IN THE GENERAL DIVISION OF
THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2021] SGHC 243

Suit No 250 of 2014

Between

Soh Keng Cheang Philip

… *Plaintiff*

And

National University Hospital (S) Pte Ltd

… *Defendant*

JUDGMENT

[Tort] — [Negligence] — [Breach of duty]
[Professions] — [Medical profession and practice] — [Liability] — [Negligence]

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Soh Keng Cheang Philip
v
National University Hospital (S) Pte Ltd

[2021] SGHC 243

General Division of the High Court — Suit No 250 of 2014
Choo Han Teck J
26–30 July, 2–6 August, 10, 17 September 2021

26 October 2021 Judgment reserved.

Choo Han Teck J:

1 The plaintiff was born on 12 March 1964. He used to work in a courier company but has been unemployed for many years. He commenced this action against the defendant which is the company that operates the National University Hospital ("NUH") for damages for negligence. He was initially unrepresented and filed his Statement of Claim ("SOC") himself on 17 February 2015. He amended the SOC on 13 November 2018 through his solicitors, and again on 1 July 2021. His affidavit of evidence-in-chief was filed on 10 June 2019.

2 The plaintiff claimed that NUH was negligent by failing to diagnose the plaintiff's medical condition and failing to "refer him to the appropriate specialist for further investigations of the [p]laintiff's symptoms". For the particulars of negligence, the plaintiff also alleges that the NUH did not "consider alternative diagnoses apart from stress or acute stress disorder". He

also claims that the NUH failed to "take all reasonable steps to investigate the plaintiff's symptoms", and in not treating him "in a proper professional manner". The facts that gave rise to these allegations of negligence occurred over five visits to NUH in 2011. Of those visits, four were at the Accident & Emergency Department ("A&E"), namely, on 16 March 2011, 20 March 2011, 13 May 2011, and 24 May 2011. The fourth visit was at the Neurology Department on 20 May 2011.

3 The actual injury complained of concerned the effects after a cervical surgery performed on him on the C3 to C6 cervical portions of the spine on 3 June 2011. The plaintiff was left with weakness and partial paralysis after the surgery. This action, however, is not concerned with the surgery itself nor against the surgeon Dr David Choy. Counsel for the plaintiff, Mr VK Rai confirmed at trial that the plaintiff is not pursuing any action in respect of the surgery or the surgeon.

16 March 2011

4 The plaintiff's case in this action is built around the five visits to the NUH referred to in paragraph 2 above. His first visit (on 16 March 2011) was prompted by chest pains and various discomforts that he experienced at 5.30am. His wife Sio Seok Har ("Sio") accompanied him to the A&E where he was attended by DW1, Dr Wu Pang Hung ("Dr Wu"). The medical notes of Dr Wu and the nursing notes showed that the plaintiff complained of non-radiating left-sided chest discomfort, and that he had been having palpitations on and off for about two weeks, and that he felt a lump in his throat. The notes recorded by Dr Wu show that the symptoms were precipitated by stress at work. The notes recorded by the triage nurse show that the plaintiff felt a lump in his heart (not

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the throat) but this was not an issue at trial, and in itself, the discrepancy does not affect my findings of fact.

5 Dr Wu ordered X-ray of the chest and that did not reveal any abnormalities of the chest. Dr Wu then consulted his colleague, DW3, Dr Peng Li, a Senior Consultant on duty in the Emergency Department. She thought that the chest pains might be stress related but had the plaintiff admitted overnight at the Extended Diagnostic Treatment Unit ("EDTU") for further investigations.

6 Later that afternoon, the plaintiff was attended by DW4, Dr Kuan Win Sen. The evidence of Dr Kuan was that the plaintiff complained about left-sided chest pain occasioned by stress at work. The pain was non-radiating. It was recorded by the doctor in the medical notes that the plaintiff said that he had tingling sensation over his right arm, but did not have any numbness or weakness nor any vomiting. He told the doctor that he slept with two pillows because he wanted to have proper neck support and not because of shortness of breath (orthopnea). The examination showed that his neck was supple and he had a full range of movement with no tenderness (pain) or deformity.

7 The plaintiff was examined by DW2, Dr Lee Sock Koon at 9.25am the next day, 17 March 2011. His chest pain had improved, and he completed a treadmill test during which he ran at a maximum speed of 5.5kmph and was able to achieve the maximum heart rate. He was thus diagnosed as having atypical chest pain, and discharged with a prescription for analgesic (painkiller).

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20 March 2011

8 A few days later, on 20 March, the plaintiff had severe difficulty breathing at 3am. He went alone to the A&E where he was attended by DW5, Dr Michael Ebuna. The plaintiff complained of a recurrence of his heart palpitations which he said arose after an argument with his wife. The main issue with Dr Ebuna was that the plaintiff claims that he had told Dr Ebuna that he had numbness, tingling sensations, and pain at the back of the neck, but Dr Ebuna did not note these down in the record. Dr Ebuna denies that the plaintiff had complained of those symptoms. The medical notes support Dr Ebuna's version and Mr Rai was obliged to point out some typographical errors in Dr Ebuna's notes as well as a contradiction in which the notes initially stated that the patient had no known drug allergies, but further down the notes it was recorded that the plaintiff is allergic to ampicillin. Counsel therefore put to Dr Ebuna that the notes did not show the plaintiff's complaints about neck pain and numbness because Dr Ebuna did not record them because he recorded his notes only at the last two minutes of the consultation, as the electronic medical records system was down during the consultation and was only up during the last two minutes of the consultation. Dr Ebuna denies counsel's charge.

9 The plaintiff says that he "felt something was amiss" after the two visits to the A&E because he felt numbness, tingling sensations, and weakness in his limbs, and so he went to a polyclinic on 4 April 2011 to consult the doctor there. He was given a referral by the doctor on duty to see a specialist in the Department of Neurology at NUH. The appointment was classified as "routine" and fixed for 24 May 2011.

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10 Although the plaintiff says that he "felt something was amiss" as the reason for going to the polyclinic, the clinic's medical notes show that his complaint was mainly for pain in the neck, tingling sensations, and that he was "concerned about heart++". The doctor's examination found "mild tenderness over lower cervical spine with reduced flexion" but no weakness in the limbs which were found to have "full power".

11 About a month later, on 7 May 2011, the plaintiff had breathing difficulties and went to the Central 24-HR Clinic where he was told by the doctor that he had "nerve dystrophy" and that it was a condition that could deteriorate rapidly. He told the doctor that he had an appointment at the Department of Neurology on 24 May, and the doctor told him that he should go. The plaintiff decided to ask for the appointment to be brought forward to 20 May 2011.

13 May 2011

12 The plaintiff says that a week before the new appointment at the NUH, he felt his limbs weakened and his walking became wobbly and unstable while he was on his way to work. He was unable to type and was told by his supervisor to resign from his job on the spot because of his physical condition, which he did. The reason and circumstances for his resignation was not verified, but I can accept that the plaintiff resigned from his job.

13 In the afternoon of 13 May 2011, the plaintiff went back to the A&E of NUH and was attended by Dr Ranjeev Kumar. He told Dr Ranjeev that he previously saw Dr Ebuna and had told Dr Ebuna that he was unable to dress himself, ride a bicycle, or even hold utensils. He told Dr Ranjeev that he had

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tingling sensations in the right hand from March 2011, and in the left hand that first occurred on the day itself. He said that there were no feelings of numbness.

14 Dr Ranjeev testified that on examination, he found the plaintiff's neck to be supple with no cervical tenderness. He found the power and tone of the upper limbs to be normal as were the lower limbs, and the gait was steady. Dr Ranjeev concluded that the plaintiff might have "altered sensation of the upper limbs" with a need to rule out myelopathy. An x-ray was done that showed no fracture or dislocation but there were degenerative changes to the C5 to C7 cervical discs which seemed to be due to normal wear and tear. Nonetheless, Dr Ranjeev discussed the plaintiff's condition with Dr Peng and the two doctors concluded that the plaintiff's condition might be due to "cervical radiculopathy" (which is a condition in which the nerve is compressed) as that would be consistent with the radiological results. As there was no indication of urgency, as there was no objective acute deterioration observed, Dr Ranjeev advised the plaintiff to keep his appointment at the Department of Neurology.

15 Three days later, on 16 May 2011, the plaintiff consulted his psychiatrist PW8, Dr Roger Ho with the same complaints, but added that he had a cramping pain in his lower back. Dr Ho wrote a memo for the plaintiff to show the neurologist, stating that he (Dr Ho) suspected peripheral neuropathy and suggested that a nerve conduction test be performed. Again, as there seemed to be no urgency, there was no suggestion for a change of the appointment at the Department of Neurology.

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20 May 2011

16 The patient on his own, requested the appointment at the Department of Neurology be brought forward from 24 May to 20 May, when he was seen by DW8, Dr Leonard Yeo. The plaintiff complained of tingling sensation and numbness, and had difficulty dressing himself. He did not complain of neck pain. After examining the plaintiff and perusing the results of clinical tests, Dr Yeo made the provisional diagnosis of peripheral neuropathy. Dr Yeo testified that he did not think that the plaintiff had "cervical spondylosis with myelopathy" because he did not exhibit symptoms typical of that condition. He arranged for the plaintiff to undergo a neurophysiological test on 27 May 2011, and for a follow-up examination on 3 June 2011. Dr Yeo noted that the plaintiff had normal muscle power except for a "very mild proximal weakness in the legs", he therefore did not think that the plaintiff required hospitalisation on 20 May. He noted that there was no acute decline of the plaintiff's conditions, as he complained of the same symptoms, namely tingling and weakness, on both visits dated 13 May and 20 May 2011. Further tests were ordered with a follow-up on 27 May 2011. However, the plaintiff decided to return to NUH on 24 May 2011, a few days before the appointment.

24 May 2011

17 On 24 May 2011, the plaintiff experienced another episode of breathing difficulties and so he went to the NUH A&E, accompanied by Sio. The plaintiff was seen by DW2, Dr Lee Sock Koon. Although Dr Lee found that the plaintiff had full power in all four limbs, he admitted the plaintiff reported a worsening of his condition. Dr Lee was of the view that the plaintiff probably had peripheral neuropathy, but had in any event decided to admit the plaintiff into

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the Department of Neurology so that a specialist neurologist could attend to him.

18 The plaintiff was reviewed at 8.50am on 25 May 2011 by DW9, Dr Rahul. On examination, Dr Rahul found that the plaintiff had "a lack of co-ordination" and "unable to tandem gait" which he could do, just a few days before, on 20 May 2011. It appeared that on 25 May, the plaintiff had exhibited more extensive symptoms. Dr Rahul's working diagnosis was that of cervical myelopathy. An MRI scan was thus carried out on the plaintiff on 26 May 2011. It showed "ossification and thickening of the posterior longitudinal ligament and osteophytic disc complex with significant canal stenosis and cord impingement from C3–4 to C5–6 level".

19 The plaintiff was therefore referred to the neurosurgery team led by Dr Chou Ning. Upon advice the plaintiff underwent a "cervical decompression laminectomy from C3 to C6" levels of the vertebrae on 3 June 2011. The plaintiff was eventually discharged from NUH on 27 June and transferred to the Tan Tock Seng Hospital for rehabilitation. The plaintiff claims that he was left severely immobilised after the surgery. Ordinarily, a plaintiff ought to have pleaded the injury and damage suffered by him before particulars of negligence might be levied against the defendant. The statement of claim pleaded that his motor and sensory functions have been adversely affected, his pain and suffering was prolonged, and his prognosis was poor.

20 Against the background of the above facts, with some other allegations by the plaintiff (which I will refer shortly), the plaintiff claims that the NUH was negligent. The negligence against the defendant was directed against the failure by the A&E doctors and the doctors at the Department of Neurology for

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not diagnosing his illness correctly. Under this claim, he alleges that the doctors did not investigate his symptoms and consider alternative diagnosis, that they did not examine him physically properly, and to refer him to the appropriate specialist for further investigations.

21 As to his loss and damage, the plaintiff claims that his condition would have been diagnosed earlier and he would have had "a better prognosis". He says that the doctors' negligence caused him to suffer increased and chronic pain, and he relies on the evidence of his expert, PW9 - Dr Keith Goh Yu-Ching ("Dr Goh").

22 The plaintiff first consulted Dr Goh on 17 June 2013, two years after his surgery on 3 June 2011. Dr Goh reported in his specialist medical report of 22 June 2018 that the plaintiff's main complaints were

(a) chronic neck pain

(b) stiffness and weakness of the muscles of the arms and legs, especially the fingers of his right hand, and right leg

(c) generalized numbness and 'tingling' sensations, especially of the right arm

(d) generalized muscle spasms affecting the whole body

(e) unsteady gait, requiring a walking stick

(f) chronic constipation

(g) sexual (erectile) dysfunction.

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Dr Goh also noted that the plaintiff, then 54, suffered from schizophrenia since he was 20 years old, and had been having seizures since 2016.

23 Dr Goh recorded the plaintiff as saying that his symptoms began in March 2011 with neck pains, numbness, and tingling sensations especially of the arms and hands, and weakness of the arms and legs. Dr Goh also noted that the plaintiff had surgery on the C3–C6 levels of the cervical spine on 3 June 2011 and that an MRI of the spine after the surgery showed "spinal cord oedema and a possible contusion at the C4–C5 level".

24 Dr Goh's evidence in support of the plaintiff's case was that the diagnosis of "Spondylosis, Myelopathy or Radiculopathy, was not made at the time of his first two visits to the Emergency Department on 16 March 2011 and 20 March 2011". He is of the opinion that this diagnosis was eventually made on 13 May 2011. He is of the opinion that "[a] correct diagnosis at the first visit to the Emergency Department on 16 March 2011 could have resulted in earlier treatment, and hence improved outcome", compared to his present clinical condition. He testified that urgent referral on 13 May 2011 could also have resulted in earlier treatment and hence improved outcome.

25 Two preliminary points should be made regarding Dr Goh's testimony now, and the crux of his evidence later, below. First, Dr Goh was presented as the plaintiff's expert, but his credentials as an expert was not presented to the court until after the trial was over. Secondly, Mr V K Rai, counsel for the plaintiff, submitted a further report of Dr Goh, dated 29 July 2021 on the last day of the trial when the evidence had concluded. I am ignoring this report because the introduction of irrelevant evidence from Dr Goh had been denied at

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trial. This further report dated the day of Dr Goh's testimony in court is therefore an attempt to introduce evidence that I had ruled irrelevant and inappropriate.

26 I will return to Dr Goh's main evidence after I deal with the crux of the plaintiff's case. The plaintiff had his surgery on 3 June 2011, an important event and one that I shall have to return to shortly, but for the moment, that marks the point where the plaintiff's claims against the defendant ends because his basic claim is that had the defendant's doctors diagnosed his condition correctly, he would have a better prognosis and not suffer the pain he has.

27 The entirety of the plaintiff's claim is based on his claims that the condition that he had that ultimately led to his surgery was peripheral neuropathy. I had set out each of the instances that the plaintiff was attended by the doctors from the NUH. The evidence on the whole — and that includes the plaintiff's own evidence — does not support the plaintiff's claims. The four important dates were 16 March, 20 March, 13 May, and 20 May 2011.

28 On the first two dates the plaintiff woke up in the early morning (before dawn) in a state of alarm because he thought he might be having heart problems. That was what took him to the A&E at NUH. The medical and nursing notes all bear the defendant's account that the plaintiff's complaint on those dates related to his chest pains. The medical notes specifically recorded that there were no weakness or numbness of the limbs; this was done pursuant to Dr Wu's screening of the plaintiff for neurological condition. Since the complaint concerned chest pains, the plaintiff was admitted to the NUH's EDTU for further examination relating to his complaint. It was then that the plaintiff mentioned a tingling sensation over his right upper limb, but he said that he did not have any numbness or weakness in the limbs, and that he did not have any

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neck pain. He successfully completed the treadmill test in the EDTU, which lasted seven minutes and 24 seconds, and included him running on the treadmill. When the doctors were satisfied that there was no sufficient cause for concern, he was discharged and given an appointment to see a cardiologist.

29 On the second date, 20 March 2011, the plaintiff returned to the A&E of NUH after having heart palpitations. He was examined by Dr Ebuna, who discharged the plaintiff after satisfying himself that there was no cause for concern of any critical cardiac problems. There was some careless note-taking by Dr Ebuna in this instance, but considering them as a whole, I am of the view that the errors do not support the plaintiff's claim that he had informed Dr Ebuna of sufficient neurological symptoms to warrant a fuller neurological examination and diagnosis.

30 For instance, Mr Rai submitted that the recording that the plaintiff had no known drug allergy was contradicted by the entry on another page of the notes that the plaintiff was allergic to ampicillin. I am of the view that this was a sloppiness arising from not correcting the previous entry after a later information was received, but it does not indicate that the plaintiff had told Dr Ebuna the neurological symptoms that would have led to a full neurological examination. The focus during this visit was, like the first, on the acute chest pains. The plaintiff's complaints of chest pain were corroborated by Dr Ho's clinical documentation on 21 March 2011 as well. Dr Ho, likewise, did not note any symptoms the plaintiff allegedly suffered. Dr Ho noted that the plaintiff was not at fall risk and was not in pain.

31 The next two visits, namely, 13 May and 20 May were the ones that concerned more neurological than cardiac complaints. The plaintiff was

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examined by Dr Ranjeev specifically for the symptoms of tingling sensation, weakness, and some pain. Dr Ranjeev then consulted Dr Peng and they concluded that the plaintiff might have cervical radiculopathy, but there were no signs of acute deterioration. Dr Ranjeev therefore advised the plaintiff to keep his appointment at the Department of Neurology scheduled for 20 May 2011, and as mentioned, the plaintiff did not wait till 27 May but returned on 24 May when he was admitted. He was examined by Dr Rahul on 25 May. On review the next day after a Nerve Conduction Study, the plaintiff was observed to be feeling well and comfortable. He had no new complaints but still complained of weakness in the limbs although he said they were not worsening. An MRI scan was done and the plaintiff reviewed by the surgical team on 28 May 2011, and surgery was performed about a week later, on 3 June 2011.

32 The plaintiff's first two visits to the A&E were primarily because of his concern over his heart palpitations. In retrospect, he probably had cervical myelopathy then but the symptoms were minor and not sufficient to alarm him. The condition was noted to have been a chronic one, rather than an acute condition that required immediate treatment. The A&E doctors had kept contemporaneous notes, none of which shows sufficient neurological complaints for the emergency doctors to respond to. The A&E department's primary role as the defendant's experts explain, is to respond to emergencies and that means all life-threatening conditions or any dangerous situations that require immediate or prompt action. DW11 - Associate Professor Mohan Tiruchittampalam, an emergency physician was called as the first of two experts by the defendant. He has an impressive credential in this field of practice, and in his report, he expressed the view that the emergency doctors at the A&E had

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acted appropriately. His reasons are lucidly set out in his report and not shaken under cross-examination.

33 I agree with A/Professor Mohan that the evidence does not indicate that the emergency doctors in March 2011 had reason to exclude cervical myelopathy at that stage. There were, in A/Professor Mohan's words, "no red flag signs" even as at 20 May 2011. One of the red flags would have been objective weakness or sensory disturbance, but Dr Ranjeev, after performing a physical examination, found no such objective loss in power or function. I accept his view that "there were no objective findings on physical examination to indicate an urgent MRI or neurosurgical consult" although he thought that immediate admission to the neurology department for further investigations would have been appropriate. The plaintiff was admitted on 24 May 2011. I am of the view that there was no undue delay. A/Professor Mohan as well as DW12 - Associate Professor Umapathi Thirugnanam, a senior consultant neurologist with the National Neurology Institute, are of the opinion that there was no undue delay in diagnosing the plaintiff's condition. I accept their opinions. Surgery was performed soon after the diagnosis but there is no evidence that the plaintiff had to have that surgery at that time, nor is there evidence that surgery was the only option although the evidence suggests that surgery would be the best solution in most cases. When the surgery should be performed is a matter for the surgeon and the patient. No evidence was led as to what the surgeon had advised the plaintiff.

34 A/Professor Umapathi is firmly of the view that the outcome of the surgery was not due to a delay in the treatment. A/Professor Umapathi is of the view that the plaintiff's poor prognosis (oedema) after his surgery is a known

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complication after such surgery. Although the plaintiff's case is that the delay in diagnosis caused his present condition, there is no evidence to show in what way the delay led to it. There is nothing to suggest that the outcome of the surgery would have been any different had it been performed two months earlier. A/Professor Umapathi reports that he disagrees "that the outcome was due to any 'delay' in the treatment. The disease had been present for a while and the deficits were mild. So the described 'delay' would not have impacted on the outcome significantly."

35 Another complaint raised by Mr Rai is that the notes taken by the A&E doctors, namely Dr Ebuna and Dr Wu, were not sufficiently contemporaneous. A/Professor Mohan testified that the notes were adequate in spite of persistent questioning by Mr Rai. A/Professor Mohan maintains that it is not only acceptable but recommended that the examining doctor records his notes after the examination of the patient is over. Mr Rai suggests that recording the notes in that way is not sufficiently contemporaneous because one should be writing down the notes as one listens, instead of recording after the complaints have been elicited. I do not think that that way of recording in this case had led to a loss of information, or as Mr Rai suggests, an incomplete record. As A/Professor Mohan testified, and I accept, that it might be bad bedside manners for doctors to be speaking to the patient and recording notes in a computer at the same time. They should focus on talking to the patient, conducting physical examination and then enter their clinical notes. Unlike a judge or a lawyer who might take notes while the others are speaking, a doctor needs to conduct physical examination of the patient, and engage the patient, rather than tapping away at the keyboard. Moreover, aside from Dr Ebuna and Dr Wu, the absence of any contemporaneous notes regarding any serious signs of a neurological

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disorder is not peculiar to one doctor but the notes of all the doctors involved in the plaintiff's visits to the A&E were consistently similar in this regard.

36 Dr Goh's evidence is based on his examination of the plaintiff a couple of years after the event, and on the medical and nursing notes recorded by others, as did the defendants' experts. As it turned out, there were some notes that Dr Goh had not seen before he wrote his expert report. Mr Rai and Miss Kuah have taken all the experts through every page of the nursing and medical notes. Those notes represent the contemporaneous record of the events. Mr Rai's idea that a note is contemporaneous only if it were written as the doctor examines the patient is an unreasonable view if only because in many situations, it would be a physical impossibility. Mr Rai rejects the evidence that the notes as contemporaneous because they were written about two minutes after the physical examination of the patient. I must respectfully reject this view.

37 The notes were written by different doctors (and nurses) on different occasions. Together, they support the conclusion that the plaintiff probably had developed cervical myelopathy in March 2011 but in a mild form. It was not the condition that worried him when he visited the A&E in March 2011. He must have felt his symptoms of tingling sensation and mild numbness in his May visits to the NUH but the doctors examined him and found the symptoms insufficiently severe to warrant an immediate admission. I accept that on the evidence, the appointment for him to be examined by the neurologist on 20 May 2011 was not an unreasonable delay.

38 Hospitals, both private and public, have limited resources and time. How they allocate them to a patient depends on the problem at hand, and in this case, the examining doctors were of the view that the clinical evidence did not warrant

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an immediate hospitalisation for the plaintiff. I accept the evidence of A/Professor Mohan and A/Professor Umapathi that the appointments fixed were reasonable in this case. In assessing the duty of care owed by doctors in an A&E context, the court held in *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd and others* [2019] 3 SLR 1063 at [85] that it is reasonable for A&E doctors to adopt a specific approach to treatment, *ie*, to be primarily concerned with diagnosing the treating the immediate cause of a patient's acute deterioration in health rather than providing a general health screening of the patient. A&E doctors are still expected to make reasonable enquiries, take a history from the patient, conduct basic investigations and take reasonable care in reaching their diagnosis, especially when diagnosing and treating a patient's presenting complaint. When doctors taking that approach reasonably suspect that the patient has underlying health problems they are unable to fully investigate, they should send the patient or advise the patient to go for follow-up consultations. In this case, I am satisfied that the doctors had made reasonable enquiries and taken the plaintiff's medical history and found no life-threatening or acute conditions that called for immediate attention. They reasonably referred the plaintiff to have a follow-up appointment with the Department of Neurology.

39 Although the plaintiff and Dr Goh assert that the delay in the surgery had caused his present condition, they have not explained how the surgery, if performed a month or two earlier would have yielded better results. The plaintiff did not call any evidence to the effect that the surgery should have been done in March or April 2011. He also did not call his surgeon to testify as to whether there were other options besides surgery, whether the surgery could be deferred pending other alternative treatment, and whether the surgery itself led to the

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present condition. It was A/Professor Umapathi who testified that the plaintiff's condition was a known complication of this sort of surgery.

40 I find that the plaintiff's evidence-in-chief to be incongruous with the medical notes. It is also noted that the plaintiff also visited the Clementi Polyclinic on 4 April 2011, and to the Central 24-HR Clinic on 7 May 2011. On neither occasion did the doctors note that he complained of symptoms of weakness and inability to walk steadily and *etc*, and yet he maintained at trial that he had told the doctors, Dr Seet and Dr Lee, that he had such symptoms. There is no record to show that the plaintiff had complained about weakness, pain, and any functional difficulties from 13 March to 24 May 2011. In the result, there is no evidence that supports his claim that the NUH doctors were negligent in their management of his complaints in any of the visits from 13 March to 24 May 2011. It seems to me that the plaintiff was scarred by his own discontent and had closed his mind to a more reasonable appraisal of his case.

41 Mr Rai is on record as having expressed the sentiment, on a couple of occasions, that he was engaged as counsel only close to trial. Nothing he said should reflect darkly on the plaintiff's previous counsel Mr Fong Wei Li because now that I have received and considered the evidence, I am of the view that Mr Fong did what was right. It cannot therefore be said that, by that same token, that Mr Rai is wrong, because the tokens may not be the same after all. What I can gather from this trial, is that Mr Rai had argued the plaintiff's case comprehensively, although not persuasively.

42 Shortly after the trial ended, the plaintiff sent letters to the court and to counsel for the defendant, airing his private grievances against Mr Rai. Those

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matters do not concern the defendant, and are not relevant to my consideration of the merits of this case. The letters are inappropriately copied to the defendant and the court, but seeing that they were probably written without advice, I will not take this up further.

43 For the reasons above, I am of the opinion that the plaintiff has not proved his case against the defendant. His claim is therefore dismissed with costs. I will hear arguments on costs if parties are not able to agree costs between themselves.

- Sgd -
Choo Han Teck
Judge of the High Court

Vijay Kumar Rai, Gursharn Gill Singh s/o Amar Singh and Jasleen Kaur (Arbiters Inc Law Corporation) for the plaintiff;
Kuah Boon Theng SC, Samantha Oei Jia Hsia and Cheong Le Yue Jess (Legal Clinic LLC) for the defendant;
Lim Wan Ting Tracia and Tay Kai Lin Brenda (Charles Lin LLC) (watching brief).

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