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MSO Express

Contents

MALAYSIAN SOCIETY OF OPHTHALMOLOGY

Dear MSO members,

Happy New Year 2022 and a Happy Lunar New Year! How has the start of the New Year been like for you? Hopefully the Year of the Tiger will be a robust one for all and sundry.

Against the backdrop of the Covid-19 situation (now into its latest Omicron variant), it seems likely that certain adaptations done during the earlier part of the pandemic are here to stay. While we all yearn for the opportunity to have face-to-face meetings and conferences, we must also accept the reality that these events are increasingly being held virtually or in the hybrid form (small physical presence with larger virtual audience).

The MSO, as well as the various Special Interest Groups (SIGs) under the Society, have embraced this new norm by organizing various webinars, conferences and public forums. We have also used the virtual platform for the majority of our committee meetings as well as our Annual General Meeting (AGM). This year will be no different. We will be organising a series of webinars to cater to both our ordinary and associate members. We are grateful for the support by friends from the industry for this endeavor.

The AGM this year will also be held virtually, tentatively scheduled to be on March 12th, 2022. Please free up your afternoon (2pm – 6pm) to attend this important event, as we will also be having many 'firsts' events surrounding the AGM: the first Tripartite Glaucoma Webinar, the inaugural AGM of the Malaysian Glaucoma Society (MGS) and a new named lecture in honour of the late Prof Dato Dr Selvarajah Sivaguru. We are honoured to have Prof Dr Bernard Chang (President of the Royal College of Ophthalmologists, UK) as the first recipient of this award.

For our newsletter this time, we are featuring Dr Zabri Kamarudin in our Personality Focus. Our affable vitreoretinal (VR) surgeon from Hospital Selayang shares an interesting account of his early years as well as how he got into Ophthalmology and VR. Another interesting tidbit about him: do you know that he's an avid angler and a superb baker?

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In this issue, we are also excited to have on board Dr Julian Tagal, who will be contributing a series of articles regarding the medicolegal aspect of our practice in ophthalmology. In his first article, he discusses the elements of how a medical negligence claims can be successful. I suggest everyone to have a read of this article: prevention is better than cure!

Lastly, we welcome anyone who would like to contribute articles to our newsletter, whether on a one-off or regular basis. Your input is greatly appreciated!

Have a great year ahead!

DR TEH WEE MIN
Editor, MSO Express
Consultant Ophthalmologist
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SERIES OF WEBINARS PLANNED FOR 2022		
Month	**Preferred Time and Date**	**Title**
March 2022	6-12 Mar	World Glaucoma Week
	12 Mar @ 3.30pm	MSO AGM
	Sat, 26 Mar @ 3pm	DKSH – MYOSIG Webinar
April 2022	Sat, 2 Apr @ 3 pm	BOSS – New Insights from OCTA in NAMD Anterior Vitrectomy from Anterior Segment Surgeons
		Alcon – MSO Grand Ward Rounds - Neuro-Ophthalmology
		Alcon – MSO Grand Ward Rounds - Glaucoma
	Sat, 23 Apr @ 3pm	DKSH – MYOSIG Webinar - Paediatrics
May 2022		DKSH – MYOSIG Webinar
	Sat, 21 May @ 3pm	BOSS MSO Cataract Video Challenging Cases
June 2022		Alcon – MSO Grand Ward Rounds - Oculoplastic
July 2022		DKSH – MYOSIG Webinar - Glaucoma
August 2022	5-7 Aug	APGC & MSJOC
	Sat, 27 Aug	Alcon – MSO Grand Ward Rounds - Vitreoretina
September 2022		DKSH – MYOSIG Webinar - Oculoplastic
October 2022		Alcon – MSO Grand Ward Rounds - Paediatrics
November 2022		DKSH – MYOSIG Webinar – Cataract refractive/MR
December 2022	Sat, 3 Dec @ 3pm	BOSS MSO Cataract Video Festival
		Alcon – MSO Grand Ward Rounds - Cornea

PERSONALITY FOCUS: DR ZABRI KAMARUDIN—THE BACKBONE OF VR SERVICES IN MALAYSIA

Early Life and Background

I was born and raised in a small "Kampung" in Perak. I consider myself very fortunate to be accepted into a boarding school in Ipoh for my secondary school years. For my SPM, I was accepted into a federal boarding school in Klang. I was very active in co-curricular activities, being an army cadet and also part of the school's basketball team.

What Made You Choose Medicine as a Profession?

As a teen in the late 80s, I thought of pursuing my career as an army officer. However, we were going through a period of economic recession at that time and I had a change of heart.

I continued my studies in a one-year UKM Matriculation Program and I was seriously considering medicine after that. However, to do so, I need to get myself into the Science Faculty and compete for a place in the medical faculty. It was very tough competition. I tried various ways to get myself into medical school, including applying for the Ministry of Defence Scholarship for an Army Medical School in Turkey but I was unsuccessful. Thank heavens, my second-semester result was quite good, and I managed to secure a place in the UKM medical faculty. As everyone knows, medical undergraduate years are really tough, and I experienced it first-hand. I still managed to graduate on time, which is the happiest moment in my life.

Career in Ophthalmology

After graduating from medical school, I was posted to Ipoh General Hospital. Even though life during this period was daunting physically, mentally and emotionally, it was a memorable time for me as I was surrounded by good colleagues. We encouraged each other to strive for the best in each of our rotations. Nevertheless, none of the postings piqued my interest.

I was then posted to Teluk Intan Hospital as a medical officer. At that time, I was eyeing a place in the Psychiatry Department. Alas, the department was fully occupied and the Hospital Director offered me a place in the Ophthalmology Department instead as an attachment. This turned out to be a blessing in disguise, as it sparked my interest in this field. However, it was not easy for me, because I struggled to examine the fundus even during my medical school years and there was a lot more to learn compared to what was taught in medical school. I was initially unsure of taking up this challenge, but dived into it anyway.

Once I was in the Ophthalmology unit, I started to use the binocular indirect ophthalmoscope, and a whole new world opened up for me. It was a real eye-opener, literally. During that moment, I made up my mind to pursue Ophthalmology and I never looked back.

I then proceeded with my Masters in Ophthalmology in USM Kubang Kerian and graduated in four years. Before long, I was posted to Kuching Hospital as a Junior Ophthalmologist. There were not many Ophthalmologists in Kuching at that time, and none of us had any sub-specialty training. I was a general ophthalmologist that had to learn and perform all sorts of surgery, including trabeculectomy, dacryocystorhinostomy, squint surgery, and even corneal transplant. However, one aspect that frustrated me most was when patients needed vitrectomy surgery. I felt helpless, not knowing where or who to refer to, and clueless on what I could do to help my patients. It was then that I told myself, I must do Vitreoretinal subspecialty.

Journey in Vitreoretinal Training

I was back to Peninsular Malaysia Teluk Intan Hospital after spending two years in Sarawak. I was tasked with heading the Ophthalmology Department at that time. Clinically, the same feeling of helplessness resurfaced when faced with patients with vitreoretinal conditions. At

Dr Zabri (centre) celebrating a significant milestone of Hospital Selayang's 2000th VR surgery in year 2016 with fellows and OT staff. That is about 6 VR surgeries per day, every day for the entire year!

that time, the only hospital that accepted VR referrals was Hospital Selayang. I then applied for the VR Training Program and requested to be posted to Ipoh, as I wanted to serve my home state. In the 1st year, I was trained in Alor Setar Hospital by experienced mentors and teachers.

After six months in Alor Setar, Dr Mariam (who was the Head of Service) transferred me to Hospital Selayang. I did ask her: what was her plan for me? And I remembered clearly her concise answer – she wanted me to fill the gap and eventually head the VR services later. Time has proved her right. I was a bit stressed up initially, knowing how strict Dr. Mariam is, but in the end, I am very grateful as I was trained by many experienced teachers and was exposed to all sorts of tough cases in Selayang as it was the national VR referral centre.

What are the Challenges in your Current Practice?

Working in the Surgical Retina field in general and running the National Referral Centre specifically is tough. It is well-known that our VR operation list was always described as a 'no sunset' list. But I have been fortunate to work with good colleagues who are also great surgeons and staff who are understanding of the demands required of them. They (doctors and staff) have been excellent and helpful companions, and as time goes by, you would probably regard them like family, as I have with mine.

People come and go, and such is the situation with the VR surgeons in civil service. The burden of disease (and the work) increases by the year.

We have started visiting other hospitals to offer our VR services so that we reach out to the patients instead of them coming all the way to us. In this way, our services are more accessible, and we get to decongest the situation in Selayang.

What is your view on the future of Vitreoretinal Service in Malaysia?

My hope is that when young VR surgeons complete their training and are sent out to serve, most states in Malaysia will have at least one VR surgeon. My ultimate goal is for everyone, whoever they may be and wherever they are, to be able to access vitreoretinal services without delay and get treatment so that we can restore or at least preserve their vision. It is not an easy task, but as the saying goes, "When the going gets tough, the tough get going". Another favourite quote of mine was inspired by an Iban warrior who once said, 'Agi Idup, Agi Ngelaban' (loosely translated to "as long as I live, I will continue to fight").

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International Specialist Eye Centre (ISEC)

A BRIEF OVERVIEW OF THE ELEMENTS TO SUCCEED IN A CLAIM OF CLINICAL NEGLIGENCE AND THE MALAYSIAN LEGAL POSITION—AN EXAMINATION OF RECENT DECISIONS INVOLVING OPHTHALMOLOGISTS

Clinical litigation is a subset of a body of law known as *Tort Law*. The word 'tort' has its origins in Latin, meaning 'twisted' or 'wrong'. Tort law is concerned with providing compensation to claimants who have suffered an injury due to the negligence of another. This restitution often takes a monetary form, or *damages.*

What is the relevant law governing clinical litigation in Malaysia?

There are two sources of law governing clinical litigation –

(1) Written Law, also known as statute, and
(2) court developed law, or common law.

The relevant statute in Malaysia includes the Civil Law Act 1956 that provides for the application of United Kingdom (U.K.) common law in West Malaysia, Sabah and Sarawak[1], hence the frequent application of U.K. judicial decisions by our judiciary. The time window to file a suit is limited by the Limitation Act 1953[2](West Malaysia) that limits the initiation of a claim to 6 years from the date the alleged negligence took place. This time limit is different in Sarawak, where the window is limited to 3 years[3]. This limitation has implications for certain types of negligence. For example, a doctor's failure to diagnose glaucoma may not be suspected until significant visual loss has occurred, which by that time may have exceeded the limitation period.

Common law in Malaysia is the second source of legal rules, according to the concept of '*stare decisis'* or '*stand by what is decided'.* This means that factually similar cases must follow a court decision or legal rule formulated or applied by a higher court.

How does one succeed in a claim of medical negligence?

For a plaintiff to succeed in a medical negligence claim, they bear the burden of proof to demonstrate three elements[4].

1. That the defendant owed them a Duty of Care
2. That in the course of disclosure, diagnosis and treatment, the defendant had breached the expected Standard of Care (SOC)
3. That the breach had caused in an injury

Duty of Care

In general, once a hospital or individual doctor undertakes a patient's care, responsibility for a patient or a 'duty of care' exists.

Standard of Care

The SOC concerns the 'level' or 'quality' of the care that can be reasonably expected from the attending doctor when managing a patient. But how do the courts decide what the standard is concerning examination, diagnosis and treatment?

In 1957 the U.K court formulated the *Bolam*[5] test holding that 'a doctor is not negligent if his actions were in keeping with a practice deemed proper by a responsible body of medical men despite there being an alternate view'[6]. In *Bolam,* the plaintiff was advised by his psychiatrist to undergo electro-convulsive therapy (ECT). He was neither warned about the risk of fractures, given relaxing drugs or restrained during treatment. During treatment, he suffered spasms and hip fractures. The issue at trial was whether the defendant was negligent for not disclosing risks and for not restraining the plaintiff during treatment. At the time, there were two schools of thought that differed regarding the need to warn and the need for restraints. The sitting judge decided that there should be allowances for difference of opinion in medical care and that a doctor should not be held negligent just because there were others who disagreed with him or her.

The *Bolam* test was subsequently applied in a series of high-profile cases in the 1980s involving

[1] Civil Law Act 1956 Section3
[2] Limitation Act 1953 Section 6(1)(a)
[3] Sarawak Limitation Ordinance (Sarawak Cap. 49)
[4] Jonathan Herring, Medical Law and Ethics (8th Edition Oxford University Press, 2020)
[5] [1957] 1 WLR 582
[6] MacNair J at para.

allegations of negligent treatment[7]. The test received widespread criticism that it allowed the medical fraternity to self-litigate its members out of allegations of negligence for as long as the defendant could produce a witness who agreed with their content of disclosure or conduct, application of the test would clear them of any wrongdoings.

A turning point came in 1997 with the formulation of the *Bolitho*[8] clause that required defendants to demonstrate that their conduct was not only in keeping with that of their peers but was also logically defensible. The plaintiff's 2-year-old son Patrick, was admitted in January 1984 with acute croup. He suffered episodes of respiratory distress in the ward, from which he recovered well. Despite being paged for, the senior houseman (SHO) never attended the child. He acutely deteriorated and collapsed, suffering cardiac arrest. At trial the SHO argued that even had she seen the child, she would not have intubated him. Expert witnesses for the defence agreed, testifying that because the child had been well between episodes, the risk of respiratory failure was low and that intubation was not without risks. The House of Lords considered the facts and held that although the SHO was negligent in failing to attend the child, she had not caused the child's death as a decision not to intubate was both in keeping with a 'responsible body of professional opinion espoused by distinguished and truthful experts' and that the view they held was capable of being logically supported, in that they had 'directed their minds to the question of comparative risks and benefits and had reached a defensible conclusion on the matter.

With *Bolitho*, the test for negligence was now a two-step test, first, whether the doctor had acted in accordance with a 'responsible body of medical men' and second, if the plaintiff can prove that this course of action was logically indefensible.

In assessing whether a defendant's conduct is acceptable by one's peers but also logically defensible, the U.K. courts currently regularly apply the *Bolam/Bolitho* test with the assistance of expert witnesses, clinical practice guidelines formulated both by NICE[9] and the various Royal Colleges[10]. As long as one's conduct is found to be 'reasonable'[11], the court has been reluctant to readily hold that one has fallen below the expected standard.

Various other tests regarding the duty to disclose risks have been formulated and are beyond the scope of this article.

Causation

Once the standard of care has been breached, the claimant still has to prove that there is a causal link between the negligent act or omission and the injury. In general, the courts apply the 'but for' test, which asks whether the injury suffered would not have happened 'but for' the negligence. The standard of proof requires the claimant to show on the balance of probabilities (i.e >50% or more likely than not) that the injury would not have occurred in the absence of the negligence. The 'but for test is a difficult hurdle for a claimant to clear as an injury may be an inevitable, natural consequence of a disease process[12], or may be caused by multiple risk factors, only one of which is the negligent act[13]. The 'but for' test may seem unjust for claimants who have been otherwise wronged but cannot clear the legal hurdle the test represents. The courts have, at different times, formulated various other tests to lessen the burden of causation. In general, however, the 'but for' test still applies.

[7] Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634 involved allegations of negligence in performing a premature mediastinoscopy leading to nerve damage; Whitehouse v Jordan [1980] 1 ALL ER 650 involved allegations of unnecessarily rough forceps delivery causing brain damage

[8] Bolitho v Hackney City Health Authority [1997] UKHL 46

[9] National Institute of Clinical Excellence

[10] Ash Samanta, 'The role of clinical guidelines in medical negligence litigation: A shift from the Bolam standard.' (2006), (14), Medical Law Review, 321

[11] In C v North Cumbria University Hospitals NHS Trust [2014] EWHC 61 (Q.B.) the judge held that the defendant's conduct did not have to be 'more reasonable' than that of the alternative that the claimant put forth, but whether the conduct put forth by the claimant was 'the only reasonable one.'

[12] Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428 Although the defendant's failure to attend to the plaintiff who eventually died of arsenic poisoning was held to be negligence, no liability was established due to the poisoning being too advanced for any treatment to have had made a difference.

[13] In Wilsher v Essex County Health Authority [1988] AC 174 the court held that although the defendants were negligent in failing to diagnose an improperly sited umbilical catheter, leading to oxygen supersaturation of a premature neonate who subsequently developed retinopathy of prematurity (ROP) and blindness, the 'but for' test was not satisfied as the negligence was but one of five present risk factors that could have caused the ROP

The Malaysian Legal Position

The current position of Malaysian law is that the *Bolam/Bolitho* tests still applies to allegations of negligence in diagnosis and treatment. The Court of Appeal took this legal position in *Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim*[14] in finding, after examining literature and expert witness statements, that the defendant had adopted an indefensible approach in managing a suprachoroidal haemorrhage during surgery, thus failing the *Bolam* test. The Court of Appeal's decision was approved by the Federal Court.

As regards causation, the 'but for' test is still applied by the Malaysian courts.

In *Lai Ping v Dr Lim Tye Ling & Ors*[15] the claimant, who presented with endogenous endophthalmitis, alleged that the defendant was negligent in delaying intravitreal antibiotics that led her to lose her vision. The court decided that there was no negligence by the doctor as expert witnesses agreed, with reference to clinical guidelines and experience that it was reasonable and defensible (*Bolam/Bolitho* test satisfied) to withhold injections until the inflammation and swelling had subsided. The court considered the question of causation and held that even if the defendant had been found negligent, the 'but for' test was not satisfied as expert witnesses from both parties agreed that endogenous endophthalmitis would likely result in visual loss regardless of treatment measures[16]. Therefore, on the balance of probability, a delay in intravitreal antibiotics was unlikely to have caused the visual loss (but for test not satisfied).

Conclusion

Generally, the Malaysian legal position is that the *Bolam* and 'but for' tests are applicable to allegations of negligence in treatment and causation subject to the qualifications as decided by the House of Lords in *Bolitho*. The courts are able to assess whether conduct approximates best practice by way of assistance from expert evidence, up-to-date clinical practice guidelines and literature. Clinicians should wisely adhere to established techniques, recommendations, and up-to-date clinical practice guidelines to maintain acceptable, defensible standards of care.

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YB SENATOR ROBERT LAU HUI YEW is a Sarawak State senator and founder of Messrs Stephen Robert and Wong Advocates.

[14] [2018] 1 AMR paras 79-81 of judgement
[15] [2014] 3 AMR
[16] Ibid at para 55-56