Evelyn Sharmini a/p Mariasoosay Nathan v Dr Yogaraj Ramanathan & Anor [2025] MLJU 4103

Malayan Law Journal Unreported

HIGH COURT (KUALA LUMPUR)

HAYATUL AKMAL ABDUL AZIZ J

CIVIL SUIT NO WA-22NCVC-245-04 OF 2021

21 November 2025

Karthi Kanthabalan (with Abigail Sarah Kumar) (P S Ranjan & Co) for the plaintiff.
Harikannan Ragavan (with Sathisharajah Yuvaraj) (Jayadeep Hari & Jamil) for the first defendant.
Amos Siew Yih Jhein (with Nicole Bor) (Azim Tunku Farik & Wong) for the second defendant.

Hayatul Akmal Abdul Aziz J:

JUDGMENT

INTRODUCTION

[1] The present case:

1.1 Revolves around injuries Evelyn (P) suffered following an elective abdominal surgery performed by Dr Yogaraj (D1) on 10.07.2018 at KPJ Sentosa Medical Centre (D2):

(1) P claimed that:

(a) She has had a history of endometriosis and fibroids since 2005 and underwent two prior surgeries by D1 in 2005 and 2016.

(b) In 2018, D1 had advised P on a surgical procedure without adequately informing P of alternative treatment options or the risks involved.

(c) P alleged that D1 failed to provide adequate advice and information on all treatment options and failed to warn her of material risks associated with the surgery.

(2) There was negligent treatment during the surgery, leading to bowel injuries and complications.

1.2 Occasioned by the alleged negligent treatment by D1, P suffered bowel perforations, requiring additional surgeries and prolonged recovery:

(1) She developed fistulas, requiring colostomy bags, and continues to live with unresolved complications.

(2) Her physical, mental, and social well-being has been severely impacted.

1.3 In this suit grounded on medical negligence, P premised her arguments on the Ds:

(1) Breach of duty to provide informed consent.

(2) Breach of duty to diagnose and treat appropriately.

(3) Direct and vicarious liability of D2 for organisational failures and lack of credentialing of D1.

THE CLAIM

(1) P is claiming for general damages, for pain, suffering, and loss of amenities.

(2) Aggravated Damages for the Ds' conduct.

(3) Future General Damages for future treatment, surgery, and related costs.

(4) Special Damages for medical expenses, travel, supplements, colostomy bags, and loss of earnings.

(5) Pre-Trial Damages for ongoing expenses.

(6) Costs for legal fees and out-of-pocket expenses.

(7) Interest.

[2] During the trial, the parties called the following witnesses:

P: PW1: Evelyn Sharmini d/o Mariaoosay Nathan

PW2: Dato Dr Meheshinder Singh a/l Babu Sing (Subpoena) (Colorectal Surgery Consultant)

PW3: Dr Paul Ng Hock Oon (Subpoena)

(Obstetrics & Gynaecology Consultant)

PW4: Ong Hean Choon (Subpoena)

D1: DW1: Dr Yogaraj Ramanathan

DW2: Dr Gunasegaran PT Ranjan (Subpoena - Specialist)

D2: DW3: Dr Murali Ganesalingam (Subpoena - Specialist)

DW4: Catherine Lim Tsuey Tying (CEO of D2)

SALIENT FACTS (from the cause papers):

[3] P was born on 24.11.1978, and is currently 47 years old, employed as a Senior Business Manager at Standard Chartered Bank:

3.1 It is shown that:

(1) D1 is a Consultant Obstetrician and Gynaecologist who, at the time of the incident, practised in KPJ Sentosa Specialist Hospital (D2).

(2) D2 owned and managed KPJ Sentosa Specialist Hospital (KPJ Sentosa) located at Kompleks Damai, No.36, Jalan Cemur, 50400 Kuala Lumpur.

(3) The relationship of the parties as doctor, patient, and hospital requires observance of duties of good faith and candour:

(a) To act in the best interest of P.

(b) Adequate disclosure of relevant clinical information leading up to her injuries, pre-treatment and post-treatment of her condition at D2.

(c) To enable her to make informed decisions on her condition and treatment.

3.2 **The clinical facts are as follows:**

In writing this judgment, I have also referred to various medical dictionaries for medical terms, in interpreting the medical term used, for easy reference:

(1) P had a history of undergoing a laparotomy myomectomy procedure for a uterine benign leiomyoma at Damai Service Hospital in 2005.

(Laparotomy myomectomy is a surgical procedure to remove uterine fibroids through an open incision in the abdomen. A uterine benign leiomyoma (uterine fibroid) is a non-cancerous growth (tumour) that develops in or on the wall of the uterus (womb) in women of reproductive age).

(2) In 2016, at KPJ Hospital, she underwent a laparotomy and resection of bilateral ovarian masses procedure.

(An open surgical procedure where an incision is made in the abdomen to remove growths from both ovaries).

(3) D1 performed both of these medical procedures.

(4) On 10.07.2018, P underwent several medical procedures, amongst others:

(i) Laparotomy:

(An open abdominal surgery that involves a large incision to the abdominal wall to gain access to the organs within the abdominal and pelvic cavities).

(ii) Adhesiolysis:

(It is a surgical procedure performed to remove or divide adhesions bands of scar-like tissue that can form inside the body, causing internal organs and tissues to stick together abnormally, which is a natural part of the healing process after injury, inflammation or surgery).

(iii) Enterolysis:

(Enterolysis is a specific type of adhesiolysis that focuses on releasing adhesions involving the intestines (bowel))

(iv) Left endometriotic cystectomy:

(It is a surgical procedure to remove an endometrioma (a chocolate cyst) from the left ovary).

(v) Cervical adenomyomectomy:

(The surgical removal of an adenomyoma (endometrial-like tissue grows into the muscular wall of the uterus) located within the cervix itself, or potentially a focal area of the adenomyosis that is primarily affecting the cervical region of the uterus).

D1 performed these medical procedures/operations at D2:

(i) The operation was complicated by a caecal tear (first caecal perforation):

(Caecal perforation is a serious medical emergency characterised by a hole or a tear in the wall of the cecum (first part of the large intestine).

(ii) D1 undertook primary repair of the first caecal perforation during the operation, though D2 did not credential him to perform it, unlike a Consultant General Surgeon.

(iii) P was discharged four days later on 14.07.2018.

(5) On 18.07.2018 (4 days later), P returned to D2 with complaints of bilious vomiting:

(vomits material that is distinctly yellow, green, or greenish yellow in colour due to the presence of bile, a digestive fluid produced by the liver and stored in the gall bladder, released in the small intestine to aid in the digestion and absorption of fats).

(a) There was foul-smelling infected fluid following a percutaneous drainage:

(A minimally invasive medical procedure used to drain fluid collections from various parts of the body by inserting a needle or catheter through the skin and into the fluid location, guided by imaging techniques like ultrasound or CT scans).

(b) A gastrografin study revealed an ileal perforation:

(A gastrografin study is an imaging procedure (X-rays and CT scan) that uses a water-soluble, iodine-based contrast agent to visualize and examine parts of the gastrointestinal tract. Ileal perforation is a medical emergency involving a hole or a tear in the wall of the ileum (the final and longest section of the small intestine)).

(c) Two days later, on 20.07.2018, P underwent a laparotomy and repair of the ileal perforation and another caecal perforation (second caecal perforation) that was detected inter-operatively by Consultant General Surgeon Dr Ng Soong Lek.

(6) On 28.07.2025 (8 days later), P had developed an enterocutaneous fistula (ECF) which was initially managed in D2 with wound dressing and a colostomy.

3.3 P has since been receiving treatment at the Pantai Hospital Kuala Lumpur from an Obstetrician & Gynaecologist Consultant, a Colorectal Surgeon and an Orthopaedic Surgeon. She has yet to recover from injuries suffered from the operation:

(1) She suffers and continues to suffer from her injuries.

(2) She has lost amenities of life caused by the negligence, breach of contractual obligations, statutory and other duties, including good faith and candour to act in the best interest of P by the Ds.

3.4 P particularise her allegations of negligence and breach of contractual duties as follows:

(1) The Ds failed to provide a safe, reliable and effective system

for:

(a) The management of the conditions of and the care of P and the complications arising therefrom, and ensuring that sufficient and adequate investigations and examinations were undertaken to identify the appropriate treatment options for P.

(b) Ensuring that patients with a history of previous abdominal surgeries and gynaecological diseases are screened by general surgeons to jointly manage the patient if a further abdominal surgery would be needed.

(c) Relaying clinical information from D2's healthcare workers to treating doctors, including D1.

(d) Detecting without delay errors or omissions by D2's healthcare practitioners, including D1, in the treatment and management of the P's case.

(e) Ensuring that P were given sufficient and appropriate advice and information concerning her true conditions regarding the various treatment options and the benefits and potential complications of each option, including those provided by other doctors and hospitals, to enable P to make an informed decision concerning a treatment option that is within the medical right to do.

(f) Inadequate screening of the skills and qualifications of the healthcare practitioners practising in D2, including the consultant doctors, thereby increasing the risk of medical malpractice suffered by their patients, including P.

(g) Failed to ensure that the healthcare practitioners practising at D2, including the consultant doctors, did not practise beyond their level of competence.

3.5 P particularise the injuries she suffers as follows:

(1) Caecal and ileal perforation:

(A full-thickness breach in the wall of the caecum (beginning of the large intestine or the ileum (final section of the small intestine) respectively. This allows the contents of the intestine to leak into the abdominal cavity, leading to serious complications).

(2) Pneumoperitoneum:

(The presence of free air or gas within the peritoneal cavity, which is the potential space between two layers of the membrane lining the abdominal cavity and covering the abdominal organs).

(3) Faecal peritonitis:

(A severe and life-threatening form of peritoneal inflammation, which occurs when the membrane lining the abdominal cavity and covering the abdominal organs is exposed to faecal matter (stool), introducing a massive bacterial load into a sterile environment and leading to infection, inflammation, and potentially sepsis).

(4) Enterocutaneous Fistula (ECF):

(An ECF is an abnormal connection that forms between the gastrointestinal tract (such as the stomach or intestine) and the skin. This results in the leakage of stomach or intestinal contents through an opening in the skin, which can be highly problematic due to the digestive enzymes in the fluid)

(5) Unnecessary and avoidable scars.

(6) A slow and painful convalescence (period of recovery).

(7) Aggravation of the osteoporosis from taking Lucrin injections.

(Lucrin (leuprorelin acetate) injections can have a significant effect on bone density and can worsen pre-existing osteoporosis).

(8) Emotional and mental distress.

3.6 It was alleged that the Ds' failed to act in accordance with their statutory duties as provided under the Private Healthcare Facilities and Services Act 1998 and the subsidiary legislations made thereunder regarding the provision of proper facilities and services, patient welfare and safety, staffing requirements, the recording, sharing and transmission of information, screening, investigations, diagnosis, treatment and advice, the giving of advice and information to patients, guidance and counselling regarding the likely cost and expense of the treatment and management:

(1) P avers that her injuries:

(a) Has brought about a change for the worse in her lifestyle and activities of daily living.

(b) She had lost her employment for nine months.

(c) Her employment prospects in the future are likely to be affected because of the injuries and their sequelae (a pathological condition resulting from a prior disease, injury or trauma), which she continues to suffer.

(2) P therefore claims damages for both her loss of earnings and loss of earnings capacity.

(3) P also avers that because of the injuries suffered and their sequelae, she is unlikely to be able to conceive, including with assistance. P therefore claims the cost of remedial treatment for such further injuries, including infertility and assisted reproduction.

(4) P also claims general damages for future loss and damages, including for the cost of future care and services, treatment, surveillance, management and maintenance of the colostomy and its sequelae.

(5) P also seeks to recover the value of the care and services provided by members of her family.

3.7 P also particularise the obtrusive and evasive conduct of the Ds:

(1) D1, despite being in possession of copies of the medical records, refused to disclose them and required her to seek them from D2.

(2) When P asked the Ds, under valid subsidiary legislation and the healthcare provider's duty of candour, for an explanation regarding the injury she suffered, the Ds failed to do so within the time stipulated in the legislation, whether sufficiently or at all.

[4] D1, in his defence, took the position that:

4.1 D1 denied P's claims and pleaded that at all material times all duties and obligations to the patient were undertaken in accordance with accepted medical practices and standards. He argued that he had treated P in good faith and with candour and had always acted in P's best interests while she was under his care and management. D1 will seek to rely on the medical records he prepared regarding the treatment and management of P under his care.

4.2 D1 disagreed with the events narrated by P and argued as follows:

(1) P had been his patient since 2005 and regularly consulted him on various gynaecological complaints. Sometime in 2012, P consulted D1 while he was practising in D2.

(2) On his referral sometime in 2014, P underwent psychiatric consultation and treatment under the care and management of D2's consultant psychiatrist on intimacy issues.

(3) Between 2014 and August 2017, P made several visits to the D1 clinic for consultation and treatment for various medical complications and complaints and had undergone treatment, including surgery.

(4) Throughout 2018 (March, April, and June) at P's requests, several letters (P's health declaration) were issued by D1

(5) concerning P's recurring gynaecological complications required for P's employer:

(a) On 07.06.2018, consulted D1 on having heavy and prolonged menstrual bleeding after stopping oral contraceptives. She complained of pelvic and loin pains that interfered with her work.

(b) She had not done the blood test and CT scan that D1 had advised her to do at the last visit on 23.04.2018 and was now scheduled to be carried out on 11.06.2018.

(c) On 11.06.2018, due to increasing pains, D1 was admitted for blood tests, CT scan and MRI scans:

(i) Due to P's poor fertility prognosis and the risk of recurring pain and complications, a surgical intervention was an option for treatment.

(ii) P was made fully aware of the nature of the surgery and the high possibility of surgical complications.

(iii) On 09.07.2018 P was scheduled for surgery.

(iv) P had asked D1 to discuss the planned treatment and available options with P's relative, who was also a medical doctor, to which, as a courtesy, D1 obliged.

4.3 On 12.06.2018, since her discharge, D1 received no news or visits from P until her admission for surgery on 09.07.2018:

(1) P's written consent for the surgery was obtained a day before the scheduled surgery.

(2) D1 performed a laparotomy via the middle incision on 10.07.2018 and found:

(a) Adhesions as expected, and the marked intraperitoneal adhesions over the loops of the small bowel were noted to be flimsy fibrinous adhesions.

(b) D1 also found the caecum to be adherent in the midline to the rectosigmoid, obliterating the pouch of Douglas.

(c) The adherence continued to the uterus and adnexa.

(d) D1 claimed to have supposedly requested that a general surgeon be on standby in case assistance was required (but no compelling evidence was adduced to establish this). D1 then proceeded to lyse the bowel loop adhesions using sharp dissection. The loop adhesions were freed.

(e) During the dissection of the Douglas pouch, D1 claimed to have identified a 0.5cm tear in the caecum that was immediately repaired. He argued that the repair job was well within the capability of D1 as it was small, well-defined and did not require the intervention of the standby general surgeon.

(f) D1 eventually mobilised both adnexal structures as well as adherent ovaries, which were stuck to the pelvic walls, and an endometriotic cystectomy was performed.

(g) D1 then dissected and mobilised the bladder to gain access to the left paracervical mass, which was palpable deep in the pelvis, before a complete resection of the left lateral adenomyoma was accomplished.

(h) D1 performed a thorough intracavity lavage and irrigation as a precautionary measure before closure. Confirming at the time that there were no leakage and haemostasis, the hylo barrier gel was administered.

4.4 Following the surgery, the post-operative events were as follows:

(1) On 14.07.2018, P had informed D1 that she had started to feel better and requested to be discharged, four days after the surgery.

(2) On 20.07.2018, she was rescheduled for a visit. Since D1 was familiar with P, he did not request that P execute the At Own Risk Form (AOR).

4.5 On 18.07.2018, two days before the scheduled visit on 20.7.2018, P returned to D2 complaining:

(1) Of vomiting, thirst, and a swollen leg. D1 attended to P.

(2) She was admitted and hydrated with intravenous fluids and planned for a Doppler ultrasound to exclude deep vein thrombosis.

(3) Blood test revealed an infection. Imaging studies of the abdomen and pelvis showed large ascites in loculations and small pneumoperitoneum. There was no gastric distension or ileus seen.

(4) The management of P was then taken over by D2's Consultant General Surgeon, Dr Ng Soong Lek, who had planned for a repeat laparotomy, possible bowel repair or segmented resection of the bowel.

(5) D1 did not participate in this medical procedure.

(6) On 28.07.2018, P had accidentally dislodged the abdominal drain, resulting in the development of an enterocutaneous fistula (ECF) from the surgical site. Dr Ng treated it.

(7) After her discharge, P returned and continued to consult D1 and Dr Ng for outpatient treatment up until 19.06.2019. She never expressed any dissatisfaction with her consultation and treatment at the time.

4.6 D1 asserts that P's medical complaints and conditions were assessed and evaluated through investigations, observations and clinical findings based on P's long and complex medical history:

(1) The management and care accorded to P were at all times made in accordance with the findings of the investigations, observations and clinical findings based on P's medical history and conditions after having undergone two major surgeries.

(2) P was managed and treated with the skill and care required of a medical practitioner in D1's position according to the practice accepted as reasonable by a body of medical opinion. She was always at liberty to seek a second opinion on her diagnosis, methods of treatment, and risks.

(3) D1 denies any allegation of negligence by acts or omissions, or breach of duty (statutory or otherwise) owed to P.

(4) Save for the caecal perforation intra-operatively on 10.07.2018, D1 denies being the material cause of any of P's pleaded injuries.

4.7 **D1's defence in response to D2's Notice of Contribution and Indemnity (against him):**

In denying D2's claim for contribution and indemnity, D1 argued that D2 is responsible for providing an effective system and organisational support for P's treatment and ensuring that D1 can practice without undue influence or interruption and D2 is put to strict proof of its claim for contribution and indemnity.

[5] D2, in opposing P's claim, took the position as follows:

5.1 D2 had filed a Notice of Contribution and Indemnity against D1, in the event the court holds the Ds are liable in the present claim. D2 seek to hold D1 responsible, to hold D1 liable to contribute, and to hold D2 harmless against the finding of any liability in the present suit by P against the Ds. It was argued that D1 medical practice in the premises of D2 was an independent contractor under a contract for services. P was managed and treated by D1 at all material times by D2.

5.2 In its defence to P's claim, D2 argued that:

(1) D2 asserts that its role was limited to providing medical facilities and equipment, while D1 operated as an independent contractor under a "contract for services."

(2) D2 denies all allegations of negligence, breach of statutory duties, and contractual obligations, stating that it followed appropriate systems and practices expected of a private hospital. P was at all material times informed of the risks and complications associated with the surgeries and had voluntarily provided her consent.

PARTIES ARGUMENTS

[6] I have duly examined and considered all the cause papers, materials adduced at the trial, and the parties' submissions. In support of her claim, P submitted on the backdrop events establishing a thirteen-year-long doctor-patient history between P and D1 from 2005-2018, leading to the 10.06.2018 surgery:

6.1 **2005-2015**

(1) First met D1 on 05.04.2005 at Damai Hospital to consult on a large cervical fibroid needing surgical intervention, after having been diagnosed with endometriosis at HKL six months prior.

(2) Dr Ravichandran (Gleneagles Hospital) and Dr Michael Foong (KPJ Tawakal) had advised surgical removal of the cervical fibroid.

(3) P eventually agreed to D1 performing the surgery to remove the benign growth and thereafter continued routine consultation with D1 several times in 2007 - 2016.

(4) When D1 was a resident consultant at D2, P met him in 2012 to refer an intimate issue.

(5) A routine ultrasound scan after mild post-menstrual pains revealed that P had a small right ovarian luteal cyst and a left cervical fibroid.

(6) On 08.11.2014, in consulting D1 on her anxiety attack concerning intimacy issue, P was referred to a D2 consultant psychiatrist, Dr Noor Jan, for treatment.

6.2 **2015-2017**

(1) On 16.12.2015:

(a) P met D2 for a routine gynaecological examination, and P requested a vaginal procedure to be performed to facilitate sexual intercourse, but was declined by D1, as it was deemed not required.

(b) On the complaint of continuing mild post-menstrual pain, an ultrasound scan revealed:

(i) A complex ovarian cyst on the right side (12 x 6 cm).

(ii) A luteal ovarian cyst in the left (4 x 4 cm).

(iii) But the blood test showed tumour markers were normal.

(2) She was scheduled for further imaging and blood tests.

(3) On 30.12.2015:

(a) While admitted at D2, P ultrasound scan by D1 showed the right ovarian cyst had reduced to 8 x 6 cm, while the left ovarian cyst had enlarged to 6 x 6 cm and a small fibroid.

(b) P underwent several imaging studies (including CT scans) of her abdomen, pelvis and chest area, with no feature of malignancy found.

(c) D1 advised P to undergo a laparotomy to extract a frozen section of the cysts to be sent for investigation to determine if it was cancerous. She was apprised that:

(i) If determined to be cancerous, a total abdominal hysterectomy and salpingo-oophorectomy (TAHBSO) would be undertaken.

(TAHBSO is a surgical procedure where the uterus, cervix, ovaries, and fallopian tubes are removed through an incision in the abdomen. It's a major surgery often performed to treat conditions like heavy periods, endometriosis, uterine fibroids, or cancer, or to reduce the risk of ovarian cancer).

(ii) Otherwise, a local resection of the cysts and fibroid may be undertaken.

(4) P was asked to seek a second opinion on the proposed medical procedure.

(5) On 13.01.2016, P returned to D1 for consultation, where an ultrasound scan revealed an enlargement of the right ovarian cyst to 11.3 cm with the left ovarian cyst at 8.5 cm. A surgery was scheduled by D1 for 02.02.2016.

(6) On 29.01.2016 D1 explained the surgical procedure:

(a) A laparotomy will be undertaken to inspect the ovary and the cyst visually.

(b) Subject to that observation, D1 will incise the entire ovary or just the right ovarian cyst and/or the left ovarian cyst.

(c) Freeze the sample for laboratory analysis.

(d) If it is benign, he will do a local resection of the fibroids.

(e) If it is malignant, he will undertake TAHBSO.

(7) With the Consent Form signed by P on 30.01.2016, she was ready for the scheduled surgery on 02.02.2016. Some of the findings during the almost 4 hours surgery were:

(a) Both the ovarian cysts were "densely adherent" to the small bowel (ileum), which required enterolysis (releasing the adhesions) of the small bowel. The left ovarian cyst was adherent to the ileum, the pelvic peritoneum and the pelvic side walls. The cysts ruptured during the dissection and contained haemorrhagic fluid. The cyst in question was sent to the laboratory for frozen section histopathology (cryosection) examination.

(b) The right ovarian cyst was found to have deep pelvic endometriosis (characterised by thick chocolate fluids) and was "densely adherent" to the pelvic peritoneum. The cryosection analysis revealed endometriosis and no malignancy. D1 proceeded to undertake the removal of the small fibroids, the largest measuring 1.5cm.

(c) D1 found the appendix to be retrocecal (behind the caecum). He then proceeded to release the adhesions around the appendix and thereafter removed the appendix.

(8) That part of the caecum (which the appendix was attached to) was cauterised (using heat) and ligated (tying of blood vessels to prevent bleeding). He then proceeded to undertake "pelvic toilet" and "haemostasis" (to stop the bleeders), which were "checked" and "rechecked". (d) D1 described the surgery as a "difficult surgery owing to extensive adhesions involving small bowel and pelvic organs", "bilateral adnexal cysts with distortion of pelvic organ anatomy," and "diffuse endometriosis".

(9) On 05.02.2016 P was discharged, with a scheduled follow-up consultation on 12.02.2016. She was found to have no troubling issues and started on the off-label use of oral contraceptives (Loette) given the "diffuse endometriosis" found during the surgery. At the follow-up consultation on 23.03.2016, D1 found P to be doing well and noted that she was still on follow-up treatment with the psychiatrist, Dr Noor Jan, for her intimacy issues.

(10) On 08.06.2017 follow-up consultation:

(a) D1 undertook an ultrasound scan and found a mass on the left side of the pelvis measuring 5.7 x 4.4 cm.

(b) On 11.08.2017 P is concerned about the irregular bleeding since May 2017. D1 wanted to see P on 23.03.2018.

(c) She continued to report irregular menstrual bleeding and worsening endometriosis symptoms, including back pain, abdominal cramps, and giddiness. These were affecting her ability to work.

(11) After an ultrasound scan and found that there was a mass on the left side of the pelvis measuring 4.6 x 3.5 cm, and it was cystic. A follow-up appointment was arranged in six weeks to conduct blood tests and assess cancer markers.

6.3 2018

(1) On 23.04.2018 on an ultrasound scan, D1 found that the mass on the left side of the pelvis had become smaller, measuring 3.84 x 3.2 cm.

(2) On 07.06.2018, on an ultrasound scan and found the mass on the left side of the pelvis had grown, measuring 5.43 x 3.17cm.

(3) Altered or Modified Medical Notes of D1, P alluded to unethical attempts by D1 at modifying medical notes concerning P

(i) Additional notes made after the first signature stating that D1 had discussed surgical options, which are “TAH +/-ovarian conservation”.

(ii) Next to this note, the words “—preferable as every surgery has more complications” have been added later.

(iii) The second surgical option was “Adhesiolysis, Resection of adenomyosis and endometriosis”.

(iv) Next to this note, the words “but risk of recurrence, — last surgery lots of adhesions, — bowel complications, — poor fertility prognosis” have been added later.

(v) A second signature also appears next to these added words.

6.4 It was established at the trial that:

(1) On 07.06.2018, D1 advised P to undergo the surgery, where the options given were only concerning the type of surgery; either a local resection or a “radical” surgery, in which her uterus and ovaries would be removed.

(2) D1 admitted that he did not advise P about the other viable treatment options which were available to her at the material time, that, according to DW2, Dr Gunasegaran PT Ranjan and DW3: Dr Murali Ganesalingam, all available options must be accorded to P, namely:

(a) To resort to the first-line oral hormonal medicine (which is likely to be more effective in suppressing the symptoms of endometriosis when compared to the off-label use of oral contraceptives).

(b) To take the second-line injectable hormonal medicine (which is likely to be more effective in suppressing the symptoms of endometriosis when compared to the first-line oral hormonal medicine).

(c) To seek a second opinion from another gynaecologist concerning the two surgical options that D1 had recommended; and

(d) Resume the off-label oral contraceptives.

(3) D1 also failed to inform P of the risks that were material to the surgeries that he had recommended. P had testified that she wasn’t warned of the risk of injuries to the bowel and the consequence of such injuries:

(a) The need for further remedial surgeries.

(b) The need for a colostomy and having to live with the colostomy for a substantial period.

(c) The possibility of a fistula.

(4) If duly apprised, she would not have agreed to undergo the surgery on 10.07.2018.

(5) D1 did not mention any of the risks in the consent form, which DW2: Dr Gunasegaran described as unacceptable.

(6) It was alluded to at the trial by P’s counsel that D1’s evidence that he did warn her of “bowel complications”, referred to in his outpatient notes of 07.06.2018 and the inpatient notes of 12.06.2018, appears to have been inserted later, using a different pen.

6.5 Apart from D1's failure to obtain informed consent, he is also liable for undertaking the surgery without the assistance of a general surgeon:

(1) Given her medical history, D1should have expected extensive adhesions and a complicated surgery.

(2) Despite having informed P that a general surgeon would be present to assist in the surgery, he did not arrange for one, though he had assured that a general surgeon would be present to attend to any anticipated surgical complications since KPJ Sentosa was a multi-disciplinary hospital.

(3) D1 had caused injuries to the bowel during the surgery.

(4) He had failed:

(a) In his duty of care, he attempted to repair the bowel injury himself, although he was not credentialled and privileged to do so.

(b) To examine the operated parts of the bowel to look out for other injuries, including partial injuries which could become full-blown perforations of the bowel later.

(5) P suffered full-blown perforations of her bowel some days after the surgery, which required a major surgery to repair the bowel perforations:

(a) During the immediate recovery period, P developed fistulas in her abdomen.

(b) There was a spillage of bowel content through the fistulas, which required colostomy bags to contain them.

(c) P lived with the fistulas for some months before two of the fistulas closed up spontaneously.

(d) However, the primary fistula, caused by the perforations of the bowel, remains unresolved. She continues to live with it until now, almost 7 years after the negligent surgery.

(e) P is likely to require a major abdominal surgery to "close" the fistula.

(f) P would have had a better chance of a full recovery if a general surgeon had been present at the first surgery, as D1 assured.

6.6 P alluded the Court to the Court of Appeal's decision on informed consent in **Assunta Hospital v Gan See Joe (suing as the administrator of the estate of Gan Hong Wee, deceased) & Anor and another appeal (Court of Appeal Civil Appeal No. B-02(NCvC)(W)-231 -02/2023):**

(1) A doctor has to give advice and information on all the treatment options available and the risks and benefits of each option so that the patient or the next of kin can make an informed decision and give a valid consent to the treatment option proposed.

(2) A doctor cannot make that decision for the patient on the basis that he or she knows that the treatment option recommended was the "best option" for the patient.

(3) The failure of the defendant doctor in Assunta Hospital to have offered the conservative treatment option as opposed to the surgery he had proposed and undertaken was held to be negligent.

6.7 It was highlighted by P that:

(1) Negligence:

(a) It is unrefuted that D1 failed to appropriately apprise P of conservative treatment options before proceeding with surgery. It is a trite law that amounts to medical negligence.

(b) The surgery was deemed negligent, leading to bowel injuries and subsequent complications, including fistulas and prolonged health issues. In addressing risks during the surgery, D1 did not involve a general surgeon in the procedure, despite promising P that one would be present, thereby leaving him unprepared to address problems for which he was not credentialed.

(2) Failure to Obtain Informed Consent:

(a) P was not adequately informed about the risks and alternative treatment options for the surgery.

(b) The consent form did not include material risks, which is a breach of the standard of care.

(c) D2 failed to properly credential and privilege (C&P) D2 for bowel repair procedures. The hospital is accused of breaching its non-delegable duty of care to Evelyn, as established by legal precedents.

(3) P seeks substantial compensation for the injuries and damages caused by the alleged medical negligence of D1 and the failure of D2 to fulfil its duty of care.

[7] In opposing the claim and in his defence, D1 argued as follows:

7.1 **Case Background:**

(1) P had been a patient of D1 since 2005, consulting him for various gynaecological conditions. He performed two abdominal surgeries in 2005 and 2016.

(2) In 2018, P underwent a laparotomy and resection of a pelvic/adnexal mass, during which a caecal tear occurred and was repaired by D1.

(3) Post-surgery complications included a second caecal injury, ileum injury, and enterocutaneous fistula, which P alleges were caused by negligence.

7.2 D1 took the position:

(1) Conservative Treatment:

(a) Conservative treatments were administered for 1.5 years before surgery was deemed necessary due to P's worsening condition. D1 argues that conservative treatment options were not effective for P. The Plaintiff did not testify that she would have opted for conservative treatment if offered, and this issue was not pleaded in her Statement of Claim.

(b) She did not state anywhere in her evidence that D1 should have advised further conservative treatment options. This issue was not raised at all during the P's case, because it was never part of her pleaded case to begin with

(c) D1 further argued that the advice that she has an option for Conservative Treatment is only relevant if there is evidence that P would have opted for such treatment:

Liew Sin Kiong v Dr Sharon DM Paulraj [1996] 5 MLJ 193**, HC.**

(d) D1 argued that all available evidence supports the view that P's medical condition needed the 1st Surgery and therefore the elected course of treatment was justified.

(2) Surgical Indication:

(a) The decision to perform the 1st surgery was appropriate and supported by medical experts, including P's own expert.

(b) D1 claimed that he was credentialed (however, no cogent evidence was produced), experienced, and qualified to perform the surgery and repair the bowel injury.

(c) The involvement of a general surgeon was not mandatory, as the first defendant could handle the repair.

(d) Experts confirmed that the 1st surgery was indicated and that the bowel injury repair was appropriate.

(e) The delayed bowel injuries are recognised complications of gynaecological surgeries and can occur even with a general surgeon present.

(f) The alleged tampering of medical or clinical records was not pleaded, lacks evidence, and is speculative:

(i) There are no supporting materials to back up the allegation. P failed to produce any cogent evidence to show the fabrication of the clinical notes or that the alleged alterations were made some weeks later.

(ii) It is merely speculation that questions D1's credibility without any lawful basis.

(iii) The law is trite: he who alleges must prove under sections 102 and 103 of the Evidence Act 1950.

(iv) In the circumstances, the Court should disregard it:

Airis Nurhana bt Alfian (an infant suing by her father and litigation representative Alfian bin Zainudin) v Darul Aiman Sdn Bhd & Anor [2024] 6 MLJ 552**.**

(v) The law permits late entries in medical records so long as they are made within a reasonable timeframe and reflect accurate information.

(3) Consent:

P was informed of the material risks, including bowel complications, which were explained to the plaintiff, and informed consent was obtained contrary to the arguments by P.

(4) The standby General Surgeon:

(a) Experts have given evidence that if D1 had the relevant experience to undertake the repair of the 1st Caecal Injury quickly, to reduce the risk of contamination (however, this point was not pleaded by D1). D1 had made a clinical judgment to repair the 1st Caecal injury by himself and not to involve a general surgeon.

(b) The 1st Caecal Injury can occur even if a General Surgeon was present during the 1st Surgery.

(c) P's expert confirmed that the 1st Caecal Injury was correctly identified and repaired.

(d) The 2nd Caecal and Ileum Injury has nothing to do with the 1st Caecal Injury, as it occurred at a different location, and it did not take place during the 1st surgery:

(i) It was only discovered during the 2nd surgery performed by the general surgeon, Dr Ng, to address the complications that had arisen.

(ii) The fistula only occurred after the 2nd surgery.

(iii) D1 cannot be held responsible or liable for the Caecal and Ileum injuries.

(iv) That said, D1, however, argued that there was no attempt to deflect any blame onto Dr Ng as alleged by P. D1 was merely saying that Dr Ng performed the later incision from where the fistula appeared during the 2nd surgery.

(e) To counter P's claim, D1 claimed that he had arranged for Consultant General Surgeon Dr Ng to be on standby to mitigate issues (no cogent evidence was produced to support this claim).

(5) The consent form and clinical notes

(a) D1 emphasised that his clinical notes referenced only "bowel complications", and this is sufficient, though it did not set out the conceivable risks: *Singapore Medical Council v Dr Lim Lian Arn* [2019] SGHC 172**:**

(b) D1 argued that the law does not state that Consent Forms should consist of material risks for informed consent to be deemed valid. The fact that the consent form does not specify that the risks were not explained does not mean they were not presented to the patient.

(c) It is an accepted practice that late entries are made in clinical records, so long as it is done within a reasonable time. *Cheng Shi Ying Cherissa v Khoo Chong Kiat and another* [2025] SGHC 53 held that medical notes are not intended to serve as a foolproof shield against litigation. Doctors often document their recollection of events after attending to patients, and it is unrealistic to expect contemporaneous, step-by-step entries.

7.3 P's Injuries:

(1) The 1st caecal injury was repaired during the surgery and remained intact.

(2) The 2nd caecal and ileum injuries were delayed complications, which are recognised risks of such surgeries and not due to negligence.

(3) The fistula occurred post-2nd surgery, performed by another surgeon, and is not attributable to D1.

7.4 In the circumstances, D1 concluded that P has failed to establish her claim that D1 is liable for medical negligence, and it must be dismissed with costs.

[8] In opposing the claim and in its defence, D2 argued as follows:

8.1 The case revolves around allegations of medical negligence related to surgeries performed by D1 at D2 hospital:

(1) P had undergone three surgeries performed by D1 in 2005, 2016, and 2018. The main complaint relates to the surgery on 10.07.2018, which led to complications requiring further treatment by another surgeon.

(2) P claimed negligence in D2 hospital's systems for patient care, screening of healthcare practitioners, communication, postoperative management, and informed consent.

(3) P also claimed D2 failed to act in accordance with statutory duties and misrepresented the quality of its services.

8.2 **D2 took the position:**

(1) Denying all allegations of negligence and arguing that P failed to provide evidence to substantiate her claims.

(2) D2 emphasised that D1 was an independent contractor and not an employee of the hospital.

(3) The hospital was accredited by the Malaysian Society for Quality in Health (MSQH), which ensures adherence to recognised standards of quality and safety.

(4) Adverse Inference for Missing Scanned Copies of Medical Records:

(a) P claimed that D2 withheld scanned copies of D1's clinical notes from 07.06.2018. D2 argued that the original medical records were made available for inspection twice and that the absence of scanned copies did not impede P's ability to prove clinical negligence.

(b) P alleged that KPJ Sentosa did not credential or privilege (C&P) D1 before allowing him to practice. D2 argued that the relevant C&P documents for the 2018 surgery were disclosed and that the earlier 2011 documents were irrelevant to the case.

(5) Non-Delegable Duty of Care:

(a) It did not owe a non-delegable duty of care to P since P specifically chose D1 for her treatment and was not dependent on the hospital for medical services. D2 cited the Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin & Another Appeal* [2018] 1 MLJ 685**, FC** and **Dr Hari Krishnan v Megat Noor Ishak,** to argue that the hospital is not liable under the principle of non-delegable duty of care.

(b) D2 argued that the duty to provide information and advice to P rests solely with D1, and the hospital did not breach any non-delegable duty.

(6) Vicarious Liability:

(a) D2 argued that it is not vicariously liable for D1's alleged negligence, since D1 was an independent contractor and not an employee of the hospital.

(b) P suggested the Court could avoid deciding on KPJ Sentosa's vicarious liability for D1's negligence.

(c) D2 stresses that vicarious liability does not apply since D1 was an independent contractor, not an employee.

(7) Causation:

D2 argued that P failed to prove a causal link between the alleged negligence and her injuries. P's expert did not make any adverse comments against D2.

8.3 D2 pray the Court to dismiss P's claim with costs or to allow D2's claim for indemnity against D1 if liability is established. It also asked for a fair apportionment of liability if both parties are found liable.

THE LAW ON MEDICAL NEGLIGENCE

[9] In a nutshell, the present case involves professional medical negligence, and it is trite law that since it involves a professional duty of care, the standard of negligence differs from that of a general duty of care. When it involves professional negligence, the standard of care must be adjusted to fit the occasion. The Federal Court in *Swamy v Mathews & Anor* [1968] 1 MLJ 138**, FC** ruled that a man or woman in a professional capacity is bound to exercise the skill and care of an ordinary competent practitioner in that profession, be it an accountant, a banker, a doctor, or a solicitor.

9.1 In professional negligence:

(1) Apart from the standard three requirements of (i) the duty of care was owed to the plaintiff, (ii) there was a breach of that duty, (iii) that the plaintiff suffered actual damages, there is a fourth requirement that must be pleaded and established.

(2) The (iv) requirement can be seen in *Arthur JS Hall & Co (a firm) v Simmons Barrat* [2002] 1 AC 615 where it was observed that the standard of care to be applied in professional negligence cases is similar as to any skilled professional who has to work in an environment where decisions and exercise in judgment have to be made in often difficult and time constrained circumstances.

(3) It requires that a plaintiff show that the error was one that no reasonably competent member of the relevant profession would have made. This is an essential element of protection against unjustified liabilities.

9.2 The duty of care:

To succeed in a negligence claim, the burden lies on the plaintiff to establish:

(1) That a duty of care was owed to them (this is seldom an issue in medical negligence).

(2) That the defendant has fallen below the standards expected of them (standard of care)

(3) Consequent upon the falling of those standards, the plaintiff suffered harm (causation).

(4) The damage suffered was not too remote, i.e. the plaintiff must show a connection or nexus between the defendant's negligent act and the injury sustained. In most instances, common sense is applied in establishing the connection between the two, but the key criterion is that the damage suffered must be reasonably foreseeable.

[10] Non-delegable Duty of Care:

10.1 In *Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd* [2024] 3 MLJ 66**, FC,** held:

(1) Hospitals owe a non-delegable duty of care to their patients, meaning they cannot escape liability by delegating medical services to independent contractors:

(a) The Federal Court's decision is a landmark decision in Malaysian medical negligence law, which established that private hospitals owe a non-delegable duty of care to their patients, even for the negligence of specialist doctors who are independent contractors.

(b) Siow Ching Yee (the patient, represented by his wife) as the appellant, and Columbia Asia Sdn Bhd (the hospital) as the respondent. The claim was also initially brought against the individual doctors involved:

(i) The patient was admitted to the hospital's emergency department for severe post-operative bleeding following a tonsillectomy at another hospital.

(ii) During treatment at Columbia Asia, a consultant anaesthetist (an independent contractor) was allegedly negligent during intubation, leading to a delay in resuscitation, a hypoxic event, and severe, permanent brain damage, leaving the patient in a vegetative state.

(iii) The core legal question was whether the private hospital could be held liable for the negligence of a doctor, who was an independent contractor, not a direct employee.

(iv) The hospital argued its responsibility was limited to providing facilities and equipment.

(2) Federal Court Ruling:

In a majority decision (4:1), the FC held that the hospital is jointly liable with the anaesthetist:

(a) It found that the hospital owed a personal, non-delegable duty of care to the patient who had been admitted to its emergency services.

(b) This ruling is a significant shift in the medico-legal landscape in Malaysia, moving away from the traditional defence of "independent contractor" for hospitals in such scenarios.

(c) It affirms that when a hospital assumes a positive duty of care to a patient in an emergency, it is responsible for the performance of that duty, regardless of its internal arrangements with the medical practitioners.

(d) The Federal Court also increased the total award for damages to approximately RM4.5 million, for which the hospital was held jointly liable.

(3) This duty is established if the patient is vulnerable and dependent on the hospital, there is a relationship of responsibility, the patient has no control over how the duty is performed, the hospital delegates an integral function (like treatment) to a third party, and the third party is negligent in performing that function.

(4) The Federal Court confirmed that private hospitals are responsible for ensuring patient safety and proper credentialing of consultants and cannot shift blame to independent contractors.

(5) Vicarious Liability:

(a) The courts distinguish between actual independent contractors and those in relationships akin to employment. Hospitals may be vicariously liable for doctors' acts if the relationship is sufficiently close to employment and the wrongful act is closely connected to that relationship.

(b) However, if the doctor is an actual independent contractor, the hospital may not be vicariously liable.

(6) Evidence and Causation:

(a) The law does not require scientific certainty for causation in medical negligence; common sense and the balance of probabilities are sufficient.

(b) If evidence is withheld, courts may presume it would be unfavourable to the party withholding it.

(c) The standard of care is not solely determined by expert opinion (Bolam test); courts must ensure such opinions are reasonable and logically analysed (Bolitho qualification).

[11] The Informed Consent for medical treatment:

(1) Implied Consent:

When a patient consults a doctor and, after a medical history has been taken, gets onto the couch as requested. It is implied that the patent consents to examination, and no formal or written permission is required.

(2) Express Consent:

It is required whenever any form of intervention or surgery is involved, especially when the patient is under anaesthesia. The law distinguishes between an intervention of "necessity" and an intervention of "convenience": S Mills and RAJ Spence, Clinical Practice and the Law (Butterworths: Ireland, 2002, pg.63):

(a) The Private Healthcare Facilities and Services Act 1998 (Private Hospitals and other Private Health Care Facilities) Regulations 2006 explicitly state that consent must be in writing (the Consent Form).

(b) MMC Guidelines, Consent for Treatment of Patients by Registered Medical Practitioners, 2017, s 14.:

"The MMC Guidelines on consent allow for brochures or standard forms, with an information sheet outlining any material risks to the patient. Still, it also states that "it should not be used as a substitute for informing or making sure that a patient understands the nature of and risks involved in the procedure, surgery or treatment." In addition, "the provision of such material per se will not necessarily discharge the practitioner from his legal duty."

FINDINGS

[13] It is trite in law that:

(1) The burden of proof in establishing a case is on the plaintiff. It is not the defendant's duty to disprove it. The evidentiary burden is trite that those who allege a fact are duty-bound to prove it (see s.101, 102, and 103 of the Evidence Act 1950). The Court of Appeal in *Selvaduray v Chinniah* [1939] 1 MLJ 253**, 254, CA** held:

> *"The burden of proof under* section 102 *of the Evidence Enactment is upon the person who would fail if no evidence at all were given on either side, and accordingly, the plaintiff must establish his case. If he fails to do so, it will not avail him to turn around and say that the defendant has not established his. The defendant can say it is wholly immaterial whether I prove my case or not. You have not proved yours".*

(2) I am also guided by the Court of Appeal in *Guan Teik Sdn Bhd v Hj Mohd Noor bin Hj Yakob & Ors* [2000] 4 MLJ 433**, CA** in observing that the Court must not only weigh such evidence on a balance of probabilities but must also consider the surrounding circumstances and evaluate contemporary evidence that may tend to establish the truth or otherwise of a given fact.

(3) The legal burden of proof being discharged is the acid test applied in any case. The Federal Court in *Johara Bi binti Abdul Kadir Marican v. Lawrence Lam Kwok Fou & Anor* [1981] 1 MLJ 139**, FC** ruled that it was all a matter of proof and that until and unless the plaintiff has discharged the onus on her to prove her case on a balance of probabilities, the burden did not shift to the defendant.

[14] I find that P was not given sufficient and appropriate advice and information concerning her actual conditions regarding the various treatment options and the benefits and potential complications of each option, including those provided by other doctors and hospitals, to enable P to make an informed decision concerning a treatment option.

14.1 Any failure to sufficiently inform is an imputation for causation. The law imposes on the doctor a duty to notify the patient of any significant or serious risk associated with the treatment. Lord Wolf in *Pearce v United Bristol Health Care* [1998] 48 BMLR 118 said:

> *In a case where it is being alleged that a plaintiff has been deprived of the opportunity of to make a proper decision as to what cause he or she should take in relation to treatment, it seem to me the law... that if there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course, it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she has to adopt.*

14.2 On the issue of informed consent, the Court of Appeal in **Assunta Hospital v Gan See Joe (suing as the administrator of the estate of Gan Hong Wee, deceased) & Anor and another appeal (Court of Appeal Civil Appeal No. B-02(NCvC)(W)-231-02/2023)** held:

(1) A doctor must give advice and information on all the treatment options available and the risks and benefits of each option so that the patient or the next of kin can make an informed decision and give valid consent to the treatment option proposed.

(2) A doctor cannot make that decision for the patient on the basis that he or she knows that the treatment option recommended was the "best option" for the patient.

(3) The failure of the defendant doctor in Assunta Hospital to have offered the conservative treatment option as opposed to the surgery he had proposed and undertaken was held to be negligent.

(4) The case stemmed from the death of a patient following a sinus surgery in 2014. The High Court had found both the attending ENT surgeon and the hospital liable for negligence. The Court of Appeal determined:

(a) Upheld Negligence Finding:

> The Court of Appeal largely upheld the finding of negligence against the ENT surgeon, who had proceeded with an elective surgery prematurely without waiting for antibiotic treatment to take effect or consulting other specialists, and without obtaining valid informed consent.

(b) No Vicarious Liability:

The Court of Appeal found that the High Court erred in holding the hospital vicariously liable, primarily because the consultancy agreement clearly stated that the surgeon was an independent contractor, not an employee.

(c) Breach of Non-Delegable Duty:

The Court of Appeal applied the doctrine of non-delegable duty of care (in line with the Federal Court decision in *Siow Ching Yee v Columbia Asia Sdn Bhd).* It held that the hospital had a statutory duty under the Private Healthcare Facilities and Services Act 1998 and its regulations to ensure that valid informed consent was obtained. The hospital's failure to properly discharge this duty constituted a breach of its own non-delegable duty.

(d) Indemnity:

The Court of Appeal adjusted the indemnity, ruling that the ENT surgeon was 100% liable for the hospital's liability to the deceased's estate due to the surgeon's unilateral actions and misrepresentations, which were the sole cause of the harm.

14.3 I also take cognisance of the evidence of the defence experts, both Dr Gunasegaran (DW2) and Dr Murali (DW3), who agreed that on 07.06.2018, the following treatment options were available to P:

(1) To take the first line oral hormonal medicine like Danazol to suppress the endometriosis; or

(2) To take the second line hormonal medicine like GnRH analogue injections to suppress the endometriosis; or

(3) To consider surgery, either a local resection or a TAHBSO, or

(4) To get a second opinion on the surgeries recommended by D1.

14.4 It has been satisfactorily established at the trial to tilt the evidential scale in P's favour.:

(1) D1 acknowledged that conservative treatment was an available option for P.

(2) Still, he decided that there would be no point in such an option and decided that the only option was surgery.

(3) It was also observed at the trial that D1's expert, Dr Gunasegaran, agreed that the consent form executed for the 2018 surgery was unacceptable. He agreed that the risks material to the said surgery should have been mentioned in it.

(4) It is unrefuted that the material risks of the surgery in the impugned consent form were not mentioned.

(5) The defence experts agreed that it would not be enough to tell the patient "Bowel complications". The doctor must explain the actual risks of a bowel injury, especially if it were to happen to a patient like P who already has a pre-existing condition like endometriosis.

(6) D1 was not being truthful with the integrity of the medical notes brought to his attention at the trial by P's counsel concerning the impugned operation in 2018 on P.

(7) It is established at the trial that D1 had recorded in his clinical notes on 12.06.2018 that, "may need a surgeon if bowel involvement as in previous history". P provided evidence that D1 had assured her that a general surgeon would be involved during the surgery. In such circumstances, D1's failure to have a standby general surgeon or colorectal surgeon from the start of the surgery constituted negligence, given that he was not credentialled for such a role.

(8) P's expert, Dr Ong Hean Choon (PW2), gave evidence that it would be in the interest of the patient's safety to start the surgery with the assistance of the general surgeon, so that the surgeon can first undertake the adhesiolysis, before the gynaecologist can operate on the gynaecological organs.

(9) I have also observed the evidence of:

(a) Dr Gunasegaran testified that he has not had any experience of starting a gynaecological surgery with a general surgeon but has called in a general surgeon or a urologist after the start of the surgery, to assist with either adhesiolysis or to repair any injury.

(b) Dr Murali testified that he has had experience in starting a gynaecological surgery with a general surgeon from the start. This is presumably for surgically challenging gynaecological surgeries.

(c) There is no evidence (internal referral form) tendered to establish that a general surgeon had been requested to be on standby for the 2018 operation.

(d) I agree as suggested by the counsel for P that the common theme in all three experts' approaches is "patient safety" and for a gynaecologist to operate within the "confines" of his competence. Merely saying that D1 verbally asked Dr Ng (the general surgeon) to stand by does not augur well for his demeanour and honesty to this Court.

(e) From the evidence, D1 had clearly underestimated the complexity and difficulty of the impugned surgery on P in 2018. His own expert, Dr Gunasegaran, agreed to this.

[15] In the circumstances:

15.1 As observed by the Federal Court, a man or woman in a professional capacity is bound to exercise the skill and care of an ordinary competent practitioner in that profession, be it an accountant, a banker, a doctor, or a solicitor.

15.2 The doctor's responsibility (duty of care) to his patient does not cease when the patient is no longer under the care of the said doctor. Reasonable care must be taken to ensure that the patient does not suffer any further harm that was reasonably foreseeable. The legal position in *Ng Eu Khoon v Dr Gwen Smith & 2 Ors* [1996] 2 AMR 1980 **HC;** *Chin Yoon Hiap v Ng Eu Khoon & 2 Ors* [1997] 4 AMR 4204**, CA** ruled that the case concerned the medical care of a premature infant managed in an incubator and under the care of the defendant doctor and hospital:

(1) It was known even then that excess oxygen may predispose a pre-term infant to retrolental fibroplasia and blindness, which the plaintiff finally did suffer from.

(2) The court found that the doctor's failure to advise the parents on the importance of further early and regular consultations, including that of an ophthalmologist, was a breach of duty of care.

(3) On appeal, this decision was reaffirmed by the Court of Appeal.

15.3 All things considered, grounded on the evidence at the trial, I find for the plaintiff and hold the Ds liable for P's pain and suffering:

(1) D1 failed in his duty to give proper advice and information, as he did not advise P at any time before the 10.07.2018 surgery that there were other treatment options available, especially conservative treatment options.

(2) Similarly, he failed to give proper advice when he did not appropriately apprise P of the material risks involved in the impugned surgery in 2018, including the risk of bowel injury.

(3) In the circumstances, D1 failed to obtain a valid and informed consent for the 2018 surgery.

(4) D1 failed in his duty to make a proper diagnosis and to give appropriate treatment by causing the avoidable bowel injuries and/or by failing to recognise and repair the bowel injuries during the 10.07.2018 surgery.

(5) D2 (KPJ Sentosa) is liable directly for failing to undertake any credentialling of D1 to prevent him from practising beyond his level of competence.

(6) In the circumstances, the Ds' acts and omissions had caused or materially contributed to the injuries suffered by P, and its sequela (pathological condition resulting from a prior disease, injury or trauma) which she still suffers from.

[16] D2 (KPJ Sentosa) is also liable for breach of its non-delegable duty of care owed to P, which it had delegated to D1. The Federal Court was clear in:

(1) *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal in Court of Appeal* [2018] 1 MLJ**, FC** and **in** *Dr Hari Krishnan & Anor v Megat Noor Ishak Bin Megat Ibrahim & Anor* [2018] 3 MLJ 281**, FC,** that the owner and manager of a healthcare facility can be held liable:

(a) Directly, for a breach of the non-delegable duty of care owed to its patients; and

(b) Vicariously, for the actions and omissions of its agents and employees, including independent contractors.

(2) *Siow Ching Yee (suing through his wife and litigation representative, Chau Wai Kin) v Columbia Asia Sdn Bhd* [2024] 3 MLJ 66**, FC,** that private hospitals owe a non-delegable duty of care to their patients, regardless of the private arrangement that they may have with their independent contractor doctors.

CONCLUSIONS

[17] I enter final judgment for P. I find that D1 was negligent and failed in his duty of care towards P, and he is therefore 100 % liable for the injuries, pain and suffering suffered by P. I hereby enter final judgment against D1(100%). There is no doubt that D1 has a duty of care owed to P, on the evidence, that duty had been breached when the standard practised descended below the bar expected of a medical professional, the fallen standard had caused P to suffer harm, injury and damages, and the harm suffered was not too remote and foreseeable.

17.2 I hold D2 not vicariously liable for the action of D1, grounded on the position taken by the Federal Court in *Dr Kok Choong Seng & Anor v Soo Cheng Lin & Another Appeal* [2017] 10 CLJ 529**, FC.**

DAMAGES

[18] The learned counsel for the plaintiff had prepared a Table of Damages setting out the items of damages claimed by P and the proposals made/not made by D1 and D2, respectively. I find this table to be informative and easy to follow, and I would like to record my appreciation for his effort. For convenience, I reproduce the said table with modification as and when it is necessary, as follows:

		Plaintiff	First Defendant	Second Defendant
No	**Item**	**RM**	**RM**	**RM**
1.	General Damages for pain and suffering and loss of amenities of life	450,000	180,000 to 200,000	80,000
2.	Aggravated Damages	500,000	Not entitled	Not entitled
3.	Future General Damages			
3.1	the cost of future treatment	121,000	-	-
3.2	General damages for pain and suffering and loss of amenities of life for future surgery;	50,000	-	-
3.3	the loss of earning capacity;	100,000	-	-
3.4	travel and incidental expenses;	3,150	-	-
3.5	the cost of nutritional supplements, special foods and vitamins;	25,200	-	-
3.6	the value of care provided by family members;	4,500	-	-
3.7	the cost of colostomy bags and other consumables;	-	48,048	-
	Subtotal	**303,850**	**48,048**	-
4.	**Special Damages**			
4.1	the hospital and medical expenses;	88,608-70	34,733-86	34,733-85

4.2	travel and incidental expenses;	6,600	3,000	618-80
4.3	the cost of nutritional supplements, special foods and vitamins;	6,600	Not entitled	Not entitled
4.4	the cost of colostomy bags and other consumables;	13,200	6,600	817-75
4.5	the value of care provided by family members;	66,000	Not entitled	Not entitled
4.6	the cost of Lucrin injections;	18,700	Not entitled	Not entitled
4.7	Loss of earnings;	139,650	Not entitled	Not entitled
4.8	the cost of obtaining copies of the medical records;	dropped	-	-
	Subtotal	**339,358-70**	**44,333-86**	**36,170-40**
5.	**Pre-Trial Damages**			
5.1	the hospital and medical expenses;	4,250	-	-
5.2	travel and other incidental expenses;	6,370-50	-	-
5.3	the cost of nutritional supplements, special foods and vitamins;	10,200	-	-
5.4	the cost of colostomy bags and other consumables;	15,300	-	-
5.5	the value of care provided by family members;	-	-	-
	Subtotal	**36,120-50**	**-**	**-**
6.	**Costs**			
6.1	Getting-up fee against Dr. Yogaraj;	300,000	-	-
6.2	Getting-up fee against KPJ Sentosa;	100,000	-	-
6.3	Out of pocket expenses	32,792-40	-	-
	Subtotal	**432,792-40**	**-**	**-**
	GRAND TOTAL	**2,062,121-60**	**292,381-86**	**116,170-40**

[19] The assessment of damages which amount is fair and reasonable, as follows:

(1) **General Damages:**

RM 420,000.00 for pain, suffering, and loss of amenities:

Dr Wan Himratul Azna binti Wan Harun v Dato' Dr Rohan Malek Johan & Ors [2017] 3 MLJ 82 (RM400,000); *Turkyah Abdulrahman Assiri v Dr Seri Suniza Sufian & Anor* [2014] 1 LNS 812 (400,000); *Pyu Pyu Ma v Dr Lim Soo How & Ors* [2019] 11 MLJ (RM250,000).

(2) **Aggravated Damages:**

RM 50,000.00 for D2's conduct in not providing the proper Credentialling & Privilege (C&P) of D1 for performing the surgical task he was not credentialled to conduct:

Prince Court Medical Centre v Lim Yoke Har & 3 Ors (Kuala Lumpur High Court Civil Suit No.: WA-22NCvC-397-05/2021) (RM1million); **Norfatehah Alias v The Government of Malaysia**

& Ors (Alor Setar High Court Civil Suit No. 21NCVC-21-08/2017) (RM450,000); *Ahmad Radhiq Arbee bin Ahmad Rejal Arbee (as a husband and dependant of Sharifah Shalihah bt Sayed Abdullah, deceased) & Ors v Kerajaan Malaysia & Ors* [2020] 10 MLJ 459 (RM300,000); **Assunta Hospital v Gan See Joe (suing as the administrator of the estate of Gan Hong Wee, deceased) & Anor and another appeal (Court of Appeal Civil Appeal No. B-02(NCvC)(W)-231-02/2023)** (350,000)

(3) **Future General Damages:**

(a) RM121,000.00 for the cost of future treatment:

The P receives care and sees Dr Meheshinder and Dr Paul Ng at regular intervals. During cross examination of Dr Meheshinder:

"Q: Doctor, just an estimate, if that sort of surgery, an extensive surgery that you say, is undertaken in Pantai, what would be the cost estimate for the patient, just a rough estimate.

PW2.1 think nothing short of RM100,000.00, all put together"

(b) RM30,000.00 for pain and suffering, and loss of amenities of life for the future treatment as recommended above.

(c) RM3,000.00 for travelling & other incidentals which is reasonable.

(d) Loss of earning capacity is dismissed where P agreed that there is no evidence she was terminated because she was unfit for work. P is still employed and earning more than in her previous employment.

(e) Cost of nutritional supplements, special foods and vitamins is dismissed for want of medical and other supporting evidence.

(f) The value of care provided by family members is dismissed for want of evidence.

(g) The cost of colostomy bags and other consumables is dismissed and conceded by P.

(4) **Special Damages:**

(a) RM88,018.00 for hospital and medical expenses. Total bill as claimed in the (BOD B8, Part B, pp. 3-57).

(b) RM3,000.00 for travelling & other incidental expenses (P concedes)

(c) RM9,900.00 (RM300.00 x 33 months) for costs of colostomy bags and other consumables (P concedes).

(d) RM10,000.00 for the Lucrin Injections (P concedes only for three years)

(e) Cost of nutritional supplements, special foods and vitamins is dismissed for want of medical and other supporting evidence.

(f) The value of care provided by family members is dismissed for want of evidence.

(g) Loss of earnings dismissed for want of evidence.

(h) The cost of copies of the medical records is not claimed.

(5) Claim for pre-trial damages is dismissed for want of evidence.

(6) **Costs:**

(a) RM150,000 for getting-up fees against D1.

(b) RM50,000 for getting-up fees against D2.

(c) RM32,792.40 for out-of-pocket expenses to be shared equally by the Ds.

TOTAL: RM 967,710.40

(7) **Interests:**

(a) Interest @ 4% on Special Damages from the date of the incident, 10.07.2018, to the date of this decision.

(b) Interest @ 5% on General Damages for pain and suffering, aggravated damages from the date of the service of the writ, which is 12.04.2021, to the date of this decision.

(c) Interest @ 5% on the Judgment Sum (including costs and pre-judgment interest) from the date of this decision, until its full realisation (P concedes on 5%)

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