Medical Negligence: Breaching the duty of care
***Noor Azlin Binte Abdul Rahman v Changi General Hospital Pte Ltd & others* [2019] SGCA 13**

I. Executive Summary

At the heart of *Noor Azlin Binte Abdul Rahman v Changi General Hospital Pte Ltd & others* [2019] SGCA 13 is the allegation that the three named doctors who attended to patient Noor Azlin binte Abdul Rahman ("**Ms Azlin**") at Changi General Hospital ("**CGH**") over a four-year period, as well as CGH, were negligent. Azlin argues that their negligence delayed the detection of the malignancy which resulted in her having lung cancer, and caused her to suffer the loss of a better medical outcome.

The High Court ("**HC**") found that the two Accident and Emergency ("**A&E**") department doctors who saw Ms Azlin did not breach their duty of care. Conversely, the HC found that CGH, as well as CGH specialist respiratory physician Dr Imran Bin Mohamed Noor ("**Dr Imran**") had indeed breached their respective duties of care. The HC nonetheless dismissed Ms Azlin's claim of negligence against them, as she was unable to show that their actions had resulted in her delayed diagnosis. On appeal, while the Court of Appeal ("**CA**") upheld the HC's decisions regarding the three doctors, it allowed her claim of negligence against CGH.

II. Background Facts

The patient visited CGH several times between October 2007 and December 2011 for lung-related ailments; in February 2012 she was finally diagnosed with lung cancer.

October 2007. During Ms Azlin's first visit to the A&E department, she complained of lower chest pain and shortness of breath. The doctor ordered a chest X-ray, which indicated an opacity in the *right* mid-zone of her chest. The doctor's notes also stated that she was a non-smoker. Although he diagnosed her with possible gastritis, he nonetheless referred her to CGH's specialist outpatient clinic, to review the opacity.

November 2007. When Dr Imran (a specialist respiratory physician) saw Ms Azlin, he ordered two chest X-rays. At that time, the state of technology was such that he was unable to digitally manipulate the November 2007 X-rays for size, contrast or brightness. His assessment was that the opacity appeared to be resolving or had resolved on its own. He gave Ms Azlin an open date for follow-up and advised her to return if she felt unwell.

April 2010. Ms Azlin visited CGH's A&E department again, complaining of right lower chest pain which started an hour before the consultation. Dr Yap Hsiang ("**Dr Yap**") ordered an electrocardiogram ("**ECG**") and an X-ray. The ECG showed normal readings, but the X-ray showed an opacity over the *right* mid-zone of Ms Azlin's lungs. Dr Yap then checked her medical records and retrieved the October 2007 X-ray and the November 2007 X-rays. At that time, no radiological reports had yet been made on the 2007 X-rays.[1] Comparing the 2007 X-rays with the April 2010 X-ray, Dr Yap noted that the opacity had been present since 2007, and that it appeared to be stable as its size remained more or less the same.

Given that (a) certain medical indicia were present; (b) the pain Ms Azlin complained of had only started the hour before her consultation; and (c) Ms Azlin told Dr Yap that she had consulted Dr Imran and was told she was fine, Dr Yap concluded that the opacity was an incidental finding (i.e. unrelated to Ms Azlin's presenting symptoms). Dr Yap's supervising doctor also agreed with his assessment. Dr Yap did not have Dr Imran's notes, relying only on Ms Azlin's account of what Dr Imran had told her.

[1] CGH did not have routine reporting for X-rays until 2010; a report would only be made if requested. The 2007 X-rays were finally reported in 2012.

Dr Yap prescribed painkillers and discharged Ms Azlin, and advised her to return if the symptoms persisted or worsened. Dr Yap then sent the April 2010 X-ray for reporting. The report *recommended a follow-up* to assess the stability of the opacity. However, Dr Yap never received it personally.

July 2011. Ms Azlin returned to the A&E department more than a year later, where Dr Soh Wei Wen Jason ("**Dr Soh**") attended to her. She complained of intermittent *left* lower ribcage pain that had persisted for almost one month. She was 32 years old then. Dr Soh ordered two chest X-rays focusing on the *left* side, and an ECG. The ECG showed normal readings. As Dr Soh was focused on the left chest, he did not notice the opacity in the right chest. He too, discharged her with medication and advised her to return if her symptoms worsened or persisted.

In the radiological report for the X-ray, the radiologist detected the opacity in the right mid-zone of Ms Azlin's lung, noted that it was stable, and *recommended a follow-up* of the opacity. However, Dr Soh too did not receive the report, and was hence unaware of the recommendations.

November – December 2011. Ms Azlin went to Raffles Medical Clinic, complaining of cough, breathlessness, and blood in the sputum. This persisted for three days. Her doctor then ordered a chest X-ray and noticed a lesion in the right mid-zone of the lung. The radiological report confirmed the presence of a round patch and ill-defined shadows at the mid-zone of the right lung and suggested that "this is likely to be the result of infection". Ms Azlin informed the doctor that a shadow had been pointed out to her during her July 2011 visit to CGH. The doctor then referred her to a respiratory specialist at CGH.

At CGH, Ms Azlin was seen by a different respiratory specialist than Dr Imran. That doctor's notes indicated that the lesion, which was seen in 2007, 2010, and July 2011, appeared stable in size, and that Azlin was still coughing with blood in the sputum. She was also identified as a smoker for the first time. He ordered chest X-rays and a Computed Tomography ("**CT**") scan; the scan revealed a nodule that appeared benign. A biopsy was recommended to establish a "baseline histological correlation" based on the scan and her smoking history.

February 2012. The biopsy confirmed that the nodule was malignant. Based mainly on the doctors' impressions and the biopsy, Ms Azlin was clinically staged with Stage I lung cancer.

March 2012. Ms Azlin had a lobectomy, and one-third of her right lung was removed. Pursuant to the lobectomy, she was pathologically staged with Stage IIA non-small cell lung cancer. She then underwent adjuvant chemotherapy.

August 2014. Ms Azlin suffered a relapse, when a CT scan revealed a new mass-like density in the right middle lobe. A biopsy confirmed that the cancer had progressed to Stage IV. A further examination of the tumour (removed in 2012) showed that she had been suffering from a rare type of lung cancer, known as ALK-positive lung cancer.

January 2015. Ms Azlin sued CGH, Dr Imran, Dr Yap and Dr Soh for negligence.

July 2015. Ms Azlin started on a clinical trial for her cancer until October 2016, when the cancer progressed to her brain and mediastinal lymph node. She was then taken off the trial and managed with radio surgery, chemotherapy and medication (including Ceritinib and Lorlatinib).

III. HC decision

In general, in deciding whether a doctor is liable for negligence in treating a patient, a court has to examine whether the doctor (a) has failed to meet the accepted standard of care (also known as the doctor's "**duty of care**"), and if so (b) whether that failure caused injury, damage or loss to the patient

(known as "**causation**").

With regard to the duty of care: applying the *Bolam-Bolitho* test,[2] the HC found that Dr Yap and Dr Soh did not breach their duties of care. Among other things, it found that from their perspective, the opacity was an incidental finding which was unrelated to Ms Azlin's presenting symptoms. But with regard to Dr Imran, though it was not a breach of his duty of care to have missed the opacity, he had breached his duty of care in failing to schedule a follow-up with Ms Azlin to ensure that the opacity was completely resolved. It was insufficient for him to have merely given Ms Azlin an open date to return.

Finally, the HC found that CGH had breached its duty of care for failing to send the April 2010 and July 2011 X-ray reports to Ms Azlin following her consultations, and for failing to communicate the findings of the reports to her. These should have been communicated to Ms Azlin, to enable her to decide whether to return to CGH for consultation, to seek a second opinion, or to do nothing.

Nonetheless, the HC dismissed Ms Azlin's claim, due to the lack of *causation*. The HC held that Azlin had not proven that she had cancer by July 2011 (i.e. the time of her last visit to CGH prior to her cancer diagnosis). As such, there was no delayed diagnosis of her cancer. Indeed, the HC found that Ms Azlin was diagnosed at the earliest possible stage of her cancer (being Stage I, as a Stage 0 cancer would not have been detected on an X-ray), and received the full treatment available to her at the earliest possible time.

IV. CA decision

On appeal, the CA discussed three main issues:

(a) The applicable standard of care for "pure diagnosis" cases;
(b) Whether the doctors and CGH had breached their duties of care to Azlin; and if so,
(c) If such breach of the duty of care caused loss and damage to Azlin.

A. Applicable standard of care

The CA agreed with the HC that the *Bolam-Bolitho* test was the applicable test for assessing whether CGH and the doctors had met their respective standards of care. While questions of *pure fact*, such as whether something was detected or not, could be answered without using the *Bolam-Bolitho* test, the test would still apply when what was alleged to be negligent was the doctor's diagnostic decision itself, i.e. a "*pure diagnosis*" case. This is because any subsequent diagnosis that incorporates interpretation and opinion must be measured against a reasonable standard of care, as understood by medical professionals. The issue of what CGH and the doctors ought to have done was intensely contextual and required a review of their decisions against established standards within the medical industry, including consideration of the perspectives of other reasonable doctors and what they would have done given the circumstances and the information available.

B. Whether there was a breach of duty

(i) Dr Yap and Dr Soh (A&E doctors)

The CA first explained the standard of care expected of doctors in the A&E department. This standard of care must be informed by the reality of the working conditions there. A&E wards are highly pressurised environments where time is of the essence. A&E doctors must necessarily adopt a "targeted approach", focussing on the patient's presenting symptoms and the elimination of life-threatening conditions. On the flip side, less attention would be given to incidental findings.

[2] The standard of care for a patient covers three general aspects: diagnosis; advice about possible treatments (including the risks thereof); and the actual treatment. The *Bolam-Bolitho* test, which applies to the first and third aspects, states that a doctor has met the requisite standard of care if the act complained of is supported by other respected doctors, so long as those doctors' opinion is internally consistent and logical.

This is not to say that incidental findings can be ignored; every doctor owes a duty to apply his mind to every finding, even incidental ones. And where an incidental finding needs to be treated urgently, an A&E doctor cannot simply ignore it (to treat the patient's presenting symptoms). But depending on, among other things, the characteristics of the incidental finding, whether it has been picked up before, and the patient's clinical history, the A&E doctor may merely need to refer the patient to the appropriate department for follow-up or order the necessary tests. It would then be the *hospital's* responsibility to ensure that there is a proper system in place, to ensure that tests are conducted and their results properly followed-up on. Additionally, as A&E doctors work in shifts and rotations, more often than not the A&E doctor who receives the patient will not follow through. As such, the patient would be left to rely on the system and the department as a whole.

The CA then agreed with the HC that the A&E doctors did not breach their duties of care.

Dr Yap. The CA held that Dr Yap's actions were sufficient to discharge his duty of care. He did not ignore the presence of the opacity in Ms Azlin's lung. When he saw her in April 2010, he ordered an X-ray and compared it with the 2007 X-rays. He concluded that the opacity was stable because there was no visible growth in size. He concluded that it was incidental to her presenting symptoms. He also ordered a report on the 2010 X-ray, and requested that Ms Azlin be called back if necessary.

However, the CA cautioned that the mere fact that a specialist had previously attended to a patient was not sufficient reason not to investigate further, or to conclude that no further follow-up was necessary. A patient's account that the specialist had told her "she was fine" would also not be sufficient reason not to investigate further.

Dr Soh. The CA held that Dr Soh had not breached his duty when he missed the opacity altogether. He saw Azlin on her final visit to the A&E department in July 2011, when she complained of intermittent left lower ribcage pain. He too ordered X-rays, one of which showed the opacity in her right chest. However, he missed the opacity in her right chest as he was focused on the treating the pain Ms Azlin complained of in her left chest. It was not unreasonable for him to have missed the opacity in the circumstances. As an A&E doctor, he was not expected to conduct a general health screening; his priority was to resolve the patient's presenting complaints.

(ii) Dr Imran (Respiratory specialist)

The CGH held that Dr Imran had breached his duty of care to Ms Azlin. As he was not certain if the opacity had completely resolved, he should not have discharged her *without a scheduled follow-up appointment*. As a respiratory specialist, he was the "last in line" to diagnose a lung opacity. There was no one else who would have been in a better position to conduct the necessary follow-up action. If he did not ensure that the opacity had fully resolved, no one else would.

Moreover, there would have been a stark difference in the follow-up action if the opacity had been present on the November 2007 X-rays (the protocol was a repeat patient consultation in six weeks' time). Thus, if Dr Imran was unsure if the opacity was indeed present, he ought to have taken the more cautious route of scheduling a follow-up. This would not have been too onerous an obligation to discharge.

(iii) CGH (Hospital)

The CA held that CGH also breached its duty of care to Ms Azlin. First, there was the question of whether CGH had carried out a proper follow-up on Ms Azlin's radiological reports. Radiological reports were routed back to the department which ordered it. A doctor in the department would then go through the reports and determine if a follow-up was necessary. As both the April 2010 and July 2011 radiological reports recommended that follow-up on the nodule be carried out, CGH then had to prove that it did follow-up in some way. But there was no evidence that it did so. There was also

no evidence to show that an A&E doctor reviewed the reports but decided not to recall Azlin for follow-up. The CA thus reversed the HC's findings in this regard.

Moreover, the CA found serious inadequacies in CGH's system for patient follow-up. First, it made little sense for *all* radiological reports on *incidental* findings to be routed back to the A&E department for review, even if an A&E doctor had ordered it. The A&E department operated under severe time pressure and was focused on the patient's acute condition. Instead, such reports should be routed to a specialist outpatient clinic, which was better equipped with specialised knowledge and the relative luxury of time and attention to ensure a proper follow-up.

Second, CGH's system for reviewing radiological reports was inadequate, as it did not allow for comprehensive patient management. In particular, there was no mechanism for consolidation of what was already known about the patient from different departments. Without complete information of the patient's medical history, including from visits to other CGH departments, A&E doctors could not make an informed decision on whether to accept the radiologist's recommendations.

For instance, each of Ms Azlin's A&E visits and consequent radiological reports were treated as isolated incidents. The A&E doctors also had no access to Dr Imran's clinical notes as he was from a different department; indeed, Dr Yap was forced to rely on Ms Azlin's account of her consultation with Dr Imran. However, if the A&E doctor reviewing the radiological reports had been able to check against Dr Imran's notes, it would have been obvious that the only specialist who had seen her over the past four years had mistakenly concluded that the opacity was resolving or had resolved. The A&E doctor would then conclude that the nodule was persistent and had not been properly assessed by a specialist. Under these circumstances, it would have been unreasonable to decide against a patient follow-up.

Finally, it was unsatisfactory that CGH did not have a system to properly record doctors' decisions. CGH's process for the review of radiological reports purportedly allowed two reviewing A&E doctors to both decide against the radiologist's recommendation to follow-up. However, that did not require any record of who these doctors were, or their reasons for not following the recommendation. Such a process lacked accountability by the reviewing doctors and was unacceptable. There was also no suggestion that it would be difficult for CGH to put such a system in place.

In totality, CGH's patient management system had resulted in Ms Azlin having been seen by only one respiratory specialist over a four-year period. And even though that specialist had erroneously concluded that the opacity observed on an X-ray was resolving or had resolved, the system did not alert the CGH doctors who saw the X-rays thereafter to this mistake. CGH owed a duty to ensure that it had in place a system which would allow for the proper management of each patient, including the proper follow-up of radiological results.

C. Did the breach cause Ms Azlin's loss?

To establish a claim in negligence, Azlin then also had to show that Dr Imran's and/or CGH's breach of duty caused or resulted in her injuries, damages or loss.

<u>*Dr Imran.*</u> The CA agreed with the HC that as of November 2007 (when Ms Azlin last saw Dr Imran), the nodule was more likely than not benign. As such, Ms Azlin was not suffering from lung cancer then, and thus Dr Imran's breach of duty had not caused any delay in a diagnosis of her cancer.

<u>*CGH*</u>. However, the CA disagreed with the HC's finding that the nodule was benign until July 2011 (her final CGH A&E visit). It stated that Ms Azlin had shown it was *more likely than not* that she was suffering from lung cancer then, due to: the short time period between July 2011 and March 2012 (when she had her lobectomy); and the diagnosis of stage IIA lung cancer in March 2012, pursuant

to the lobectomy.[3] Reasoning backwards, the lung cancer must have gone through Stages IA and IB in the period leading up to March 2012. And the evidence showed that while the nodule grew slowly between 2007 and 2011, the most significant increase in size occurred between April 2010 and July 2011.

The CA further held that CGH's failure to have a proper system in place, to ensure that Ms Azlin's case was appropriately followed-up on, caused a delay in diagnosing Ms Azlin with lung cancer. If it were not for the delay in diagnosis and hence treatment, the cancer would not have progressed from Stage I to Stage IIA; the nodule would not have grown; and it would not have spread.

The CA therefore reversed the HC's holding in this regard. It further ordered that the issue of loss and damage (including amount of damages for Ms Azlin) be remitted back to the HC for further assessment. The CA also stated that it would be appropriate for CGH to consider a settlement for the case. It pointed out that Ms Azlin would continue to face physical and emotional challenges as a result of her medical condition. An amicable settlement would help her achieve some sense of closure, allowing her to focus on battling her cancer and recovering as best as she could.

V. Legal Implications

There are lessons here for both doctors and hospitals. First, doctors (including A&E doctors) should be careful to follow-up on incidental findings, whether personally, or by referring the patient to the appropriate department for follow-up or ordering the necessary tests. Specialist doctors should also follow-up with patients in cases of uncertain diagnosis, given that they are best placed to resolve any uncertainties in diagnosis, and also because other doctors would rely on their diagnosis. This is especially as they are the "last in line" to diagnose problems within their speciality.

At the same time, medical professionals should take heart in the CA's statements that the issue of what the doctors ought to have done is intensely contextual and requires a review of their decisions against established standards within the medical industry. Indeed, the CA explained that the *Bolam-Bolitho* test gives due recognition to the realities that medical science would always be in a state of discovery and learning, and innovation should not be discouraged. The CA recognized that judges are not in the best position to resolve questions of genuine medical controversy that confront the medical industry, and will not prefer one body of medical opinion over another unless it has been shown to be logically indefensible.

Second, hospitals should be careful to implement comprehensive patient management systems to prevent lapses in treatment. These systems should ensure that: (a) doctors have access to all patient information within the hospital system, to guide their clinical decision-making process; (b) all decisions made by the hospital doctors are properly recorded, including the reasons for such decisions; (c) medical reports on incidental patient findings are routed to the relevant specialist outpatient clinic, to ensure proper follow-up; and (d) recommendations for patient follow-ups are indeed followed.

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[3] The CA noted that in determining if Ms Azlin had cancer in July 2011, it was irrelevant that she was clinically staged at Stage I in February 2012. This was because the clinical staging was based mainly on the doctors' impressions and a biopsy. In the interests of certainty, the CA adopted the pathological staging done after the lobectomy instead.