.

In respect of the subsequent behaviour of the parties, firstly on the plaintiff`s part, she did not go anywhere else to seek treatment after she left the defendant`s clinic. It was not until the following day, when her symptoms worsened, that she went to the SGH. If the defendant had told her that detached retina was a serious eye condition and that she had to seek immediate treatment from an eye specialist or the A&E unit of a hospital, why would she have refused to take his advice? Why would an educated person like the plaintiff not understand the defendant`s explanation about the urgency of her situation? Especially when she had been running a fever for seven days and in that period had seen two doctors on four occasions. The defendant`s explanation that this was because she had a lunch appointment the following day requires that the plaintiff be a rather irrational person with a high threshold for pain. However, she did not impress me as an irrational person. Furthermore, the clinical assistant, Ng, could not recall the plaintiff refusing to follow the defendant`s advice to go to a hospital urgently. She said that it would be unusual for a patient to refuse to follow such advice. Therefore, it would follow that if this had happened, it would be likely that she would be able to recall this, especially when she was able to recall `distinctly` that the defendant had advised the plaintiff that he suspected she had a detached retina.

The second point relates to the defendant`s letter of explanation to the Singapore Medical Council (`SMC`) following a complaint lodged by the plaintiff against him. This is the part of his letter concerning the advice to go to hospital:

> *The possibility of detached retina crossed my mind on the eye symptom. I had in the past diagnosed cases of detached retina based purely on similar symptoms. These cases were sent as urgent referral and were confirmed by my specialist colleagues (opthalmologists).*
>
> ***I informed her that if her symptoms of blurring of vision, seeing more spots persisted or if her sight deteriorated she should go to see an opthalmologist via the Accident and Emergency Unit immediately**. This point was made as the next day was 24th December 1996 - Christmas Eve and our clinic would be closed at noon. The next day would be 25th December 1996 and would clinic would be closed.*
>
> *...*
>
> *I was concerned of a possible detached retina in her left eye as I am fully aware of the presentation of detached retina and its serious consequences and that it needed an urgent opthalmologist consultation.*
>
> *I advised her to `visit the SNEC, an eye specialist or the Accident and*

> *Emergency Unit of any hospital` if her vision persisted to be blur or if she sees more spots or any impairment of vision. In my medical record card I wrote `cannot exclude Detached Retina. To see Dr PRN` - ie* ***to go to the eye specialist or Accident and Emergency Unit if her sight remained blur or deteriorate****.*

In respect of the portions in italics above, the defendant was asked why he had told the SMC that his advice to the plaintiff to go to the eye specialist or the hospital was only conditional upon her sight remaining `blur` or deteriorating. At first he evaded the question somewhat. I then pointed out to him that to a person who was comfortable with the English language, those passages meant that his advice to her to go to the hospital was conditional upon her symptoms of blurred vision or seeing more spots persisting, or her sight deteriorating. The defendant`s response was as follows:

> *This letter was written to my professional peers at Singapore Medical Council. It is obvious to them that detached retina warrants urgent eye consultation. It is never conditional. I had stressed this to Plaintiff. `You have this problem you must go`. She did not refuse to go. She wanted to go the following day in the afternoon. I told her that in this case, she could not wait. She had to go to Accident & Emergency immediately. In the dialogue with Plaintiff, I told her that I was not able to refer her to SNEC or an eye specialist that day because it was already about 4pm by then. It would have been too late to get an appointment for her. I informed her that we could not wait until the next day. She had to go immediately on 23.12. She still did not want to go. I told her: `You have to go. Your vision is blur, and detached retina had to be excluded. You go if it persists, especially if you see more spots or your vision deteriorates.` This sort of bargaining and dialogue took some time. At the end of the consultation, I followed her out of the room and in the waiting room, I reminded her to go immediately. I wrote in my card, `To see Dr PRN`. It means it is medically indicated that she saw a doctor. She was just reluctant to go immediately. Worse still if it deteriorates.*

It should be noted that the defendant`s response does not address the question as to why, if he had unconditionally advised her to go immediately to the hospital, he should write to the SMC in such a manner.

Another point is this. In the plaintiff`s medical record card, the defendant had made the following record:

> *Cannot exclude detached retina. To see Dr PRN*

The defendant exhibited this medical record card in his letter to the SMC along with a very helpful key to the abbreviations used by him in the card. In relation to that particular entry, the key to the abbreviations states as follows:

> *PRN [equals] when medically indicated, in this case it means when the patient`s vision remains blur or deteriorates to go to hospital Accident and Emergency Unit*

It should be noted that on the face of it, this explanation accords wholly with the definition given in Stedman`s Concise Medical & Allied Health Dictionary (3rd Ed) of the Latin term `pro re nata`, for which PRN is the acronym. The term is defined as `as needed, as required`. This is consistent with the prima facie conditional position in his letter to the SMC.

The defendant had said that the letter to the SMC was written to his professional peers to whom it was obvious that detached retina warranted eye surgery and his advice to the plaintiff to go to a hospital immediately could never be conditional. This line of argument is best explained by the evidence of Prof Cheong Pak Yean, an expert called by the defendant. Prof Cheong had written a report to the SMC in support of the defendant`s treatment of the plaintiff. His substantive comments are not too long and it is worthwhile to set them out in full:

> *I wish to comment as follows.*
>
> *1 A significant difference in the account of the consultation on 23rd December 1996 by Mdm Pai and yours is on the urgency of the eye referral.*
>
> *Mdm Pai alleged that you `did not inform me that there was infection` but noted that you did counselled referral to Singapore National Eye Centre (SNEC), an eye specialist or the Accident and Emergency Unit (A&E) of any hospital. Your clinic records documented the clinical diagnosis as retinal detachment as far as the eye ailment was concerned. That was the basis for your discussion of the referral to specialist`s attention.* ***The course of management you had for the patient was that she should proceed to the A&E if the eye symptoms persisted*** *.*
>
> *The laboratory referral 3 days later was in relation to the fever in the event the patient was not admitted into hospital and clearly was not in relation to the left eye ailment.*
>
> *I note that your account is based on contemporaneous written records as in the photocopied clinic records.*
>
> *2 One Professor Stuart L Brown of University of California at San Diego was quoted in the statutory declaration. The source document from Professor Brown is however not provided.*
>
> *I note that Professor Brown`s opinions were based only on the patient`s recollection and medical records provided by SNEC and do not have the benefit of referring to your medical reports. It would be instructive to study the original statement of opinions by Professor Brown to see whether the quotations were contextual and valid now that you have provided a medical account of the consultation on 23rd December 1996. To be fair to Professor Brown, I believe that he should now be given a copy of your medical reports and asked for further comments. It is also in the course of natural justice to do so.*
>
> *3 The final diagnosis in this case was Kelbsiella Endoopthamitis, which is a very rare infection in immuno-competent patients. There was paucity of definite eye signs in its early stage. At this stage, it is not easily detected, even by many eye surgeons. In my almost 20 years of practice, I have never diagnosed a case or have referred a patient who subsequently is diagnosed as such. I have*

> *checked my library of medical books kept for the post-graduate doctors that I supervised and this condition is never mentioned in any of the books.*
>
> ***I note that you had clinically suspected detached retina** , a far more common and plausible explanation of the left eye symptoms at the 23rd December 1996 consultation **and instructed the patient to seek urgent attention should it persist** . This is acceptable medical practice.*
>
> *I would also like to commend you for your clinical acumen of suspecting a serious underlying problem in the left eye even though the patient only complained of `a thin film in my left eye`. You have further elicited other relevant eye complaints and though there were no definite eye sign, you have correctly advised the patient of the urgency of the matter and the referral avenues.*
>
> *In my opinion, far from being negligent as the complainant had alleged, the documents provided showed that you have practice with care and diligence and in a high professional standard we expect of doctors in Singapore.*

To any reader of this letter it would be clear that there is no suggestion that the defendant had unconditionally advised the plaintiff to go immediately to a hospital. Asked whether the underlined portions above support the plaintiff`s version that the defendant`s advice was conditional, Prof Cheong said that:

> *... In communication to fellow doctors, it is not necessary to state courses of action which had obviously happened ...*

such course of action being the defendant`s advice to go immediately to the hospital. Questioned further on this leap of logic, Prof Cheong said:

> *This is letter written by a doctor for other doctors to read. All doctors know that detached retina is a medical emergency and would assume that a referral to A&E immediately would have been the first course of action. Not necessary to state the obvious, that the patient, after direction to go to A&E had refused to go because what came after that is [in] my report. `The course of management you had for the patient was that she should proceed to the A&E if the eye symptoms persisted.` In the management of a patient, the doctor takes a certain course of management through time. Each direction in the course of management depends on clinical assessment and feedback. In communication to fellow doctors, it is not necessary to state courses of action which had obviously happened. That would explain the thinking process of a doctor.*

Yet Prof Cheong`s letter, set out in the preceding paragraph, clearly states that the defendant`s advice to go to the hospital was conditional. It seemed to me that Prof Cheong had chosen this stance in order to avoid the clear admission in his letter to the SMC, as well as the defendant`s letter, that the advice was conditional, a stance that is totally at odds with the evidence in the documents and with simple logic. In saying that this explains the thinking process of a doctor, Prof

Cheong had chosen to hide behind a professional wall that he hoped the court would not penetrate. On my part, I cannot accept the logic suggested. For if this were the manner in which most doctors think, then I am afraid my impression of them would be totally overturned and my confidence in the mental processes of members of the medical profession thoroughly shaken. However, I do not think this to be the case. I do not believe for one moment that this noble profession is populated in the main by people whose thought processes are so fundamentally perverse. That certainly is not my experience in relation to the other doctors who gave evidence before me, nor to the vast majority of those whom I have known or encountered in other situations, whose intellect I have the greatest respect for. I therefore came to the reluctant conclusion that this statement of Prof Cheong could not be true and that he had taken such a clearly untenable position in order to help the defendant out of an awkward situation.

I should add that the defendant`s allegation that the plaintiff had refused to go to the hospital immediately is a very important fact pertaining to his liability to the plaintiff in damages; whatever may have been his position with respect to his professional peers, it is certainly a fact not immediately obvious to laypersons. Yet this fact was not pleaded in the defence. Finally, I note that there is a strange absence of logic in the need for the defendant to emphasise that the SNEC and eye specialists would close early the following day which was Christmas Eve and would be closed on Christmas day. If his concern was for her to go to the hospital immediately, I cannot see the need to mention of those facts.

All the evidence point to the conclusion that the defendant did not advise the plaintiff to go to the hospital immediately and I would hold that the plaintiff`s version as to what happened at the consultation on 23 December 1996 is the truth.

Having made a determination of the sole dispute of fact, I turn to examine the nature of the breaches. The plaintiff claimed that the defendant was liable to her in damages due to his breach of duty or negligence in two respects, pertaining to the consultations on:

(i) 19 December 1996; and

(ii) 23 December 1996.

Consultation on 19 December 1996

The plaintiff`s case is that given her medical history which was available to the defendant, and in the context of the consultation of 18 December, he should have tested her for urinary tract infection (`UTI`) when she consulted him again on 19 December. If the defendant had done so, he would have found that she had UTI and prescribed the appropriate antibiotic for it. This would have prevented the eye infection. There are two issues that fall to be considered under this head of claim and they are:

(i) whether the defendant`s failure to test for UTI was negligent;

(ii) whether, if he had tested for UTI and prescribed an antibiotic, this would have prevented the eye infection.

The plaintiff called ttwo experts, namely Dr Chuang Wei Ping and Prof Rodney Cartwright. Dr Chuang gave evidence as an expert in the field of general practice. He obtained his MBBS from the University of Singapore in 1977 and a Diploma in Laryngology and Otology from the Royal College of Surgeons,

England, in 1984. He began his career as a medical officer at Tan Tock Seng Hospital before moving on to a government outpatient clinic. After about two years, he set out on his own to practise as a general practitioner (`GP`) in 1980. In 1981, he left for Britain and worked as a senior house officer in a number of hospitals there, primarily in ENT departments. He moved up to become a registrar in 1985. He returned to Singapore in 1987 and has continuously been in private practice since then. He is the author of a book entitled Forensic Audiology.

Dr Chuang said that even on the first consultation on 18 December, he would have tested the plaintiff for UTI. This was because he noticed from the medical record card that she was an unusual patient. She was prone to UTI. He said that he formed this conclusion from the fact that the defendant had, on previous occasions, prescribed co-trimoxazole which was the preferred antibiotic for UTI and a number of other infections. Also, Mist Potassium Citrate (`MPC`) had also been prescribed on previous occasions, which raised his suspicion that this was for UTI. Further, the defendant had recorded UTI in several places and gave, as an example, the consultation of 24 February 1992, where the word `dysuria` appears. Dr Chuang explained that this meant pain on urination and was a symptom of UTI. MPC was prescribed to flush out the urinary tract. It made the urine more alkaline, thereby making it more difficult for the bacteria to survive. Dr Chuang also noted that females were more prone to UTI than males and this was another factor he considered. He said that no medical student would have passed his finals without suspecting UTI as a possible cause of the plaintiff`s fever on 18 December. However, he then agreed that the treatment prescribed by the defendant on that day would have met the minimum standard in that a lot of GPs would have done the same, although he himself would have tested for UTI. But when it came to the second consultation on 19 December, Dr Chuang emphasised that no reasonable doctor in Singapore would have missed out on the UTI test. This was because it was the fourth day of fever.

Under cross-examination, Dr Chuang conceded that it was not shown anywhere in the medical record card - which covered the plaintiff`s entire history of treatment at the defendant`s clinic since she started going there in February 1992 - that she had three occurrences of UTI in a year. He agreed that dysuria was not caused solely by UTI, although in 95% of the cases it was. He also conceded that Apo-sulfatrim could be prescribed for infections other than UTI and that on one occasion the defendant had prescribed it for the plaintiff`s blocked nose. As for MPC, Dr Chuang conceded that it could be used to replace potassium loss, although it was a strange way of doing it as it had an unpalatable taste. He also accepted that it could be used to treat diarrhoea, although again it was an unusual remedy.

The plaintiff`s other expert, Prof Cartwright, who hails from Britain, is the Consultant Medical Microbiologist at the Mt Alvernia Hospital and the Emeritus Consultant Medical Microbiologist at the Royal Surrey County Hospital, both at Guildford. He holds a Bachelor of Medicine and Bachelor of Surgery from Birmingham University and specialises in medical microbiology. He is a fellow of the Royal College of Pathologists and a past director of the Public Health Laboratory Service South Thames. He is an Honorary Visiting Professor in Clinical Microbiology at the University of Surrey.

Prof Cartwright said that although his current work was laboratory based, he had an active clinical practice and saw patients with infections on a regular basis. He gave evidence that he agreed with Dr Chuang that no reasonable GP in Singapore would have omitted to test the plaintiff for UTI on 19 December. Prof Cartwright said that his conclusion was based on reasons similar to those advanced by Dr Chuang, ie that the plaintiff had, on a number of previous occasions, been prescribed medication consistent with the treatment of UTI. Also, on 18 and 19 December she presented symptoms consistent with UTI and, therefore, this possibility should not have been ruled out without performing a simple urine test at the very least. However, in cross-examination, his position shifted a little and he conceded that the symptoms were not unequivocal as to UTI because an upper

respiratory tract infection, a more common malaise, could also cause similar symptoms.

The defendant called Prof Cheong Pak Yean, a consultant physician in Family and Internal Medicine, to give expert evidence on his behalf. Prof Cheong obtained his MBBS from the University of Singapore in 1974. He also holds a Master of Medicine (Internal Medicine), is a member of the Royal Colleges of Physician, UK, and a Fellow of the Academy of Medicine Singapore, the Royal College of Physicians Edinburgh, the College of Family Physicians Singapore and the American College of Physicians. He has held a slew of appointments in various medical committees, including the Singapore Medical Council and is an Adjunct Associate Professor of Family Medicine and external examiner at the Faculty of Medicine, NUS.

Prof Cheong pointed out that in the entire medical record of the plaintiff kept by the defendant`s clinic, spanning the period February 1992 to December 1996, there were only ten instances in which an antibiotic was prescribed. None of these was for UTI save one, and that was the last consultation on 23 December 1996. As for MPC, it was prescribed on four occasions. The first was on 24 February 1992, in which the defendant had recorded that the plaintiff had complained of dysuria. However, a UTI test was conducted and the result was negative, indicating that there was no infection. On the next two occasions, MPC was prescribed on the plaintiff`s request, and on the earlier of these it was recorded that she was going abroad. On the fourth and final occasion, it was recorded that she complained of abdominal discomfort and had diarrhoea for a week. Prof Cheong said that from the medical record card, there was no incident of proven UTI prior to December 1996. Prof Cheong concluded that the plaintiff`s medical history available to the defendant did not indicate that she was prone to UTI and disagreed with Dr Chuang`s evidence in this respect.

In support of this conclusion, Prof Cheong provided a detailed analysis of the plaintiff`s medical record card with references to all the relevant consultations conducted and treatments prescribed. In stark contrast, Dr Chuang made rather sweeping statements with only general reference to the medical record cards. In cross-examination, Dr Chuang had to concede some of the points that he had made so forcefully when giving evidence-in-chief. On the other hand, counsel for the plaintiff, Mr Kronenburg, was not able to refute Prof Cheong`s evidence in this respect. I find his analysis to be clear and convincing. Indeed, there is no evidence that between 1992 and 1996, the plaintiff had suffered from UTI, let alone had a pre-disposition to it. I therefore hold that there was no evidence before the defendant in December 1996 that the plaintiff was prone to UTI.

That being the case, was it negligent of the defendant to omit to conduct a test for UTI on 19 December? Mr Kronenburg submitted that it was. The plaintiff had been running a fever for at least three days when she went to the defendant a second time on 19 December. Mr Kronenburg submitted that, apart from the plaintiff`s symptoms and medical history, the cost of conducting such a test was so small - there is evidence that the test material only costs about $0.50 - that it should have been carried out in this case.

The parties agree that the relevant test to apply is the ***Bolam*** test (**Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118), which is that it is not negligence if the defendant had acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art notwithstanding that there is a body of opinion that would take the contrary view, as modified by **Bolitho v City and Hackney Health Authority** [1997] 4 All ER 771[1997] 3 WLR 1151. In the ***Bolitho*** case, the House of Lords held that although:

> *... [t]he assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence ... where a judge can be satisfied that the body of expert opinion cannot be logically supported at all ... such opinion will not provide the bench*

mark by reference to which the defendant`s conduct falls to be assessed.

The House further said that:

> *... if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.*

With this in mind, I now turn to the evidence of another expert called by the defendant. He is Dr Nicholas Paton, a Consultant Infectious Diseases Physician and Head of the Department of Infectious Diseases, Communicable Diseases Centre, Tan Tock Seng Hospital. Dr Paton holds undergraduate and postgraduate medical degrees from the University of Cambridge and is a member of the UK Royal College of Physicians. After two years as a House Officer at Addenbrooke`s Hospital, Cambridge, after qualification, he was appointed registrar at St Vincent`s Hospital/Liverpool Hospital, Sydney. After about five years, he became senior registrar and research fellow at St George`s Hospital, London. Two years later, he came to Singapore as senior registrar at Tan Tock Seng Hospital, becoming a consultant and the Head of the Department of Infectious Diseases after another two years. He is a Fellow of the Academy of Medicine, Singapore, and a Clinical Senior Lecturer at the NUS. He has published numerous papers on infectious diseases and co-authored or written chapters in five medical texts.

This was what Dr Paton said in his affidavit evidence-in-chief in relation to the consultation of 19 December:

> *5 On the basis of the symptoms with which Ms Pai presented on 18th and 19th, it would have been quite exceptional for any GP in Singapore to have reached the correct diagnosis, namely Klebsiella bacteraemia with probable liver abscesses, lung abscesses and/or pyelonephritis. It therefore seems strange to raise the issue of competence over the Defendant`s failure to make the correct diagnosis, and more specifically his failure to perform a test that may well have been negative, and even if positive would probably not have resulted in the correct diagnosis being made or correct management being instituted (see below). Nevertheless, I will address this issue of whether the urine should have been tested on 19th December 1996.*
>
> *6 From the perspective of a hospital-based specialist, if a patient such as Ms Pai presented to our infectious diseases clinic we would probably have performed a number of investigations. These would probably have included a full blood count to look for circumstantial evidence of dengue fever or other viral infection, a malaria film if the patient had any history of travel to the surrounding region, serology for influenza and perhaps dengue, a chest X-ray and perhaps a urine dipstick test or microscopy. Very often we would perform these tests for the sake of completeness, as an infectious diseases specialist would be expected to provide a reasonably thorough investigation to confirm a diagnosis. Thus from the point of view of a hospital-based specialist a urine test would have been included in the list of desirable tests, but I would not have said it was mandatory in this case. Indeed, if one of our medical officers had seen Ms Pai in our clinic I would not be surprised to learn later that she had been sent away*

with symptomatic treatment and no investigations performed.

7 Although I do not have first hand experience of general practice in Singapore, I am aware that the situation is quite different from a hospital-based practice. ***Due to the volume of patients seen, the GPs here cannot possibly do all the tests that might be indicated in all patients who walk through the door. It therefore falls upon the GP to be selective about the tests that are done, and striking the balance between doing too much and too little is difficult*** *. Whereas the medical student sitting for final exams or the hospital specialist will make sure that all the indicated tests are done ie, practise defensive medicine to some extent (defensive against examiners or lawyers respectively), the emphasis for a GP is to keep investigations to a reasonable minimum, and to treat patients as rapidly and economically as possible. A fresh graduate from medical school or a hospital-based specialist would be quite incapable of running a GP clinic which sees about 70 patients a day on average and would feel most uneasy being deprived of the luxury of time to think and capacity to perform investigations to the level at which they felt comfortable.*

8 In addition to briefly evaluating the symptoms mentioned by patients and performing a brief physical examination of the relevant body areas, the GP`s background knowledge of the patient will also influence the decision-making process. This background information is sometimes quite detailed and somewhat subjective and is sometimes advantageous to the GP in helping him to make appropriate sense of patients` symptoms. Medical students sitting for finals or the hospital-based specialist seeing the patient once only rarely have access to this information and thus have to base their decisions only on simple objective facts.

9 Ms Pai presented with symptoms of fever, headache, backache, giddiness and cough. These are certainly consistent with a viral infection and most GPs, I suspect, would have made this diagnosis. The presence of cough would point very much towards a respiratory tract infection, and with the absence of cardinal symptoms of a lower urinary tract infection (see below) it is understandable that this latter diagnosis was not entertained. In addition to the clinical facts that are much more suggestive of a simple viral infection, the background of Ms Pai would also influence the interpretation that any GP puts on symptoms. Looking through the records of Dr Yeo`s clinic, I note that she had presented to this clinic (and perhaps others) 8 times in 1992, 11 times in 1993, 6 times in 1994, 8 times in 1995, and 6 times in 1996 prior to the presentation on 18th December. Many of these presentations were with relatively innocuous symptoms such as cold, cough, fever, headache, sore throat, diarrhoea, etc, that were almost certainly caused by trivial viral infections, which required nothing more than symptomatic treatment (ie no antibiotics) and which resolved spontaneously. I do not see any evidence for recurrent lower urinary tract infections (evidence being the presence of a positive dipstick test or culture). Thus given the background of a patient who presented frequently with relatively trivial symptoms compatible with viral infections, I think the interpretation and diagnosis made by Dr Yeo on 18th and 19th December, namely that of a viral upper respiratory tract infection, was reasonable. In my opinion, given this patient`s background and the constraints within which a GP has to operate, the failure to perform a urine test at this stage does not

represent incompetence. [Emphasis is added.]

I find Dr Paton`s evidence in this respect to be a paragon of logic and moderation. He analysed clearly the symptoms presented by the plaintiff on the previous occasions that she had consulted the defendant, and concluded that they do not form any basis for saying that the defendant, as a GP, ought to have carried out a urine test for UTI on 19 December. I must state that the witnesses on the plaintiff`s behalf had not given any evidence that would cast doubt on Dr Paton`s conclusion nor on the bases for it that he had set out. I find the words italicised in para 7 of his affidavit to be particularly important. It is always easy, with the benefit of hindsight, to say that had the defendant done the urine test this or that would have happened. What is important is to view the matter from the perspective of GPs. They are constantly dealing with patients who present themselves with all manner of symptoms. The decision to carry out a particular test must be left to their professional judgment and I cannot say that there is any evidence that in the situation before the defendant on 19 December, it would be negligent of him not to have tested the plaintiff`s urine. Prof Cartwright had said that when the plaintiff returned the following day with the same symptoms, it would have been reasonable for the defendant to conduct a urine test to rule out UTI. However, I would say that it would be equally reasonable for him to think that perhaps he ought to change the symptomatic medication, which he did, since only 24 hours had elapsed, although it may well be different if she had returned after three or four days. As for Mr Kronenburg`s point that given the relatively low cost of the material involved, the defendant ought to have done the test to rule out UTI, in my view it is not so straightforward. First of all, it is not just the cost of material that is relevant. The doctor`s skill is required to interpret the result and this would increase the cost to the patient. More important is the implication that such a holding would have on the practice of medicine in Singapore. In my view, to hold the defendant liable in negligence in the present circumstances would lead GPs to adopt an unnecessarily defensive approach to their practices and to order all manner of tests just to rule out remote possibilities. I do not think that such an approach is justified in the present circumstances. Accordingly, I hold that the defendant was not in breach of his contractual duty nor negligent in not carrying out a urine test for UTI on 19 December 1996.

For completeness, I have to consider whether, if the defendant had tested the plaintiff`s urine for UTI and prescribed an antibiotic, this would have prevented the eye infection. There is an overlap here with the issues pertaining to the consultation of 23 December and I shall first deal with that consultation and revert this question later in this judgment.

Consultation on 23 December 1996

I have made a finding of fact that the defendant had not advised the plaintiff to go immediately to the hospital when she consulted him on 23 December 1996. As it is also the defendant`s own case, supported by his own experts, that a detached retina is a medical emergency and any competent GP would have advised his patient to go immediately to a hospital or to an eye specialist, it would follow that in not doing so he had fallen short of the standard of care required of him as a GP.

The next question to consider is whether the plaintiff`s eye would have been saved had the defendant, on 19 December, advised her to go to the hospital immediately. The plaintiff said that had she been so advised she would have gone and indeed I see no reason why she would not have done so in view of her intellect and the fact that by that time she had been running a fever for about a week along with the rest of her symptoms. The next question is what would have happened at the hospital. Evidence of this is given by the defendant`s own expert, Dr Ang Beng Chong, an eye

specialist in private practice. Dr Ang obtained his MBBS from the University of Singapore in 1967 and is a Fellow of the Royal Australian College of Surgeons and the Royal College of Surgeons of Edinburgh. He was elected to the Academy of Medicine in 1976. Dr Ang had served in the Eye Department of the SGH and Mt Alvernia Hospital before setting up his own practice as a Consultant Opthalmologist at Mt Elizabeth Hospital. He is a part-time lecturer and clinical teacher at the NUS and a visiting Professor of Opthalmology at Tianjin Medical College, China. He is also the Head, Division of Vitreo-retinal Surgery, Department of Opthalmology, NUH and a visiting consultant at the Singapore National Eye Centre (`SNEC`). He was instrumental in setting up the Department of Opthalmology at the NUH. He has published 70 scientific papers and three books and is on the editorial board of Asia-Pacific Journal of Opthalmology.

In oral evidence-in-chief, Dr Ang was asked whether the plaintiff`s eye could have been saved if she had been treated at the hospital on 23 December. This was his reply:

> *There is a possibility. Chances would be better than 24.12.96. That is logical. Provided:*
>
> *(1) On 23.12.96 the doctor made the correct diagnosis.*
>
> *(2) That appropriate treatment given.*
>
> *(3) Eye responded to treatment.*
>
> *Possible for eye not to respond. With reference to the S-curve drawn by Professor Cartwright yesterday, at the early stages, less organism so few signs. At the later stage where more signs appear, also a lot more organisms and therefore more difficult to treat. If Plaintiff had gone to A&E on 23.12.96, sometime in the afternoon, a general doctor would look at her, she would have a note saying suspected detached retina and would be referred to eye doctor. The first line of consultation is usually a trainee eye doctor. He would examine patient for signs, especially detached retina. He would not find detached retina because there are hardly any other signs, he would be in a dilemma what to do next. He could either call his consultant in, or if brave, state no detached retina and tell patient to come back if symptoms persist or get worse. If he calls in consultant, consultant would examine eye. Because of his experience, he may find more, eg, early signs of inflammation, eg, cells in the vitreous. He might diagnose it as sterile uvitis which would be an acceptable diagnosis. Possible that consultant is familiar with EKE, he might do more tests. Because she had fever, he would not rule out infectious ophthalmitis. At that stage not likely he would aspirate the vitreous because it is not an innocuous procedure. He would just give her antibiotics orally or intravenously and watch for response.*

In cross-examination, Dr Ang agreed that there were more factors in favour of the eye being saved had the plaintiff gone to the hospital on 23 December instead of on 24 December. Dr Ang also agreed that if the plaintiff had gone to the A&E Unit of the SGH on 23 December 1996, it was more likely than not that her eye would have been saved. This was the exchange in cross-examination, which was not altered in re-examination:

> *Q: Put - Had Plaintiff gone to A & E of SGH on 23.12.96 evening, her eye would probably have been saved.*

A: Possible.

Q: More likely than not?

A: Yes.

The plaintiff`s expert, Prof Cartwright, gave a great deal of evidence on the mechanism of infection and the response of the bacteria to various antibiotics. In essence, he said that had the plaintiff attended at the A&E Unit of SGH on 23 December 1996, her eye would probably have been saved. As the defendant`s own expert, Dr Ang, was in agreement with this point, there is no need for me to go into the details of Prof Cartwright`s evidence.

It is necessary for me to consider the question of causation. On 23 December 1996, the plaintiff presented herself to the defendant. Apart from her symptoms of fever, chills, giddiness and body pain, she told him that she had blurred vision in her left eye. The defendant examined that eye and found that the cornea was clear. From his examination he suspected that she had a detached retina. He did not advise her to go immediately to a hospital as he ought to have done if she had a detached retina. In any event, it turned out that he was wrong about the detached retina. It was likely that at that stage the bacteria had infected her inner eye. The defendant did not suspect such infection. But he cannot be faulted for that because all the experts agree that this particular infection was so unusual that it would be unreasonable to expect a GP to be able to make such a diagnosis. So here we have a situation where a doctor has failed to make the correct diagnosis, but it was not unreasonable that he should miss it completely. However, he suspected a serious ailment, ie detached retina, but that suspicion was wrong. Yet if he had sent her to the hospital on that basis, which he ought to, the actual infection would have been discovered and the eye saved. The question is whether liability ought to attach to the defendant in such circumstances.

Mr Kronenburg relies on the **McGhee v National Coal Board** [1972] 3 All ER 1008, in which the House of Lords held that a person who substantially increases another person`s risk of injury through negligence has thereby materially contributed to the victim`s injury. There the House held that the defendant, who was the plaintiff`s employer, was negligent in not providing the plaintiff with washing facilities. Because the plaintiff had to cycle home after work with brick dust adhering to his skin, this had added materially to the risk of his developing dermatitis, which he did contract. Mr Kronenburg submitted that in the present case, the defendant had materially contributed to the risk of the plaintiff contracting the eye infection by not advising her to go immediately to the hospital for treatment on 23 December 1996.

Counsel for the defendant, Mr Wee, submitted that ***McGhee v National Coal Board*** was qualified by the House in the subsequent decision of **Wilsher v Essex Area Health Authority** [1988] 1 All ER 871. Lord Bridge, delivering the sole reasoned speech of the House said at p 881:

> *The conclusion I draw from these passages is that **McGhee v National Coal Board** laid down no new principle of law whatever. On the contrary, it affirmed the principle that the onus of proving causation lies on the pursuer or plaintiff. Adopting a robust and pragmatic approach to the undisputed primary facts of the case, the majority concluded that it was a legitimate inference of fact that the defender`s negligence had materially contributed to the pursuer`s injury. The decision, in my opinion is of no greater significance than that and the attempt to extract from it some esoteric principle which in some way modifies, as a matter of law, the nature of the burden of proof of causation which a*

plaintiff or pursuer must discharge once he has established a relevant breach of duty is a fruitless one.

In my opinion, this discussion is academic because there is no question that the plaintiff bears the burden of proving her case in negligence in this case and that was the basis upon which I have made my findings. The defendant had a duty, in contract and in tort, to advise her to go immediately to hospital on 23 December to seek treatment for her eye and he had breached it by his failure to so advise her. There is every reason to impose liability in this case and I so hold. A GP is the first line of defence to a patient, who goes to him not just to cure ordinary coughs and colds, but also to spot the more serious illnesses that require specialist or immediate attention. It is not fair to expect a GP to be able to diagnose all urgent ailments accurately. But if he thinks a patient`s symptoms and signs indicate something serious and urgent, he owes the patient a duty to get her to immediate treatment. It should not make any difference whether his diagnosis of the actual condition was accurate or not. The defendant had said that when the plaintiff complained about the film over her left eye, he checked the cornea and pupil and found them normal. So he suspected, accurately, that the problem was with the back of the eye. Given his limited experience in this specialised area, he did not think of the bacterial infection in question. That is not to be held against him. But the defendant knew that it was something potentially serious. As a GP, it was his duty to ensure that his patient was advised to seek immediate treatment at the hospital if he suspected or believed such immediate treatment to be necessary.

Whether plaintiff`s eye could have been saved if Apo-sulfatrim given on 19 December

some effect on the course of the infection on balance the probability would be expected to be lower, although the possibility of increased release of bacteria from the source might raise probability of the eye becoming infected In respect of the consultation of 19 December, I had earlier held that the omission by the defendant to conduct a urine test for UTI on that occasion was not a breach of duty or negligent. I had also stated that I would for completeness consider whether the plaintiff`s eye would have been saved had this been done. Having dealt with the evidence of the medical experts, it is appropriate at this juncture to deal with that issue. First of all, there is the question of whether the plaintiff`s urine would have tested positive for UTI. Prof Cartwright was of the view that it would. The defendant`s expert, Dr Paton, was also in substantial agreement as he said that in the circumstances it would more likely than not that the plaintiff had UTI. The next question is whether the defendant would have prescribed the same antibiotic to the plaintiff on 19 December as he had done on 23 December. There is no evidence that he would not and I have no doubt that he would. The antibiotic concerned was Apo-sulfatrim. The evidence of the medical experts are as follows:

(a) Prof Cartwright was of the opinion that it was probable that her eye infection would have been prevented. It would thus follow that she would not have lost the sight of her left eye.

(b) Dr Ang agreed with the suggestion of Mr Kronenburg that if she was prescribed the antibiotic, that would probably had wiped off the bacteria that caused the eye infection.

(c) Dr Paton was equivocal. In his evidence-in-chief, he said that Apo-sulfatrim would not have had an effect on the plaintiff because it was likely that by 19 December the infection involved abscesses in one or more organs, ie the liver, kidney or lung. He said that although a short course of antibiotics might have partially suppressed the infection for a few days, it would not be adequate to eradicate the infection at the organs and therefore he could not confidently conclude that this would have

prevented the bacteria from reaching the eye. However, in cross-examination he conceded that Apo-sulfatrim may have had , but qualified that it was unlikely to be strong enough to prevent the bacteria from entering the eye. Asked to clarify the words italicised, he said that it might in some way alter the natural progression of the infection, including a reduced chance of the eye being infected, or postponed the infection of the eye. Finally, he said that although even with administration of Apo-sulfatrim, the circumstances would still exist for an eye infection to occur, ` [the] .`

Dr Chuang, who was called by the plaintiff to give evidence on general medical practice also gave evidence in favour of the plaintiff on this question. However, I did not understand him to be an expert on this particular aspect and therefore did not give much weight to his evidence in this respect. However, in view of the clear evidence of the plaintiff`s expert, Prof Cartwright, and one of the defendant`s expert, Dr Ang, and in view of the equivocal evidence of the defendant`s other expert, I would hold that had the plaintiff been administered Apo-Sulfatrim on 19 December, the infection would not have reached her eye. It would follow that had the defendant tested her for UTI on 19 December, he would have prescribed Apo-Sulfatrim and she would have taken it and this would not have resulted in her eye infection and the subsequent loss of her left eye.

Limitation Act

Mr Wee submits that the plaintiff`s claim is time barred. This is because the writ was filed on 11 January 2000, whereas the negligent act the basis of the defendant`s liability took place on 23 December 1996. This is more than the three-year period provided under s 24A of the Limitation Act (Cap 163, 1996 Ed), the appropriate sub-sections of which are as follows:

> *(1) ...*
>
> *(2) An action to which this section applies, where the damages claimed consist of or include damages in respect of personal injuries to the plaintiff or any other person, shall not be brought after the expiration of -*
>
> *(a) 3 years from the date on which the cause of action accrued; or*
>
> *(b) 3 years from the earliest date on which the plaintiff has the knowledge required for bringing an action for damages in respect of the relevant injury, if that period expires later than the period mentioned in paragraph (a).*
>
> *(3) ...*
>
> *(4) In subsections (2) and (3), the knowledge required for bringing an action for damages in respect of the relevant injury or damage (as the case may be) means knowledge -*
>
> *(a) that the injury or damage was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty;*
>
> *(b) of the identity of the defendant;*
>
> *(c) if it is alleged that the act or omission was that of a person other than the defendant, of the identity of that person and the additional facts supporting the bringing of an action against the defendant; and*

(d) of material facts about the injury or damage which would lead a reasonable person who had suffered such injury or damage to consider it sufficiently serious to justify his instituting proceedings for damages against a defendant who did not dispute liability and was able to satisfy a judgment.

(5) Knowledge that any act or omission did or did not, as a matter of law, involve negligence, nuisance or breach of duty is irrelevant for the purposes of subsections (2) and (3).

(6) For the purposes of this section, a person`s knowledge includes knowledge which he might reasonably have been expected to acquire -

(a) from facts observable or ascertainable by him; or

(b) from facts ascertainable by him with the help of appropriate expert advice which it is reasonable for him to seek.

(7) A person shall not be taken by virtue of sub-section (6) to have knowledge of a fact ascertainable only with the help of expert advice solong as he has taken all reasonable steps to obtain (and, where appropriate, to act on) that advice.

It is not disputed that the plaintiff was warded on 24 December 1996 and remained in SGH under the care of specialists of the SNEC until 26 January 1997. The plaintiff gave evidence that she sought further advice in relation to her injury. She consulted one Prof Stuart Brown of the Department of Opthalmology, University of California, San Diego in respect of the liability of the SNEC and SGH. In February 1998, Prof Brown concluded that there was nothing improper about her treatment by those institutions. After further consideration, on 3 June 1998, Prof Brown advised the plaintiff that the defendant`s treatment was unacceptable. Mr Kronenburg submits that in view of these facts, time did not run until 3 June 1998, or at least until the day the plaintiff was discharged from the hospital. This would mean that the action was brought within three years.

Mr Wee submitted that the date of the plaintiff`s knowledge should be 30 December 1996 when the doctors advised her of their prognosis, or on her own admission, sometime in the first half of January 1997. It seems to me that the second alternative does not support the defendant`s position because the writ was filed within three years of 11 January 1997. In any case, the defendant`s submission on this point is clearly untenable for the reasons that follow.

`Knowledge` for the purpose of s 24A may be actual or constructive. The defendant does not submit that the plaintiff had actual knowledge. Indeed, the plaintiff said that she had no idea of it until 3 June 1998 and up to about February 1998 was pursuing the matter on the basis that the SNEC or SGH were liable. However, knowledge can be constructive knowledge. In ***Hendy v Milton Keynes Health Authority*** (The Times, 8 March 1991), the Queen`s Bench Division held that the plaintiff`s knowledge had depended on the date she received the expert`s report. However, the court held that in a less complicated case, knowledge would arise when the victim appreciated in general terms that his problems were attributable to the operation even if the precise terms of what had gone wrong were not known. ***Broadley v Guy Clapham & Co*** (The Times, 6 July 1993) is a decision of the English Court of Appeal. The report summarises the decision as follows:

A person alleging medical negligence was fixed with a cause of action when she knew, or could have known with the help of medical advice reasonably obtainable, that her injury had been caused by damage resulting from something done or not done by the surgeon during her operation. Knowledge detailed enough to enable the plaintiff`s advisers to draft a statement of claim was not required before time began to run.

I cannot see how, in the circumstances of this case, constructive knowledge could attach to the plaintiff without expert assistance. The parties agree that the plaintiff`s affliction was a rare eye infection. At the very least, it was necessary for the plaintiff to seek an opinion from an expert after giving full instructions about the circumstances. That being the case, I cannot see how the plaintiff could have done this before she was discharged from SGH on 26 January 1997. And at the very least, she was entitled to a reasonable period after that date to obtain such expert advice. In the premises, I would hold that the plaintiff`s claim was made within the three-year limitation period.

Conclusion

In the premises, I find that the defendant was in breach of his contractual duty to the plaintiff, alternatively that he was negligent, in failing to advise her on 23 December 1996 to go immediately to the hospital. I also find that if he had so advised her, she would have gone. And if she had gone to the hospital on that day, on a balance of probability, her eye would have been saved. Accordingly, I find the defendant liable to the plaintiff in respect of the loss of her left eye for such damages as may be assessed.

I will hear counsel on the question of costs.

Outcome:

Claim allowed.