Eye cases that widened the vision on medical negligence

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Medical negligence law has undergone a significant transformation, shifting from a paternalistic, doctor-centred model to one emphasising patient autonomy and informed consent. Two landmark eye cases changed the law on medical negligence. The Australian case of Rogers vs. Whitaker (1992) moved the pendulum from being doctor-centric to being more patient-oriented.[1] Rogers' case was adopted in Malaysia in Foo Fio Na vs. Dr. Soo Mun & Anor [2007].[2] However, the Foo Fio Na case created some ambiguity as to whether the Rogers vs. Whitaker decision applied only on the standard of care for the disclosure of risks and advice, or whether it was applicable for diagnosis and treatment only or for both standards of care as Rogers was interpreted in Naxakis (1999)[3] This uncertainty was finally laid to rest in the Dr. Hari Krishnan & Anor vs. Megat Noor Ishak bin Megat Ibrahim & Anor appeal.[4] The latter case, also referred to as the Eye Appeal, set several new benchmarks in medical negligence law.[5] These eye cases widened the vision on medical negligence. This editorial, reviews these pivotal cases that have reshaped medical negligence law in Malaysia, highlighting their implications for clinical practice and patient rights.

Rogers vs. Whitaker

Material Facts[6]
Ms. Whitaker was almost blind in her right eye since a penetrating injury at the age of nine. She had continued to lead a substantially normal life, completing her schooling, entering the workforce, marrying, and raising a family. Forty years later, following consultation with Dr. Cohen, an Ophthalmologist, she was referred to Dr. Rogers for a surgical view. Ms. Whitaker saw Dr. Rogers only after a year. Ms. Whitaker, then aged 47, was advised to undergo surgery on the right eye, as it would, in addition to cosmetic improvement will markedly restore vision in that eye. Ms. Whitaker was concerned about any risks or complications of surgery to the right eye. The trial judge noted that Ms. Whitaker had "incessantly raised questions, including the risks of unintended or accidental interference with her good, left eye." She had even requested to cover her good eye to ensure that the wrong eye would not be operated on. Ms. Whitaker did not specifically ask whether the surgery on her right eye could affect her left eye. It was only after three weeks following the consultation that she consented to surgery.

Post-surgery, Ms. Whitaker's left eye became blind due to sympathetic ophthalmia. Many experts supported Dr. Rogers' action of not informing the risk of Sympathetic Ophthalmia during the consent process, as it was very rare, an incidence rate of only 1:14,000 or 0.007% although there was also evidence that the chance of occurrence was slightly greater when, as in this case where there had been an earlier penetrating injury to the eye operated upon.[7] Disclosure of risks was in line with the then-prevalent Bolam principle,[8] which was doctor-centric, whereby the profession decides on the standard of care for disclosure of risks, provided the decision withstands logical analysis by the courts as held in Bolitho.[9] It was a single comprehensive duty encompassing both standards of care, diagnosis and treatment, and disclosure of risks. The experts further asserted that they would only inform the patient of this risk if asked specifically about this complication.[10]

Held On appeal, the appellate court held that the Bolam/Bolitho test should only be applied as the standard of care for diagnosis and treatment. In this case, there was no alleged lack of skill in performing the surgery. The Rogers case involved disclosure of risks and advice. The courts held, "It is not for the profession to decide what is to be disclosed. It is for the patient to make his/her own decisions about his/her life." The courts held that for the patient to either accept or refuse the proposed treatment after receiving the relevant appropriate information. The patient had to decide whether sufficient information was given to him to make an informed decision. This was a landmark decision, making it mandatory for doctors to warn patients of material risks inherent in a proposed treatment. The courts held that material risks are what "a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or if the doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it, i.e., material risk should be taken into account and anything of a risky nature, is reasonable."

The Rogers eye case, established a separate and distinct standard of care for disclosure of risks, which was subjective and patient-centric. Blindness is a significant material risk, especially so as this patient had only one good eye. The patient was very apprehensive and anxious before the surgery. This is subjective as to the patient's expectations. This case highlights that, though the incidence rate is taken into account, it is the seriousness of the inherent risk that needs to be given primary importance.

Case 2: Dr. Hari Krishnan & Anor vs. Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal [2018][11]

The patient consulted an ophthalmologist in a private hospital, who diagnosed retinal detachment and advised immediate eye surgery. Following the patient's consent, he underwent eye surgery, however, due to several complications, the ophthalmologist, the anaesthetist, and

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the hospital were found to be negligent, and the court awarded MYR200,000 as general damages and an unprecedented sum of MYR1,000,000 as aggravated damages. The award of damages by the High Court was reaffirmed by the Court of Appeal. The three parties then obtained leave to appeal to the Federal Court on various questions of law.

Material Facts[11]

The Patient who sustained a giant retinal tear with detachment in the right eye was referred by a general practitioner to the Ophthalmologist, who saw the patient in a private clinic on 26.8.1999. The patient was advised to undergo immediate retinal detachment operation (1st operation), which was done in an Eye Hospital. The patient was discharged two days later on 30.8.1999, and given an appointment a week later. Subsequently, "the patient's right eye became watery, his vision was blurry, and there were tears of blood when he sneezed." Alarmed, the patient rang up the Ophthalmologist immediately, who reassured him and advised him to see him on the appointment date. Nevertheless, on 4.9.1999, unable to withstand the pain, the patient went to see the Ophthalmologist at his private clinic. On visual inspection, the Ophthalmologist confirmed that there was bleeding in the eye but reassured him and advised the patient to return on the appointment date on 7.9.1999.

On 7.9.1999, when seen at his private clinic, the patient was reassured and told that recovery would be slow and fixed the next appointment at the Hospital on 14.9.1999. When seen on the date, the patient still had complaints of continuous pain and strong pressure in his eye. Following a visual examination, the patient was told that the retina of his right eye had folded outward and that a second operation had to be done immediately. However, after the ophthalmologist performed a scan, the patient was informed that his earlier findings of the folded retina and the need for a second operation were incorrect. As such, there was no need for surgery, and another appointment was fixed on 21.9.1999.
On 21.9.1999, following an examination, the patient was informed that the retina in his right eye had folded or partially detached, and proposed an operation (2nd operation) to be done immediately. The patient requested a scan to confirm the findings because he felt that his vision had improved. However, he was informed that a scan was unnecessary as the ophthalmologist was able to confirm the findings on visual inspection, and that the improved vision was only temporary, which may subsequently worsen.

The patient consented for the 2nd operation and requested for the same anaesthesiologist who gave him anaesthesia for the 1st operation, but was told that an equally competent anaesthesiologist was on duty, would administer anaesthesia. Following surgery, the next day on 22.9.1999, the ophthalmologist informed the patient, that "some problems had occurred during the 2nd Operation." The patient had apparently regained consciousness during the operation and bucked while the ophthalmologist was strengthening the retina using a laser. As a result, "the patient suffered Supra-Choroidal Haemorrhage (SCH) with profuse bleeding in his right eye." Nevertheless, the patient was reassured he "would regain eyesight provided that the retina remained intact after the bleeding in the eye subsides." He was, however, not informed of the possibility of blindness in the right eye.

Subsequently, the patient experienced severe pain, continuous bleeding and a total loss of vision in his right eye. The patient was advised "to stay in the Hospital for seven days, and to sit in an upright position at all times so that the blood in his eye could subside." The patient was discharged on 26.9.1999. The next day, a referral letter was given to see another ophthalmologist (No. 2) of the Hospital for a second opinion on the status of the right eye. Only on reading the referral letter, the patient realised that the lens in his right eye had been removed during the 2nd Operation.

The ophthalmologist (No. 2) informed the patient that "retina in his right eye was badly uprooted with a lot of internal blood clotting." He was of the opinion that the suggestion to wash the front part of the eyes by Ophthalmologist (No. 1) would be futile. On 1.10.1999, the patient returned to consult the Ophthalmologist (No. 1). The patient was told that there was still bleeding in his eye and that a procedure needed to be performed and referred the him to another Ophthalmologist (No. 3) who upon examining the patient was of the opinion that the right eye was beyond salvaging. On the advice of Ophthalmologist (No. 2) the patient consulted an Ophthalmologist (No. 4) in Singapore who informed the patient that "right eye was badly damaged, having been drenched in blood for more than 25 days." On 15.10.1999, on the advice of ophthalmologist (No. 4) the patient underwent surgery, which included the patching of the retina and the removal of blood clots, in an attempt to salvage his vision. The efforts proved futile.

In a medical report dated 24.11.1999, the Ophthalmologist (No 1) affirmed that the patient's right eye being permanently blind due to retinal detachment, and that his left eye needs prolonged follow-up treatment. The Patient filed a medical negligence suit against the Ophthalmologist, the Anaesthetist and the Hospital alleging that the injuries and loss of vision in his right eye were caused by the negligence of all three defendants.

Decision of High Court

The High Court allowed the Patient's claim and held all three defendants liable. The courts found the Ophthalmologist and the Anaesthetist negligent in "failing to warn the patient of the risks of bucking and blindness, and in the care and management of the patient" On the issue of vicarious liability, the Court found the Hospital liable for the negligence of the Ophthalmologist and the Anaesthetist. The courts held that the "internal arrangements between Ophthalmologist and the Anaesthetist with the Hospital were exclusively within their knowledge, and that the Hospital had allowed the former two to hold themselves out as the Hospital's agents, servants or employees." Accordingly, the courts awarded damages as follows to the patient: general damages of MYR200,000.00, aggravated damages MYR1,000,000.00 and special damages MYR8,014.00

Decision of the Court of Appeal (COA)
The COA affirmed the decision of the High Court. The courts held that the Ophthalmologist was negligent in his care and management of the patient in the 2nd operation. The COA found no evidence that either the Ophthalmologist or the Anaesthetist had explained the risk of bucking to the patient. The Ophthalmologist had, "wrongly advised the patient to undergo the 2nd operation, and thereby subjected him to unnecessary risks, including the instance of bucking which led to the blindness." Further, "the operation adopted by the Ophthalmologist for the haemorrhaging, was found to be against all textbook and established clinical teachings." The COA concluded that the Anaesthetist had failed to explain the risk of bucking as he had never met the patient prior to the administration of anaesthesia. Further, "he failed in his responsibility to keep the patient anaesthetised completely, relaxed, and pain-free throughout the operation." Expert witnesses asserted that bucking could have been avoided and controlled by additional drugs. The COA considered the fact that "the muscle relaxant drug wore off as a clear indication of negligence, and held that there was clear mistiming of the top-up dose."

On the matter of vicarious liability, the COA, held that "patients present themselves at a hospital to seek treatment from that hospital". In view of the "inextricable relationship between hospitals and doctors, the Hospital's liability for the negligence of the doctors, are not absolved by pure internal arrangements." The COA elaborated, "In our view in the admission of a patient, a hospital must be regarded as giving an undertaking that it would take reasonable care to provide for his medical needs. There is an overriding and continuing duty upon a hospital as an organisation to provide services to its patients. The hospital cannot be a mere custodial institution to provide a place where medical personnel meet and treat patients. (see Ellis vs. Wallsend District Hospital [1989] 17 NSWLR 553)." The COA, held out that "the Ophthalmologist was a doctor of the Hospital, the patient paid the required fees to the Hospital. He did not have a choice as to the Anaesthetist. Further, the Hospital provided all the facilities, drugs and nurses for the operation." Based on these factors, the COA affirmed the High Court's finding of vicarious liability on the part of the Hospital.

On the issue of damages, the COA agreed with the award of damages by the High Court which had taken into account the patient's severe pain, loss of vision, nervous shock and distress, embarrassment and humiliation, deprivation of ordinary life experience, and lost promotion prospects.

The Federal Court (FC) made a few landmark decisions in the Eye appeal.
a. Preliminary objection – request for a retrial due to a non-speaking judgment
Objections were raised by the doctors and the hospital, as the lower court had given a non-speaking judgment, wherein the judge merely makes a finding without assigning reasons or clarifying why he was influenced to do so. They appealed for a retrial. The FC whilst disapproving such practices of giving non-speaking judgments, held that this does not automatically warrant a retrial, "because the party seeking the retrial has the burden of proving that there was some substantial wrong or miscarriage of justice by the trial court before such relief can be granted." The FC took cognisance of the fact that the adverse events occurred in 1999, the trial only began eight years later in 2007, and concluded in 2010. The trial lasted 23 days and involved 10 witnesses. The FC held that to order a re-trial after two decades would be unfair and would be unduly prejudicial to the party bearing the burden of proof. In such cases, where a non-speaking judgment is given, the courts held that "the appellate courts have a duty to make their own findings of fact based on the on the evidence available in the records of appeal."

b. The standard of care in medical negligence
The first question raised, was whether "it is the Bolam test or the test in the Australian case of Rogers v Whittaker [1993] 4 Med LR 79 which should be applied to the standard of care in medical negligence, following, after decision of Federal Court in Foo Fio Na vs. Dr Soo Fook Mun & Anor [2007] 1 MLJ 593, conflicting decisions of the Court of Appeal of Malaysia, conflicting decisions of the High Court in Malaysia, and the legislative changes in Australia, including the re-introduction there of a modified Bolam test." The Bolam test is effectively a paternalistic "doctors know best" test whereby the courts must accept the views of a responsible body of men skilled in the particular discipline, even if there exists another responsible body of men with a different view. The reasoning for this test was "the courts, not being medically trained, are not equipped to resolve genuine differences of opinion on matters that are beyond their expertise." The Bolam test8 was subsequently qualified in Bolitho vs. City & Hackney Health Authority,[9] which asserted that the expert opinion must be capable of withstanding logical analysis.

The eye appeal was heard along with Zulhasnimar Hasan Basri & Anor vs. Dr Kuppu Velumani P & Ors.[12] The FC clarified the position in Malaysian law, reiterating that "a distinction is to be made between diagnosis and treatment in medicine, and the duty to advise the patient of risks. The former is not within the expertise of the courts and thus cannot be resolved by the courts, whereas the latter is an issue of fact that the courts are able to determine." Thus the Bolam test, qualified in Bolitho still applies to the standard of care in medical diagnosis and treatment, while the Rogers test as adopted in in Foo Fio Na vs. Dr. Soo Fook Mun applies only to the duty of disclosure of risks associated with a procedure.[13] In the eye appeal the doctors were found to be negligent on both accounts, the standard of care for diagnosis and treatment, in addition to the standard of care for disclosure of risks and advice.

c. Aggravated damages in Medical Negligence
The second question of law posed by the three parties to the to the Federal Court was "Whether aggravating factors should be compensated for as general damages, therefore rendering a separate award of aggravated damages unnecessary, as decided by the English Court of Appeal in Richardson vs. Howie [2004][14] and explained in Michael Jones' Medical Negligence textbook."[15] In Malaysia, aggravated damages have previously been awarded as a separate head of damage in Mohd Ridzwan bin Abdul Razak vs. Asmah bt Hj Mohd Nor, in a sexual harassment case.16 The FC thus held that there was no reason to exclude this kind of damages from

being awarded in medical negligence cases which involve real injury to a person's body. Further, in defamation cases aggravated damages are lumped along with general damages and not awarded as a separate category as seen in Lim Guan Eng vs. New Straits Times Press (M) Bhd,[17] Ling Wah Press (M) Sdn Bhd & Ors vs. Tan Sri Dato Vincent Tan Chee Yioun,[18] Chin Choon v Chua Jui Meng [2005].[19] Hence, the FC concurred with the award of an unprecedented sum of MYR1,000,000 as aggravated damages. The aggravated awards are not compensatory but punitive and it looks ominous that the courts will not shy away from imposing aggravated damages in future, and these sums may keep increasing in tandem with other damages which have been extrapolating over the years.

d. Can a Hospital delegate its duty of care?

The third question of law posed by the Hospital was, "Where the doctors are qualified professionals in a private hospital and working as independent contractors by virtue of a contract between the private hospital and the doctors, can the private hospital be held vicariously liable for the sole negligence of the doctors?" The FC held that "the doctors were independent contractors and not agents, servants, or employees of the private hospital. As such, the hospital could not be vicariously liable for the doctors' negligence." Nevertheless, the FC held that the hospital was liable for breach of its non-delegable duty regarding the anaesthetic services provided to the patient. In the case of Dr. Kok Choong Seng & Anor vs. Soo Cheng Lin,[20] the FC held that "the doctrine of non-delegable duty of care as expounded by the English Supreme Court in Woodland vs. Swimming Teachers Association and others[21] could apply to private healthcare institutions. However, the court in Dr. Kok Choong Seng held that "the doctrine did not apply to the facts of that case, and the private hospital therein was not liable for the doctor's negligence." This provided the potential grounds to impose this non-delegable duty of care on private hospitals, in an appropriate case. Unlike in Dr. Kok Choong Seng, the FC in the Eye Appeal held that the Woodland test was fulfilled concerning the Anaesthetist's negligence but not the surgeon. As regards the surgeon's negligence, the FC found similarity of facts with those of Dr. Kok Choong Seng. In both cases the diagnosis and treatment of the patient's eye, including the surgery, was made between the patient and the surgeon, and the hospital had merely provided the facilities and services for the operation. Whereas the Anaesthetist was the only one on duty at the hospital on the day of the surgery. He was the one on duty to provide general anaesthesia for all operations at the hospital on that day. The patient was not provided a choice to select the Anaesthetist for his operation, though he had requested for the same Anaesthetist. "The patient had no control over how the hospital chose to provide anaesthetic services, whether by delegation to employees or otherwise; the hospital had delegated to the anaesthetist the responsibility to administer doses to the patient properly; the anaesthetist was negligent in the performance of the duty delegated to him by the hospital." The Eye Appeal is the first case that held that a non-delegable duty of care exists by a private hospital for the medical negligence of independent contractors. The FC took cognisance of the proviso in Woodland to impose liability "only to the extent where it is fair, just and reasonable." The question as to whether private hospitals, will be found to owe a non-delegable duty of care to their patients will continue to be addressed on a case-by-case basis. It is thus clear that private hospitals are not immune from being held liable for a non-delegable duty of care. We probably will see more such awards in future.

DISCUSSION

The evolution of medical negligence law in Malaysia has been significantly shaped by these two landmark cases involving ophthalmic surgery: Rogers vs. Whitaker and Dr Hari Krishnan & Anor vs. Megat Noor Ishak bin Megat Ibrahim & Anor (the "Eye Appeal").[1,4] Rogers v Whitaker (Australia, 1992) shifted the standard for risk disclosure from a doctor-centric to a patient-centric approach, holding that clinicians must inform patients of material risks that a reasonable person in the patient's position would consider significant, regardless of the risk's rarity.1 Malaysia adopted this principle in Foo Fio Na vs. Dr Soo Fook Mun & Anor, but ambiguity persisted as to whether this standard applied solely to risk disclosure or also to diagnosis and treatment.[2] This uncertainty was resolved in the Federal Court's "Eye Appeal" decision (Dr Hari Krishnan & Anor vs. Megat Noor Ishak bin Megat Ibrahim & Anor), which clarified that the Bolam/Bolitho test governs the standard of care in diagnosis and treatment, while the Rogers test applies to the duty of risk disclosure.[4] The Eye Appeal also set new benchmarks: it affirmed that aggravated damages can be awarded separately in cases of real injury, and that private hospitals may be liable for the negligence of independent contractors under the doctrine of non-delegable duty of care, particularly when patients have no choice in their care provider.

CONCLUSION

These cases have collectively enhanced patient autonomy, clarified legal standards for clinicians, and expanded institutional accountability. The evolving jurisprudence underscores the need for Malaysian healthcare professionals to prioritise transparent communication and informed consent, and for institutions to recognise their broader responsibilities in patient care.

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