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

[2022] SGHC 259

Suit No 554 of 2019

Between

Chia Soo Kiang
(personal representative of the estate of Tan Yaw Lan, deceased)
… *Plaintiff*

And

1. Tan Tock Seng Hospital Pte Ltd
2. Dr Dorai Raj D. Appadorai
3. Dr Lee Wei Sheng
4. Dr Ranjana Acharya

… *Defendants*

JUDGMENT

[Tort — Negligence — Medical negligence — Breach of duty]
[Tort — Negligence — Medical negligence — Informed consent]

Chia Soo Kiang (personal representative of the estate of Tan Yaw Lan, deceased)
v
Tan Tock Seng Hospital Pte Ltd and others

[2022] SGHC 259

General Division of the High Court — Suit No 554 of 2019
Choo Han Teck J
15, 16, 18, 19, 22–25, 31 August, 5, 13 September 2022

13 October 2022 Judgment reserved.

Choo Han Teck J:

1 Madam Tan Yaw Lan ("Mdm Tan") was 74 years old and had a history of multiple ailments, including ischaemic heart disease (a chronic heart disease), type 2 diabetes, stage 4 chronic kidney disease, hypertension, hyperlipidaemia (high cholesterol), heart failure with ejection fraction, paroxysmal atrial fibrillation, asthma, mild bronchiectasis, anaemia, and recurrent urinary tract infection. She was admitted to Tan Tock Seng Hospital ("TTSH") on 18 January 2018 for an acute myocardial injury and was discharged on 23 January 2018. Thereafter, she was managed in the outpatient cardiology clinic.

2 Some months later, being troubled by a persistent fever, Mdm Tan went back to TTSH on 20 April 2018 by ambulance. She reached the Emergency Department at 4.17pm. Dr Muhammad Nursuhairi bin Sumarni ("Dr Nursuhairi"), who was a Senior Resident at the TTSH Emergency

Department, attended to her at 4.49pm. He found her to be fully alert. She was accompanied by her granddaughter, but was able to tell the medical staff that she did not have any shortness of breath or palpitations. Dr Nursuhairi examined her and ascertained that she did not have nausea, vomiting, rectal bleeding or blood in her stool. She did not have any sign of rashes, and dengue was ruled out. Her heart and lung sounds were also normal, that is, not congested. A full record of Dr Nursuhairi's examination is found in his affidavit of evidence-in-chief.

3 The significant findings at the time of Mdm Tan's admission to the Emergency Department was that she was having a fever of 39.1°C, and a blood pressure of 149/73. Her oxygen saturation was initially low, at 93%, but eventually rose to 98% with oxygen supplementation. That was discontinued when her oxygen level rose to 96% unaided. Dr Nursuhairi's diagnosis was that Mdm Tan was suffering from sepsis, an infection of unknown source. He was fortified in his view by the laboratory results of various tests that was ordered. He started Mdm Tan on Tazocin, a broad-spectrum antibiotic to treat her sepsis. Mdm Tan was then transferred to a general ward at 11.06pm.

4 The doctors who first attended to Mdm Tan at the general ward on 20 April 2018 were the third defendant, Dr Lee Wei Sheng ("Dr Lee"), who was at the material time, a House Officer on call with the Department of Medicine at TTSH, and later by Dr Amanda Chong Hui Zhi ("Dr Amanda Chong"), who was at the material time, a Medical Officer on call in the same department. Dr Lee was informed of Mdm Tan's admission before midnight. He studied the clinical notes on Mdm Tan in preparation for a review of her case, but the first review was done by Dr Amanda Chong (at 11.39pm) because Dr Lee had to attend to another case. Dr Lee examined Mdm Tan at 7.11am on 21 April 2018.

Both he and Dr Amanda Chong ascertained that Mdm Tan was alert, and her reason for admission was for a fever that lasted two days. They also observed that she was generally lethargic. Her personal history of numerous past and existing medical conditions was noted by Dr Amanda Chong and Dr Lee, and they were of the opinion that Mdm Tan had sepsis, with urinary tract infection or hepatobiliary sepsis as the potential source of infection. The doctors noted that Mdm Tan also had anaemia associated with her existing medical conditions.

5 Dr Amanda Chong and Dr Lee were also of the opinion that Mdm Tan's sepsis was complicated by coagulopathy, a type 2 myocardial infarction, and acute kidney injury as well as a chronic kidney disease. Dr Lee made a note in his clinical report with the words, "Refer CVM for T2MI". He testified that although he was able to diagnose a type 2 myocardial infarction, as a first-year House Officer, he was not experienced with the management of such a diagnosis and not fully certain of the subsequent management plan. He therefore made the note to check with the Senior Consultant during the morning ward round as to whether the referral to a cardiologist was needed.

6 Dr Amanda Chong prescribed an antibiotic, Augmentin, and insulin on a sliding scale. She noted that Mdm Tan was on chronic medications, aspirin (for her heart) as well as losartan and Lasix (for her hypertension). Dr Amanda Chong decided to stop these medications because aspirin, being a blood thinner, may lower Mdm Tan's blood clotting capability, which may be a problem because she had a low haemoglobin count on admission. She withheld losartan because it might interfere with Mdm Tan's kidney functions. As Lasix is a diuretic, she decided to stop that too because she observed that Mdm Tan was already "dry and required intravenous fluids". She testified that these were

meant to be temporary and subject to review. Dr Amanda Chong is not a party to these proceedings, but testified on behalf of the defendants.

7 Mdm Tan was examined on 21 April 2018 from 9.29am to 9.50am by Dr Ranjana Acharya ("Dr Ranjana"), the fourth defendant, who is presently a Senior Consultant at the Department of General Medicine at TTSH. At the material time, she was rostered as the consultant in charge of reviewing new admissions in the general ward. Dr Ranjana's affidavit of evidence-in-chief sets out in detail her review of Mdm Tan's medical history. She agreed with Dr Amanda Chong and Dr Lee that Mdm Tan had sepsis from an unknown source, complicated by coagulopathy, a type 2 myocardial infarction and acute kidney injury on chronic kidney disease. Dr Ranjana accepted the medical decisions made by Dr Amanda Chong and Dr Lee, including the choice of antibiotic. She added an additional antibiotic, oral Doxycycline, to cover for community-acquired pneumonia, and switched the Mixtard insulin for long-term insulin control, to a sliding scale insulin support. She was of the opinion that it was not necessary to refer Mdm Tan to a cardiologist as the management of type 2 myocardial infarction is to treat the underlying cause, which in Mdm Tan's case, was her sepsis, and that the doctors in the General Medicine department were competent to manage such patients. The experts called by the defendants are all of the same opinion.

8 Mdm Tan began to show improvement by 22 April 2018, the third day since her admission. Her fever subsided, and her haemoglobin level increased. She had no new complaints. On the fourth day, an intern, Clare Cheong Wei Zhen ("Ms Cheong") who was participating in a two-week attachment under the TTSH Nursing Internship programme, attended to Mdm Tan and asked her if she would like to take her shower. Ms Cheong testified at the trial. By that time,

she had already enrolled in the Yong Loo Lin School of Medicine at the National University of Singapore, and was in her fourth year of study. Mdm Tan told Ms Cheong that she would like to have a shower, but only after her breakfast. Ms Cheong asked Mdm Tan again shortly after Mdm Tan had her breakfast. Mdm Tan said that she was ready to shower. Ms Cheong saw that Mdm Tan was able to walk without assistance, but nevertheless she supported Mdm Tan by the arm to the shower room. Ms Cheong also testified that Mdm Tan was chatting with her while she was helping Mdm Tan.

9 After Mdm Tan was done with her shower, Ms Cheong helped towel her and began dressing her. Mdm Tan was able to slip her left arm into her left shirtsleeve without difficulty. When Ms Cheong was about to assist with the other arm, Mdm Tan suddenly went limp and slumped sideways onto Ms Cheong. Ms Cheong testified in her affidavit of evidence-in-chief that she immediately rang the call bell, though under cross-examination, she said that she was not sure whether she rang the call bell or opened the bathroom door to call for help. In any event, Nurse Huynh Qyunh Thuong ("Ms Huynh") was at her workstation just outside the bathroom. She said under cross-examination that it took her less than five seconds to reach the bathroom and begin assisting Ms Cheong with Mdm Tan.

10 Ms Cheong and Ms Huynh were joined by Mr Tan Tit Chai, the Nursing Manager and other staff. They had Mdm Tan seated on a wheeled commode chair and wheeled back to her bed where resuscitation was carried out, but Mdm Tan did not regain consciousness. Mdm Tan passed away about three weeks later, on 13 May 2018. Her son, Mr Chia Soo Kiang (the "plaintiff"), sued as her personal representative. The claim against TTSH is based on the vicarious liability of its employees, including the second, third, and

fourth defendants, namely, Dr Dorai Raj D. Appadorai ("Dr Dorai"), Dr Lee and Dr Ranjana, respectively.

11 The first cause of action is founded on negligence. The plaintiff claims that the doctors were negligent in not diagnosing Mdm Tan correctly in the Emergency Department and on admission to the ward. Further, the plaintiff claims that the doctors and nurses were negligent in taking Mdm Tan for a shower, and for not resuscitating her promptly. The second cause of action is founded on a failure to obtain consent from Mdm Tan when the doctors stopped her medication of aspirin, losartan and Lasix.

12 So far as the negligence in diagnosis is concerned, the plaintiff's case is that the doctors failed to realise that Mdm Tan had a type 1 myocardial infarction (an acute heart attack), when she arrived at the Emergency Department on 20 April 2018, and even when the doctors saw her in the morning of 21 April 2018, the type 1 myocardial infarction was not picked up. Mr Clarence Lun ("Mr Lun"), counsel for the plaintiff, relies on the evidence of his two experts, Dr Chong Yu Eric Silvio ("Dr Eric Chong") and Dr Lim Chong Hee ("Dr Lim"). Dr Eric Chong is a Cardiologist in private practice under the ESC Heart Clinic, and Dr Lim is a Cardiothoracic and Heart Surgeon, also in private practice with CH Lim Thoracic Cardiovascular Surgery.

13 The treating doctors of TTSH as well as its experts are unified in their view that Mdm Tan did not have a type 1 myocardial infarction on admission to the Emergency Department or on admission to the ward. They maintain that the diagnosis of sepsis from an infection of unknown source, complicated by type 2 myocardial infarction was therefore correct. The defendants' counsel, Ms Mar Seow Hwei, called Dr Yeo Khung Keong ("Dr Yeo"), a specialist in

Cardiology and a Senior Consultant in the Department of Cardiology at the National Heart Centre Singapore. Dr Yeo is of the opinion that Mdm Tan had a cardiac arrest on 23 April 2018 during her shower, but a cardiac arrest is not the same as a heart attack. A cardiac arrest might have resulted from a heart attack, but it could also have been caused by a pulmonary embolism, though there were no signs or symptoms of this from the time she arrived at the Emergency Department until her collapse. There is no definitive answer, as Mdm Tan's family declined to have an autopsy performed. On this specific point, I have no hesitation accepting Dr Yeo's evidence over that of the plaintiff's experts. I will expand on this shortly.

14 Mr Lun rests his case on Dr Eric Chong and Dr Lim's view that Mdm Tan presented with a NSTE-ACS (non-ST segment elevation acute coronary syndrome) upon admission to TTSH, or in other words, a type 1 myocardial infarction. At trial, Dr Eric Chong made reference to the "three criterias [*sic*] of clinical assessment of heart attack": symptoms such as breathlessness and diaphoresis, abnormal ECG readings and elevated troponin levels.

15 The experts are of the view that there are differences in the diagnosis and treatment of a type 1 and type 2 myocardial infarction. The experts on both sides agree that a type 1 myocardial infarction is a medical emergency which requires immediate intervention. Key signs of a type 1 myocardial infarction include shortness of breath and chest pain, as well as elevated troponin levels with significant rise and fall. On the other hand, a type 2 myocardial infarction is a secondary ischaemic cardiac injury and the degree of damage caused is very different from a type 1 myocardial injury. The defendants' experts take the position that the management of type 1 and type 2 myocardial infarction differs

significantly. In particular, they say that the treatment for type 2 myocardial infarction is to treat the underlying condition that causes the cardiac insult. In Mdm Tan's case, this would have been her sepsis of unknown source. Dr Huang Po Yu ("Dr Huang"), an Emergency Medicine specialist called by the defendants is the only doctor on the defendants' side who suggests that the label "type 2 myocardial injury" is a misnomer, and what Mdm Tan had was a "chronic myocardial injury". However, he agrees with the rest of the defendants' experts that the appropriate treatment regimen would be to treat the underlying condition, which was sepsis.

16 Mr Lun argues that Mdm Tan fulfilled the three clinical assessment criteria for a type 1 myocardial infarction, which are: symptoms such as shortness of breath, abnormal ECG readings and elevated troponin levels. First, in arguing that Mdm Tan suffered from breathlessness, Mr Lun points to a video taken of Mdm Tan on 18 April 2018, two days before she was admitted to TTSH. He argues that she was shown to be in a "distressed state of breathing" and that Mdm Tan's granddaughter showed this video to Dr Nursuhaini upon her admission to TTSH's Emergency Department. Dr Nursuhaini and Dr Ranjana testified that they were not shown any video, but are of the view that even if they had seen the video, it would not have changed their management of Mdm Tan.

17 It is undisputed that this video was taken two days prior to Mdm Tan's admission. The crucial question is whether Mdm Tan had shortness of breath when she was examined by the doctors. The doctors' evidence, supported by the clinical notes, show that Mdm Tan did not have shortness of breath at the material time. Even if the video had been shown to the doctors on 20 April 2018, it was not relevant because the doctors had direct observation of Mdm Tan's

breathing capability at the time of her admission. Second, in relation to Mdm Tan's abnormal ECGs, the evidence of the experts is that the abnormal ECGs were indicative of Mdm Tan's chronic condition, her ischaemic heart disease, which had persisted for years. There were no new or significant ECG changes. Lastly, Mdm Tan's troponin levels were elevated, though they were recorded as improving from 136 to 130 ng/L (on 21 April 2018, from 12.30am to 8.07am). Such a pattern of elevated but stable troponin levels, as the experts and medical literature explain, is consistent with a type 2 myocardial infarction, which is the defendants' case.

18 At trial, Dr Eric Chong advanced his view that the treating doctors should have ordered a whole range of tests, scans and investigations for Mdm Tan, including an echocardiogram or CT scan to conclusively confirm or rule out a myocardial infarction. But I agree with the treating doctors and the defendants' experts that these were unnecessary in the circumstances. Each test, scan and investigation carry its own risks and should not be ordered unless there are reasons to do so. From the evidence, I accept that there was no necessity to order those tests.

19 Dr Eric Chong also insisted that Mdm Tan's high calcium score suggests that a coronary angiogram should have been ordered. But Mdm Tan already had a high calcium score of 1,402.6 on her myocardial perfusion scan two years before, on 11 October 2016, a risk factor for ischaemic heart disease, which the defendant doctors had duly noted. Mdm Tan was referred to the cardiovascular management clinic in 2016, where she was offered the option of a coronary angiogram to visualise her coronary anatomy, but she declined. As Dr Yeo explained at trial, a coronary angiogram is an invasive procedure which carries many risks, including damaging a patient's kidneys. Given that Mdm Tan's

main presentation on her admission in April 2018 was sepsis, the treating doctors were right to focus on treating the sepsis, and it was not necessary for a coronary angiogram to be ordered. Her high calcium score in October 2016 also cannot possibly point to a diagnosis of type 1 myocardial infarction in April 2018.

20 The plaintiff's case that is based on an acute heart attack is not clear, and from the evidence of his two experts, and the arguments of Mr Lun, I am of the view that Mr Lun had misunderstood the medical evidence of both sides in so far as he claims that the doctors at the Emergency Department had been negligent in not recognising that Mdm Tan had a type 1 myocardial infarction. The evidence does not support a finding that Mdm Tan was having an acute heart attack on 20 April 2018. What is clear to me is that if Mdm Tan did have a heart attack on 20 April 2018, it was more likely to be a type 2 myocardial infarction.

21 I accept the evidence of the defendant expert, Dr Yeo that Mdm Tan suffered a cardiac arrest when having her shower. I accept that that cardiac arrest may not have been due to a myocardial infarction because it is equally possible that the cardiac arrest had been caused by a pulmonary embolism.

22 There were no indications that Mdm Tan had to be admitted into an Intensive Care Unit ("ICU") or a High Dependency Unit ("HDU"). Dr Ranjana was experienced enough to manage patients such as Mdm Tan. She and the defendants' experts are all of the view that at the material time, Mdm Tan was not required to be in an ICU or HDU. It is important to understand that a cardiac arrest is unpredictable, and that Mdm Tan's collapse, had it been caused by a heart attack, irrespective of whether it was a type 1 or 2 myocardial infarction,

could have occurred at anytime, anywhere – even in an ICU or HDU. That being the case, it will be unjust and wrong to criticise the defendants or the employees of TTSH for not predicting the collapse. It is incontrovertible that after Mdm Tan was treated for sepsis, she showed signs of recovery and by 23 April, she was able to sit, have her breakfast, chat with the nurses and walk unassisted to the shower room. This suggests that the TTSH doctors' approach to treating the underlying sepsis was working. There is no evidence of an impending cardiac arrest at all.

23 The defendants' experts are of the opinion that a patient in Mdm Tan's circumstances may eventually suffer a cardiac arrest, but that is not a sufficient reason to place her in the ICU or the HDU. The doctors explained that the protocol for admitting a patient to an ICU or HDU are clear, and that Mdm Tan did not require ICU or HDU care at the time as she was haemodynamically stable from her admission on 20 April 2018 until her collapse in the morning of 23 April 2018. The plaintiff's experts seem to take the view that anyone who has the underlying conditions that Mdm Tan had, ought to be placed in an ICU or HDU. That may be what doctors in private hospitals might do because when advising in excess of caution, patients are comforted in knowing that the private hospital will readily accept them so long as the ICU or HDU charges are paid. Public hospitals are required to maintain a balance between a patient's needs and the proper allocation of beds. In the ideal medical world, every patient can be admitted to an ICU or HDU just to be sure, even though there is no assurance that had that patient suffered a cardiac arrest in the ICU, she would have been saved. In this case, the evidence shows that the resuscitation efforts were performed competently.

24 So far as the claim that the defendants were negligent in not sending Mdm Tan to the ICU or HDU is concerned, we are drawn back to the basic point that Mdm Tan was correctly diagnosed as having sepsis from an unknown source. All her previous hospital admissions, and her prevailing chronic illnesses, including kidney disease and heart failure were duly noted, and excluded as warranting immediate treatment. Treating a type 2 myocardial infarction requires treating the underlying cause, which in Mdm Tan's case was sepsis, and that was within the competence of the general ward under the supervision of a Senior Consultant, Dr Ranjana. Her management of Mdm Tan has proven to be correct.

25 Mr Lun latched onto the clinical note by Dr Lee stating "Refer CVM for T2MI" and from those four words, he expanded the plaintiff's case with a full-throated argument that Mdm Tan ought to have been referred to a cardiologist, and that Dr Ranjana's decision not to do so amounted to negligence. From her affidavit of evidence-in-chief, and her responses under cross-examination, I am of the view that Dr Ranjana is a competent Senior Consultant and was fully qualified to manage Mdm Tan, even if she had a type 2 myocardial infarction. Dr Ranjana gave her evidence clearly, methodically, and exhibited a degree of professionalism under cross-examination such that I have no hesitation in accepting her evidence.

26 It is important to understand that at the material time, an acute cardiac arrest was not the problem. It was the sepsis. The evidence of the experts for the defendant fortifies my view that there was no need to refer Mdm Tan to a cardiologist or be admitted to an ICU or HDU at the time because the General Medicine department was well-placed to treat patients with a type 2 myocardial infarction. Dr Yeo also testified that referring a patient with "classical" type 2

myocardial infarction to a cardiologist would be an "unnecessary referral" as doctors in the General Medicine department are trained and qualified to manage such patients. Having evaluated the evidence of all the doctors, especially Dr Ranjana and Dr Eric Chong, I should think that if given a choice, most patients in the circumstances of Mdm Tan would have elected to be treated by Dr Ranjana. Moreover, the evidence of the defendants' experts Dr Huang, a specialist in Emergency Medicine, and Dr Kang Mei Ling ("Dr Kang"), a specialist in Internal Medicine, was unequivocal that the management of Mdm Tan by Dr Ranjana could not be faulted – whether in the diagnosis or treatment, and in not referring Mdm Tan to a cardiologist or admitting her to the ICU or HDU.

27 The second criticism of Mr Lun in so far as the first two days of Mdm Tan's admission (20 and 21 April 2018) were concerned was that the defendants were negligent in changing the medication that Mdm Tan was on. It was wrong, Mr Lun claims, to have stopped the "life-saving" aspirin, losartan, and Lasix. Dr Ranjana, supported by the defendants' three experts, is of the opinion that stopping the three medications had no bearing on Mdm Tan's eventual collapse. As Dr Kang said, by that time, Mdm Tan had a more severe condition that needed to be treated first. Mr Lun also did not present any evidence that continuing Mdm Tan on the three medications would have had the effect of preventing her collapse.

28 Mr Lun also submits that the treating doctors at TTSH failed to communicate with each other when transferring the care of the patient. He says that Dr Amanda Chong had changed the prescription of Tazocin to Augmentin and withdrew aspirin, losartan and Lasix without documenting her reasons. It seems that Mr Lun expected the doctors to communicate orally with each other

when handing over their cases. They often do, of course, but communication between doctors is often done when they read the medical notes already documented by previous physicians. It is not necessary that doctors discuss with the next doctor who takes over the care of the patient when their written plans, clerking notes, and case notes serve as sufficient communication for the next team. Moreover, as it turned out, changing the medication had no bearing on diagnosis or to Mdm Tan's collapse.

29 The second string to Mr Lun's bow on the withdrawal of Mdm Tan's medication is that the fault of the doctors lay not only in the act of withdrawing the medicine, but in doing so without the patient's consent. It is indubitably accepted that a doctor cannot commence treatment without his patient's consent, but it has never been contemplated until now that a doctor cannot stop treatment without the patient's consent. This is not because better minds had not thought of it previously, but because the cessation of medication is a strictly clinical decision; and one that exposes the doctor to negligence if he were indeed negligent in doing so — not for failing to get the patient's permission to do so. There are exceptions, as Dr Yeo testified, but they involve major treatments such as those for cancer.

30 A wrongful cessation of medication is a matter of negligence simpliciter. Or, if a doctor stops or threatens to stop medication in order to obtain payment, then it is an ethical problem for an ethics committee to investigate. It is inconceivable to expect a doctor, for example, to ask a patient if he would like a Panadol. He may have to check if the patient has any relevant allergies, but does not have a duty to ask if the patient consents to a pain-killer, an anti-inflammatory, an anti-histamine, or such other drugs, though he might tell the patient to stop taking the medication once he feels better. Conversely, if he finds

that a given medication is not working for the patient, he will stop it. Saying that he will advise the patient that he should stop using it is a polite way of telling the patient that he should stop it. If the patient refuses, the doctor is entitled to say that he will not prescribe it. He cannot be expected to prescribe a drug that he had just advised should not be used. The patient is not the clinician, but a clinician cannot be expected, as Dr Kang says, to provide a "running commentary". The idea of liability for not seeking a patient's consent to stop medication or treatment under the guise of informed consent is a solution without a problem. On the contrary, it will be the seed of big problems.

31 In any event, Dr Ranjana and her team did not merely stop the medications for Mdm Tan. They changed the antibiotics to one that has a wider coverage. The medications that were stopped were to avert acute complications. As Dr Ranjana testified, nothing is rigid, and should the situation change, the medication may be reinstated. The evidence from all sources show that Mdm Tan was being fully and carefully observed so that the medical team may move swiftly and with flexibility when needed. In the event, there was no need for adjustment so far as those medications given nor those withdrawn were concerned.

32 Although Dr Eric Chong suggests that the consent of Mdm Tan's caregivers should have been obtained for "medication changes", and that such changes should have been recorded, I do not think that the two experts, Dr Eric Chong and Dr Lim themselves, or any doctor, would ask their patients for permission to stop or change the medications they had prescribed. Furthermore, Dr Eric Chong laboured under the misunderstanding that consent may be given by a caregiver who is not a legal deputy of a person incapable of giving consent herself. Mdm Tan was alert and conscious at all times when the medications

were changed. Hence, even if any consent had to be taken, it must be from Mdm Tan herself, and not her "caregiver". It is entirely within the responsibility and competence of doctors to act in the patient's best interests when prescribing and withholding medications according to their professional judgment.

33 The plaintiff claims that it was Dr Dorai, the Consultant on-call with the Department of General Medicine on the night of 20 and 21 April 2018, who had a duty of care to advise and obtain the informed consent of Mdm Tan and her family to withhold the three medications, aspirin, losartan and Lasix from Mdm Tan. I think that the plaintiff has misunderstood the role of the consultant on-call. The on-call consultant is readily contactable during the on-call hours, and if contacted, would provide guidance to the on-call team over the telephone or to review the patient. However, as Dr Dorai was not contacted by the on-call team, he did not review the patient. There was no duty of care that arose between Dr Dorai and Mdm Tan in the present case. The plaintiff's claim against Dr Dorai has even less merit than any of his other claims.

34 The plaintiff's claim that TTSH was negligent in taking Mdm Tan for her shower is similarly without basis. First, Mr Lun submits that the hospital ought to have obeyed the family's instruction not to have Mdm Tan take her shower. The only evidence he has is the hearsay evidence of the plaintiff that Mdm Tan was old-fashioned and did not believe in having a bath or shower when ill. This is contradicted by the direct evidence of Ms Cheong who gave a clear and coherent account of how she asked Mdm Tan, and how Mdm Tan readily agreed, to have a shower on 23 April 2018. Furthermore, although Ms Cheong was not a trained nurse, assisting a patient with a shower does not require any specialised skills. It is something any of Mdm Tan's own family members could have done.

35 Finally, Mr Lun submits that TTSH was negligent in being too slow in its efforts to resuscitate Mdm Tan after her collapse. This claim is also without merit. I accept the evidence of Ms Cheong that she had responded immediately to Mdm Tan's collapse, by either pulling the call bell or opening the door to call for help. The plaintiff claims that Mdm Tan should not have been moved back to her bed. Reading the Statement of Claim (Amendment No 2) ("Statement of Claim") and the submissions of Mr Lun, one might imagine that the shower room was a great distance away from the nursing station as it is from her bed. As the evidence unfolded, with photographs, it transpires that the nursing station was just outside the shower room on its left, and Mdm Tan's bed was just outside it on its right. Indeed, they were next to the shower room.

36 The position of Mdm Tan's bed vis-à-vis the shower room supports the evidence of the hospital staff and the experts that it made better sense to move Mdm Tan back to her bed to commence resuscitation than to do so on the floor of the shower room. Crucially, immediate resuscitation in the shower was not necessary because Mdm Tan was still breathing and her airway was still intact. Moving her to the bed which was connected to crucial resuscitation equipment such as oxygen and drip stand is the correct thing to do. In any case, the shower room was not a safe location to perform resuscitation. The floor would likely have been wet, the space constrained and the room lacking in the necessary equipment. Had the staff performed resuscitation in the shower room, they may have been rightly criticised for not moving Mdm Tan to her bed first.

37 In summary, the three allegations against the defendants are woefully short of evidence, and have been methodically refuted by not just the treating doctors and nurses, but also the defendants' expert witnesses. First, Dr Eric Chong's evidence at trial that Mdm Tan had a type 1 myocardial infarction is

perplexing. It was clear that Mdm Tan was admitted on 20 April 2018 with fever as her primary complaint. She did not present with any of the hallmarks of a type 1 myocardial infarction, such as chest pain or shortness of breath, there were no new concerning ECG changes and her troponin levels were elevated, but flat. That she was suffering from a type 2 myocardial infarction upon her admission was unanimously agreed upon by all the doctors from the General Medicine department that saw her. The defendants' experts all agree that the correct approach was to treat her sepsis as the underlying source. The evidence convinces me that the diagnosis of sepsis from an unknown source was the correct diagnosis.

38 Second, in Dr Eric Chong's first affidavit dated 10 December 2020 filed in support of the plaintiff's case, he stated categorically that Mdm Tan had a type 2 myocardial infarction when she was admitted to the Emergency Department. He subsequently changed his mind and filed a supplementary affidavit dated 20 February 2021 in which he states just as categorically as he did in his first affidavit, that Mdm Tan had NSTE-ACS (non-ST segment elevation acute coronary syndrome), or a type 1 myocardial infarction. When the trial commenced, Mr Lun tried to have Dr Eric Chong's first affidavit withdrawn. I rejected this request. The defendants are entitled to subject that evidence to scrutiny. They did. And it failed the test.

39 Furthermore, it turns out that Dr Eric Chong's first affidavit was lifted almost verbatim from the affidavit of a Professor Saul Myerson ("Professor Myerson") from John Radcliffe Hospital in Oxford, England, who the plaintiff initially intended to call as an expert, but for some reason, did not. Professor Myerson took the view that Mdm Tan had a type 2 myocardial infarction. In justifying the complete change of his opinion from his first to second affidavit,

the only explanation Dr Eric Chong gave was that he had since seen fresh evidence. Although he says that this fresh evidence includes the details of Mdm Tan's admission to TTSH in January 2018 and the video of her experiencing laboured breathing, I do not think these pieces of evidence would have led to him to make a complete turnaround in his evidence. It seems to me that Dr Eric Chong had not at all applied his mind to the issues when preparing his first expert report, but instead adopted the views and words of Professor Myerson. This puts Dr Eric Chong's neutrality and independence as an expert in considerable doubt. Furthermore, the defendants' expert Dr Yeo, explains that Mdm Tan's entire clinical history, ECGs and the various laboratory results do not lead to a clinical finding that Mdm Tan had a type 1 myocardial infarction. It may also have been possible that Mdm Tan's eventual cardiac arrest was caused by a pulmonary embolism. There is no conclusive finding on this as no autopsy was done. It thus remains a plausible cause that Mdm Tan's collapse had nothing to do with the defendants' conduct. I am of the view that Dr Yeo presents the more coherent and considered view than Dr Eric Chong.

40 When a patient who has the kind of chronic ailments that beset Mdm Tan for so long dies suddenly, one might be forgiven for focussing, with hindsight, to see a connection between those ailments and the death. But what Mr Lun and his experts are doing is quite the opposite. They are saying that given Mdm Tan's conditions, the defendants ought to have been soothsayers and foresee her cardiac arrest. The coroner's report states that Mdm Tan died of ischaemic heart disease with pneumonia, which was likely the source of the sepsis. The actual cause of her cardiac arrest remains unknown as there was no autopsy, at the family's request.

41 That leaves only one more question to be answered, if it is at all answerable – how did the plaintiff's experts, especially Dr Eric Chong, come to the conclusion against the weight of the medical evidence and the evidence of facts? Strictly, a court need only find in favour of the evidence that seems more probable than the opposing one, but there are aspects of Dr Eric Chong's own evidence that renders it unreliable. We should not forget Dr Lim's evidence. But his report was brief and he gave little reasoning in it. During cross-examination, he conceded that he was asked to supplement the reports made by Dr Eric Chong. I am thus left to conclude that Dr Eric Chong was advancing, albeit far too dogmatically, to put it politely, that had he received Mdm Tan at the Emergency Department on 20 April, he would have managed her differently. I will not go so far as to say that he would have been wrong, but he is not on trial. The question is whether the management by Dr Ranjana and her team was negligent. For the reasons above, I am of the view that they were not.

42 Finally, I am obliged to address the question of damages even though it is academic, given my finding that the defendants were not negligent. This trial was not bifurcated. Hence the plaintiff had to lead evidence of the injury and damage and the amount of compensation the estate is entitled. I say estate because the Statement of Claim made no dependency claim. Mr Lun produced no evidence, only an assumption on his part, that the brief period that Mdm Tan was in coma and suffered brain and spinal injuries was the result of the acts of the defendants. The law requires evidence, not assumptions. It is true that Mdm Tan's estate would have received $15,000 for bereavement and $10,000 for funeral expenses under ss 21(4) and 22(4) of the Civil Law Act (Cap 43, 1999 Rev Ed) respectively. I should add that even these details have not been particularised in the plaintiff's Statement of Claim. Given the figures, this claim

should have been brought in the Magistrates' Court — not even the District Court. As it turned out, that does not matter as it would have failed in any court.

43 For the above reasons, I find that the plaintiff has failed to prove his case and the action must be dismissed with costs. I will hear the question of costs at a later date.

- Sgd -
Choo Han Teck
Judge of the High Court

Clarence Lun Yaodong, Cheston Ow and Renesh Boss (Fervent Chambers LLC) for the plaintiff;
Mar Seow Hwei, Lee Qiu Li and Lydia Yeow Ye Xi (Dentons Rodyk & Davidson LLP) for the defendants.