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

[2025] SGHC 53

Originating Claim No 235 of 2023

Between

Cheng Shi Ying Cherissa

… *Claimant*

And

(1) Khoo Chong Kiat
(2) Royal Clinics of O&G Pte Ltd

… *Defendants*

JUDGMENT

[Professions — Medical profession and practice — Liability]
[Tort — Negligence — Breach of duty]

Cheng Shi Ying Cherissa
v
Khoo Chong Kiat and another

[2025] SGHC 53

General Division of the High Court — Originating Claim No 235 of 2023
Choo Han Teck J
4–7 and 11–14 February 2025, 17 March 2025

3 April 2025 Judgment reserved.

Choo Han Teck J:

1 Ms Cheng Shi Ying Cherissa ("Ms Cheng") is 32 years old. She was working as a Marketing & Communications Executive in a funeral and undertaking business that was founded by her father-in-law. In September 2019 when she was pregnant, she consulted the first defendant, Dr Khoo Chong Kiat ("Dr Khoo"). Dr Khoo is a 51-year-old senior consultant obstetrician and gynaecologist practising under the name and style of "CK Khoo Clinic for Women & Laparoscopy". The second defendant, Royal Clinics of O&G Pte Ltd, is the company that formally employed Dr Khoo. This was Ms Cheng's first pregnancy. She had ten consultations with Dr Khoo between September 2019 and April 2020.

2 On 2 May 2020 around 12.05am, she was admitted to Mount Elizabeth Novena Hospital to begin induction of labour. A nurse inserted a medication known as "Cervidil" into Ms Cheng's vagina to soften the cervix in preparation

for birth. A nurse performed a vaginal examination at 4pm and found that Ms Cheng's cervix was still closed. At 9pm, Dr Khoo examined Ms Cheng and performed a cervical sweep, which refers to an obstetric practice of stretching the cervix with the doctor's fingers to induce labour. Ms Cheng claims to be unaware of the procedure, but nothing turns on this. Her cervix dilated to 3cm after the cervical sweep, and Dr Khoo performed an artificial rupture of the membrane of her amniotic sac at 10.40pm.

3 On 3 May 2020 at 9.20am, Dr Khoo performed another vaginal examination and observed that Ms Cheng's cervix had only dilated to 4cm. According to Ms Cheng, Dr Khoo informed her at 9.25am that an emergency caesarean section was required, and she consented to it. Dr Khoo then told her that he wanted to "try something" to see if Ms Cheng could still proceed with natural delivery. He proceeded to move his hand inside Ms Cheng's vagina and performed a second cervical sweep by "manually widen[ing]" her cervix to 10cm. Dr Khoo denies Ms Cheng's account of events. He says that he only performed a vaginal examination, not a cervical sweep. He maintains that the only cervical sweep he did was at 9pm on 2 May 2020. Dr Khoo's position is that at 9.25am on 3 May 2020, he discussed with Ms Cheng the possibility of a lower segment caesarean section ("LSCS") should her labour remain slow. He arranged for an operating theatre and an anaesthetist, Dr Wendy Teoh, to be on standby just in case. However, at 9.40am, he found that Ms Cheng's cervix had fully dilated to 10cm. There was therefore no clinical indication for a LSCS and he proceeded with the natural delivery.

4 Dr Khoo left Ms Cheng with a nurse about 10am. On the nurse's instructions, Ms Cheng began pushing and 15 minutes later, she was told that the baby was "crowning". The nurse then told her to stop pushing and wait for

Dr Khoo. Two other nurses entered the delivery suite shortly after. Dr Khoo returned to the delivery suite about 10.30am and the nurses told him that the baby was "crowning". He instructed Ms Cheng to push again. After Ms Cheng's initial push, Dr Khoo moved to her left-hand side and started applying pressure at the top of the fundus of her uterus using his right palm. This technique is known as "manual fundal pressure" and is used to expedite vaginal birth. Prior to the application of manual fundal pressure, Dr Khoo performed a mediolateral episiotomy, which is a controlled cut made at the perineum (*ie,* the area between the vagina and the anus) to relieve tension and prevent extensive vaginal tears during childbirth. Ms Cheng's baby was successfully delivered in good health at 10.35am.

5 The cause of this action follows Ms Cheng's claim that after the delivery, Dr Khoo informed her that he noticed some faecal matter in her vagina and would stitch her up, then immediately proceeded to do so. She assumed that Dr Khoo's stitching was the standard delivery procedure for all patients who had just undergone vaginal delivery. Dr Khoo, on the other hand, denies having noticed any faecal matter. He says, furthermore, that because fleet enema had been administered prior to delivery, it is unlikely that there would have been any faecal matter to seep through the tear. Dr Khoo testified that he noticed a rectovaginal buttonhole tear of 0.5cm when he was repairing the episiotomy, and he informed Ms Cheng and her husband, Mr David Wong before proceeding to repair two layers (*ie*, the rectal wall and the vaginal wall) of the tear. This is corroborated by Dr Khoo's clinical notes timestamped 11am on 3 May 2020, although he incorrectly referred to the rectovaginal tear as a "fistula". He prescribed Ms Cheng with Duphalac (stool softener) and Enhancin (antibiotics). Ms Cheng was discharged from the hospital at 11.30am on 4 May 2020.

6 On 5 May 2020, Ms Cheng noticed that she was excreting faecal matter through her vagina and she informed Dr Khoo about this *via* a WhatsApp message on the same day at 8.38pm. In her message, Ms Cheng stated that there was "still some small poo discharge from [her] vagina". Dr Khoo responded that he needed to examine her and "may need to stitch some more". According to Ms Cheng, the reference to "still" in her message follows from her interaction with Dr Khoo after her delivery on 3 May 2020 when Dr Khoo told her that there was faecal matter in her vagina.

7 On the morning of 6 May 2020, Dr Khoo examined Ms Cheng and told her that a rectovaginal fistula ("RVF") had developed, likely to be the result of the repair breaking down and the tear extending to form an abnormal communication between the vagina and the rectum. He recommended two colorectal specialists to Ms Cheng, one of whom was Dr Ng Kheng Hong. Dr Khoo called Dr Ng Kheng Hong and turned on speakerphone mode in the presence of Ms Cheng and Mr David Wong to explain Ms Cheng's condition. Thereafter, at approximately 1pm on the same day, Ms Cheng and Mr David Wong consulted Dr Ng Kheng Hong at his clinic. Dr Ng Kheng Hong did not find any fistula while examining Ms Cheng and advised conservative management. After returning home, Ms Cheng noticed an increase in faecal discharge from her vagina.

8 About 6pm on the same day, Ms Cheng went to the Singapore General Hospital's Accident & Emergency ("SGH A&E") ward on Dr Khoo's advice and was admitted for observation. Dr Mok Zhun Wei ("Dr Mok") and Dr Ravichandran Nadarajah observed a 0.5cm defect from the anal verge and she was referred to a colorectal surgeon, Dr Ng Jia Lin. On 8 May 2020, Dr Ng Jia Lin treated Ms Cheng conservatively and advised her to repair the RVF after

the inflammation had settled down. Subsequently on 10 June 2020, Ms Cheng consulted Associate Professor Tang Choong Leong for a second opinion.

9 On 28 October 2020, almost six months after Ms Cheng had given birth, Associate Professor Tang Choong Leong performed a repair of the RVF. The wound healed by 5 January 2021. However, Ms Cheng claims that as a result of the incident, she suffered from major depressive disorder (postpartum onset, otherwise known as "postpartum depression"), post-traumatic stress disorder including mother-infant bonding difficulties, first degree uterine prolapse and grade two bladder prolapse (*ie,* cystocele). These injuries, which have led to financial and non-financial losses, are the basis of Ms Cheng's claim of damages against Dr Khoo.

10 Ms Cheng's first expert witness is Professor Andrew Robert Korda ("Professor Korda"), a gynaecologist and urogynaecologist practising at the Royal Prince Alfred Medical Centre in Sydney, New South Wales. Professor Korda is also an accredited expert for medico-legal opinion. Ms Cheng's second expert witness is Dr Michael John Mar Fan ("Dr Mar Fan"), a senior colorectal surgeon at Sunnybank Private Hospital Specialist Centre in Australia. Dr Mar Fan was trained in colonoscopy at the National University Hospital in Singapore for a year. Apart from that, neither doctor had practised medicine in Singapore. The first expert witness for Dr Khoo is Dr Han How Chuan ("Dr Han"), a senior consultant obstetrician and gynaecologist and urogynaecologist at HC Han Clinic for Women. His second expert witness is Dr Kam Ming Hian ("Dr Kam"), a senior consultant colorectal surgeon practising at Kam Colorectal Centre. Both doctors have been practising medicine in Singapore.

11 The main cause of action is in negligence. Ms Cheng claims that Dr Khoo failed to obtain her informed consent before performing the cervical sweeps, performing an episiotomy, applying manual fundal pressure during delivery and repairing the rectovaginal tear. Although Ms Cheng claims that Dr Khoo performed a second cervical sweep sometime between 9.25am and 9.40am on 3 May 2020, there is no evidence supporting her claim. There are also no contemporaneous medical records or witnesses to verify Ms Cheng's account. Dr Khoo maintains that what he conducted at that time was merely a vaginal examination and the only cervical sweep he performed was on 2 May 2020 at 9pm. In any case, nothing turns on the alleged second cervical sweep as there is no evidence that either of the cervical sweeps had caused the eventual tear and RVF. Professor Korda even testified that he does not think that manual cervical dilation could have caused the tear.

12 Dr Khoo says that he had "provided sufficient explanation" to Ms Cheng on the purpose and benefit of the cervical sweep, and that it is not standard practice for consent to be obtained in any case. Similarly for the episiotomy and manual fundal pressure, Dr Khoo explains that it is not standard practice for consent to be formally obtained as these are routine procedures of natural vaginal deliveries. This position is corroborated by Dr Han, who says that written consent "is not typically obtained for a cervical sweep" and that if an obstetrician deems that a cervical sweep is useful, he or she would "usually verbally inform the patient" before proceeding with it. Dr Han explains further that "an obstetrician would not obtain written consent for an episiotomy, but would tell the patient that he is performing a small controlled cut, which he will go on to repair once the baby is delivered".

13 Professor Korda, on the other hand, says that it is "appropriate practice to [obtain] informed consent prior to any procedure", including a cervical sweep and episiotomy. This can be verbal consent. He explains that while the obstetrician should discuss the procedure prior to proceeding with it, it is not necessary to discuss bleeding, infection and the possibility of cervical incompetence for a cervical sweep.

14 I accept Dr Khoo's evidence that he had explained to Ms Cheng the purpose and process of a cervical sweep before proceeding with it. At trial, Ms Cheng admitted that Dr Khoo mentioned that he could attempt to widen the cervix, and she agreed to let him try. Given that an episiotomy involves making an incision with the use of a scalpel, Dr Khoo should have exhibited good bedside manners by explaining to Ms Cheng that he was about to perform a controlled cut before proceeding with the episiotomy. However, medical procedures often involve numerous steps and routine actions. Requiring doctors to obtain explicit consent for each individual act within a medical procedure is impractical and would place an unreasonable burden on them. It is clear to me, based on Dr Han's testimony, that doctors in Singapore are not required to obtain formal consent for an episiotomy or manual fundal pressure, which are routine procedures of natural vaginal deliveries. Furthermore, I recognise that Dr Khoo was aiming to expedite the delivery process as the baby's head was crowning and the cardiotocography ("CTG") trace indicated foetal distress. It would have been an act more of courtesy than duty to let a patient know before performing an episiotomy or applying manual fundal pressure. Dr Khoo's failure to tell Ms Cheng beforehand about both procedures is not a breach of the standard of care as a medical practitioner in those circumstances.

15 Furthermore, Ms Cheng claims that she was not even informed of the diagnosis of the rectovaginal tear. In the clinical discharge summary dated 4 May 2020, Dr Khoo recorded the diagnoses he made and the procedures he carried out on Ms Cheng. However, there was no mention of a rectovaginal tear. Similarly, the handover form from the delivery suite to the ward dated 3 May 2020 at 12.30pm has no record of a diagnosis of a tear or the repair surgery. Ms Cheng also made no mention of the tear to Dr Wendy Teoh (whom she spoke to one hour after her delivery on 3 May 2020) and her sister-in-law (whom she texted about her childbirth experience on 5 May 2020). Counsel for Ms Cheng, Mr Kamalacumar, argues that if Ms Cheng had indeed been informed about it, she would have informed Dr Wendy Teoh and her sister-in-law as it would have been fresh on her mind.

16 On the other hand, Dr Khoo says that Ms Cheng was informed of the rectovaginal tear after the delivery and her consent was obtained before he performed the repair. He admits, however, that he did not explain the exact length and measurement of the tear, and only told Ms Cheng and Mr David Wong that it was a "very small hole". This is supported by Dr Khoo's clinical notes on 3 May 2020 at 11am, which indicate that Ms Cheng and Mr David Wong were informed of the "0.5cm fistula".

17 Mr Kamalacumar submits that the entry on 3 May 2020 at 11am is "problematic" because it was not made contemporaneously. Instead, it "[came] after a 11.30am entry by a nurse". He also says that there are various inconsistencies in the clinical record which makes it "suspicious". First, Dr Khoo recorded the condition as a "fistula" instead of a "tear" in the entry. Mr Kamalacumar points out that this is factually inaccurate as the fistula formed as a result of a breakdown of the repair of the tear. The diagnosis as of 3 May

2020 was thus a tear, not a fistula. Second, although Dr Khoo claimed to have informed Dr Ng Kheng Hong on 6 May 2020 about the exact injury that Ms Cheng suffered, Dr Ng Kheng Hong's clinical record incorrectly indicated that there was a "3rd to 4th degree repair done by Dr Khoo". Third, Dr Khoo drew a midline episiotomy in his clinical notes, which is very different from the mediolateral episiotomy that he actually performed on Ms Cheng. As such, Mr Kamalacumar submits that it is more likely that Dr Khoo retrospectively wrote "[s]mall 0.5cm fistula" in his clinical records when Dr Mok informed him on 6 May 2020 that Ms Cheng had a 0.5cm fistula.

18 In my view, Dr Khoo should have noted down the tear and its repair procedure in the handover form and clinical discharge summary since they were not part of routine deliveries. Nevertheless, I do not consider Dr Khoo's account of events to be inconsistent with this omission. Medical notes and reports are prepared to "document critical facts about medical management"; they are not intended to be a foolproof shield against potential litigation. It is impossible for doctors to make contemporaneous notes of every step of every procedure they perform throughout the day as multiple events often occur simultaneously in medical practice. For instance, an entry timestamped 11am may not have been written at precisely that time, as the doctor may have been busy attending to the patient at that moment. The timing may simply be a reasonable estimate of when a procedure was conducted. I accept Dr Khoo's evidence that doctors typically "write down [their] recollection of what happened as the entry". This explains why Dr Khoo's 11am entry came after the nurse's 11.30am entry. Such entries may not always be entirely accurate and detailed, given that doctors are rushing to attend to other patients at the same time. It is not implausible that minor errors occur during the process of documentation. I see no reason to question the overall reliability of Dr Khoo's entry on 3 May 2020 at 11am.

19 Next, Ms Cheng claims that Dr Khoo was negligent because he failed to provide appropriate medical advice, diagnosis, treatment and care to her. The application of manual fundal pressure during the delivery as an accepted procedure is strenuously disputed. The ancillary question is whether that caused the rectovaginal tear. Professor Korda says that, "[F]undal pressure is not practised in any civilised or developed country in the world." His view is that the application of manual fundal pressure contradicts the World Health Organisation guidelines and "likely caused the anovaginal tear" in this case. Given that Singapore is a developed country, he assumes that manual fundal pressure must not be accepted as a practice here. To support his stance, Professor Korda relies on an article titled "The prevalence of uterine fundal pressure during the second stage of labour for women giving birth in health facilities: a systemic review and meta-analysis" (the "Farrington Article"). The Farrington Article was published in a journal called "Reproductive Health" in 2021. The authors in the Farrington Article acknowledge the widespread use of fundal pressure today but say that "efforts to prevent this potentially unnecessary and harmful practice are needed". The terms "rectovaginal tear" and "anovaginal tear" have been used interchangeably in various court documents, but Dr Mar Fan has stated at trial that the more accurate term is "rectovaginal tear" because the actual defect here is a rectal buttonhole injury.

20 Counsel for Dr Khoo, Ms Kuah, argues that the authors of the Farrington Article did not delve into evidence to support their position that there is no benefit to manual fundal pressure and that there are increased adverse outcomes with the application of manual fundal pressure. At trial, Ms Kuah adduced a letter written to the editor of the American Journal of Obstetrics & Gynaecology, titled "Not yet the last word on fundal pressure". This was published in September 2022 and was written by Dr Federico Prefumo, an

Italian obstetrician and gynaecologist. Dr Prefumo explains that manual fundal pressure is expressly advocated by the Japanese Society of Obstetrics & Gynaecology, and he sets out the Japanese guidelines for performing the manoeuvre safely. Ms Kuah argues that Italy and Japan are both developed countries where the practice of manual fundal pressure is widespread. Professor Korda says that even if there was foetal distress, the solution would have been to carry out an instrumental delivery (*ie*, vacuum or forceps delivery) or a caesarean section, depending on which was the most appropriate at the time. Ms Kuah responds that there is a higher risk of perineal damage in an instrumental delivery, to which Professor Korda agrees.

21 Dr Han says that he "totally disagrees" with Professor Korda's views on manual fundal pressure. He asserts that manual fundal pressure has always been commonly used during deliveries in Singapore, even by trained nurses. He alleges that "70% of the time [obstetricians] need [to apply] fundal pressure to deliver the baby". He claims that there is a place for fundal pressure in modern obstetrics, depending on the indication for fundal pressure. In this case, there were signs of foetal distress and pathological CTG. Any senior obstetrician would have wanted to adopt the fastest method of delivering the baby. He says that the baby was successfully delivered in 1.5 minutes in this case, but if Dr Khoo had used a vacuum, it would have taken a much longer time as Dr Khoo would have needed to prepare the vacuum and the patient's position. The usage of forceps or vacuum could also have caused foetal injury and maternal injury. Similarly, a crash caesarean section was not suitable as the baby's head was already crowning and arranging for the procedure would have taken a much longer time, especially because this was during the period of Singapore's COVID-19 circuit breaker measures.

22 On this point, I prefer Dr Han's evidence over Professor Korda's evidence. Dr Han is an experienced senior consultant obstetrician and gynaecologist who has been practising in Singapore for 35 years. He had been working in a public hospital for 32 years before moving to a private hospital. His wealth of experience indicates that he must be familiar with obstetric practices among medical practitioners in Singapore. Although Professor Korda, being 83 years old, is an even more experienced obstetrician and gynaecologist as well as an accredited expert for medico-legal opinion, he has not practised clinical obstetrics since 1998 and stopped being involved in obstetric emergencies since 2013. He is of the opinion that rectal buttonhole tears are "exceedingly rare" and that he would not have seen many of such cases. More importantly, Professor Korda has not practised medicine in Singapore before. He even admitted at trial that he has no "direct knowledge" of the practice of obstetrics and gynaecology in Singapore and is unable to comment on the practice in Singapore.

23 I accept Dr Khoo's evidence that by the time he arrived at the delivery room at 10.30am on 3 May 2020, Ms Cheng was already experiencing "maternal fatigue" after pushing for some time on the midwives' instructions. Based on Ms Cheng's CTG, there were indications of decreased variability, repetitive late decelerations and poor contractions. These were signs that the foetus was in distress and had Dr Khoo waited further to observe whether Ms Cheng could push the baby out on her own, the baby might have been exposed to a more significant risk of harm. Both Professor Korda and Dr Han agree that an instrumental delivery carried a higher risk of perineal damage, and that a crash caesarean section was not appropriate since the baby's head was already crowning. As such, I find that Dr Khoo had not been negligent when applying manual fundal pressure to assist Ms Cheng during her delivery.

24 In any event, it is unlikely that the application of manual fundal pressure caused the rectovaginal tear. Dr Han concedes that he does not know what caused the rectovaginal tear, but Professor Korda says that the application of fundal pressure likely caused the tear as the baby was "pressed against Ms Cheng's rectum". Dr Han disagrees with this view, explaining that since the baby was delivered within five minutes from the time fundal pressure was applied, it indicates that the direction of fundal pressure was being correctly applied towards the birth canal and not the rectovaginal wall. Professor Korda admitted at trial that he "[could not] remember" that the baby's head had been crowning when Dr Khoo administered manual fundal pressure. Professor Korda's suggestion that the rectovaginal tear was caused by Dr Khoo's application of manual fundal pressure thus appears to be based on the erroneous assumption that the baby was pressed against Ms Cheng's rectum. I accept Ms Kuah's submission that this was unlikely to be the case as the baby was already crowning. This meant that the baby was "well within the birth canal" and the top of the baby's head was at the vaginal opening. I therefore do not think that Dr Khoo's application of fundal pressure had caused the rectovaginal tear.

25 Ms Cheng's third main contention is that Dr Khoo was negligent in his repair of the rectovaginal tear. There are two questions in this regard. The first is whether Dr Khoo was competent in performing the repair, or whether he should have consulted a colorectal surgeon for the repair. The second is whether Dr Khoo's repair of the tear in two layers, instead of three layers, was in accordance with the required standard of care.

26 Professor Korda says that as an obstetrician, he would always seek a colorectal opinion when the tear is "more than 7cm from the anal verge or the

vagina [is] contaminated by faecal material". This is consistent with the view of the authors in a 2020 article published in the International Urogynecology Journal, titled "Isolated rectal buttonhole tears in obstetrics: case series and review of the literature" (the "Roper Article"). The Roper Article was also cited by Dr Han in his expert report. Dr Kam's position, however, is that it is not necessary to consult a colorectal expert just because there is faecal soiling. But the obstetrician must ensure that the faecal soiling is "cleaned with chlorhexidine or iodine to ensure a sterile field of operation". It is not disputed that Ms Cheng's tear was 2.5cm from the anal verge. Therefore, the only question that remains is whether there was faecal soiling, and if so, whether the opinion of a colorectal specialist should have been sought by Dr Khoo prior to performing the repair.

27 Ms Cheng's position is that Dr Khoo informed her that he noticed "poop" in her vagina and will "stitch [her] up" immediately after the delivery. However, she did not actually see or know if she had bowel movement during the delivery. Dr Khoo maintains that there was no faecal matter in the vagina at the time of delivery. Instead, Ms Cheng merely felt the sensation of the baby descending the birth canal which was similar to the sensation of passing motion. Furthermore, Dr Han says that it is "very unlikely" for faeces to have come out through the small buttonhole tear of 0.5cm. This is corroborated by Dr Kam, who says that with fleet enema having been administered before delivery, the rectum and anus would have been cleared of faecal matter and thus it is unlikely that faeces leaked into the vagina. Dr Khoo explains that faecal matter was subsequently able to pass through the tear on 5 May 2020 and 6 May 2020 because Ms Cheng had diarrhoea (presumably as a result of consuming the prescribed Duphalac), making her stool more watery or loose.

28 Mr Kamalacumar argues that it is not open to Dr Khoo to claim that there was no faecal soiling because Dr Khoo did not specifically deny or not admit the material fact in the Defence of the 1st and 2nd Defendants (Amendment No. 1). Mr Kamalacumar also says that fleet enema had been administered more than 13 hours before Ms Cheng's delivery, around 9pm on 2 May 2020. It only cleared the faeces in Ms Cheng's rectum at that point, and did not halt digestion thereafter. He submits that Dr Kam's perspective was one of a colorectal surgeon who administers fleet enema one to two hours before a procedure. He says that Dr Kam opined that it is "highly likely in every case" of a rectovaginal buttonhole tear that there "will be some faecal soiling" due to the direct communication between the rectum and the vagina. Hence, it is possible that there could have been faecal soiling through a 0.5cm tear. Furthermore, when Ms Cheng visited the SGH A&E on 6 May 2020, Dr Mok had a call with Dr Khoo. Dr Mok's contemporaneous record of the call states that Dr Khoo noted a "small buttonhole opening with small amount of fecal [*sic*] material" post-delivery.

29 Ms Kuah asked Dr Mok if he could be certain that Dr Khoo's mention of the presence of faecal material referred to when the tear was first identified post-delivery rather than what Ms Cheng had just reported to Dr Khoo. Dr Mok answered that his documentation was "based on the history provided by [Ms Cheng] and after a call made to Dr Khoo". Ms Kuah submits that Dr Mok had to process pieces of information he received from two different sources, and thus it is likely that Dr Mok had mistakenly attributed the mention of faecal material post-delivery to Dr Khoo, when it should have been to Ms Cheng.

30 I find that there was likely no faecal soiling at the time of Ms Cheng's delivery. Dr Han and Dr Kam are unified in their view that it is very unlikely

for faeces to have passed through the small 0.5cm tear at the time of delivery, especially as fleet enema had already been administered. More importantly, none of the medical records of Mount Elizabeth Novena Hospital indicate that there was faecal soiling during the delivery. These records, which can be updated by nurses as well, are kept by Mount Elizabeth Novena Hospital, not Dr Khoo. There would have been no reason for Dr Khoo, or any nurse, to have deliberately omitted the material finding that there was faecal soiling on 3 May 2020. Dr Khoo would not have been aware at that point that he would be faced with a risk of litigation. Furthermore, the fact that Dr Khoo did not specifically deny the fact in the Defence of the 1st and 2nd Defendants (Amendment No. 1) is not a bar to his argument now as he had denied each and every allegation contained in the Statement of Claim (Amendment No. 1) as if each had been specifically set out and traversed. In the circumstances, it is unlikely that Dr Khoo observed faecal soiling on 3 May 2020. His decision to repair the tear without consulting a colorectal surgeon was therefore appropriate and reasonable.

31 Professor Korda and Dr Mar Fan opine that with a colorectal specialist's input, a de-functioning colostomy ought to have been considered as an alternative treatment option. This is a surgical procedure whereby a section of the patient's colon is brought out through an opening in the abdominal wall to create a stoma. The patient's faeces are then collected in a stoma bag that the patient wears over the opening at the abdomen. This diverts faeces away from the repair site and presumably reduces the likelihood of a RVF forming. The patient would have to wear the stoma bag everywhere they go until the tear has healed and the colostomy has been reversed. Ms Kuah submits that a de-functioning colostomy is only considered if a patient sustains a severe tear that is difficult to repair or has a high chance of breaking down after repair. I agree

with Ms Kuah that since Ms Cheng's buttonhole tear was not even a third degree or fourth degree tear, the possibility of a de-functioning colostomy would not have been relevant. A competent colorectal specialist, if consulted, would likely not have suggested this as an appropriate treatment option.

32 The next question is whether Dr Khoo should have done a three-layer repair, instead of a two-layer repair, of the rectovaginal tear. This involves the repair of the rectal mucosa first, followed by the rectovaginal fascia and then the vaginal skin. Each layer must be repaired separately with individual stitching. Dr Khoo clarified at trial that he performed a two-layer repair by stitching "the rectal side first, then followed by the vaginal side". Ms Cheng casts doubt at Dr Khoo's claim, alleging that he had "embellished his evidence" by providing this clarification only at trial.

33 Mr Kamalacumar argues that even if it is accepted that Dr Khoo performed a two-layer repair, it is not disputed that Dr Khoo did not repair the rectovaginal mucosa. Dr Khoo's position is that "it was not possible to visualise the rectovaginal fascia or septum" due to the small size of the tear. Therefore, it was "entirely appropriate" in the circumstances for him to have performed a two-layer repair. If he had insisted on opening the tear up to expose the rectovaginal septum, it would have caused "significantly more damage". In response, Mr Kamalacumar says that Dr Khoo should have performed the repair in an operating theatre with better lighting, appropriate instruments and with the assistance of a colorectal surgeon to facilitate the dissection of the layers. His position is that there would have been no issues delaying the surgery until an operating theatre was ready. Mr Kamalacumar refers to an article titled, "Obstetric rectal buttonhole tear and a successful three-layer repair: A case report" (the "Ngene Article") cited by Dr Mar Fan. The Ngene Article was

published in the Case Reports in Women's Health in 2023. In the Ngene Article, the repair of the tear in the case study took place after seven hours and was successful.

34 Professor Korda relies on the Roper Article for the proposition that a repair of a rectal buttonhole tear should be performed with "a minimum of three layers". In this article, the authors reviewed the literature on isolated rectal buttonhole tears in obstetrics. They say that "[e]ven in situations where repairing the rectovaginal fascia is not possible, surgeons use other intervening tissue such as omentum or labial fat". Dr Mar Fan's opinion is that although the tear was only 0.5cm, it was "not impossible to find" and that it could have been extended "superiorly" or "cranially" for repair. This involves enlarging the original 0.5cm tear for the surgeon to have a larger operative field.

35 Dr Han agrees that "three layers is ideal" and in theory it is important to repair the rectovaginal fascia. However, he says that in practice, it is sometimes not possible to see the septum and any repair may "cause more tear". Dr Han claims that it was "very difficult for any doctor" in this case to have seen the 0.5cm tear in the inner layer. Dr Han emphasises that the buttonhole tears reported in the Roper Article and the Ngene Article were much larger than Ms Cheng's tear. For instance, the cases reported in the Roper Article involved tears ranging from 3cm to 6cm, and the tear described in the Ngene Article was 5cm. Those tears were six to twelve times bigger than Ms Cheng's tear and consequently, far easier to see. In response to Mr Kamalacumar's suggestion that Dr Khoo could have waited until an operating theatre was available, Ms Kuah points out that the patient in the Ngene Article "needed to be transferred from a district hospital to an obstetrician-led unit in a regional hospital in South Africa". This does not represent the standard of care in

Singapore, as Dr Han says that doctors in Singapore would not "leave an open wound for seven hours". Further, Dr Han claims that the lighting in Mount Elizabeth Novena Hospital is "fantastic" and repairs of more severe injuries such as third degree and fourth degree tears have been performed successfully in the delivery suite. Lastly, Dr Han and Dr Kam disagree with Dr Mar Fan's opinion on extending the tear, saying that doing so would have carried much higher risks of complications.

36 I accept the evidence of Dr Khoo's experts that he had fulfilled the required standard of care in repairing the tear with two layers. The rectovaginal tear in this case was only 0.5cm, which is much smaller than the tears cited in the articles. In fact, almost half of the cases in the Roper Article, which involved bigger tears ranging from 3cm to 6cm, were also repaired by doctors in two layers. Even if enlarging or extending the tear was a viable option, doing so would have led to far greater risks, such as a longer healing time and recovery, more swelling and oedema and a higher chance of subsequent breakdown. There is no evidence to suggest that the lighting or surgical instruments in the delivery suite were lacking. Professor Korda admits that he has never actually seen the conditions of the Mount Elizabeth Novena Hospital delivery suite before. The evidence of Dr Khoo's experts, both of whom have been in medical practice in Singapore for at least 25 years, fortifies my view that there was no need to engage the assistance of a colorectal surgeon nor perform the repair in the operating theatre.

37 Mr Kamalacumar also argues that Dr Khoo did not perform a digital vaginal examination after suturing to test the integrity of the suture from the vaginal side. He submits that, according to Professor Korda, a digital rectal examination and a digital vaginal examination should have been performed. He

further submits that Dr Khoo only did a digital rectal examination and, therefore, did not ensure that the defect was completely closed. Dr Khoo testified that he performed a vaginal examination to satisfy himself that there was adequate repair of the buttonhole tear and episiotomy. I am of the view that even if Dr Khoo had not done a digital vaginal examination, there is insufficient evidence to show that this omission had caused the RVF.

38 Ms Cheng claims that she had a prolonged first stage of labour, which meant that a caesarean section should have been carried out. It is her position that Dr Khoo's failure to proceed with a caesarean section had caused her uterine prolapse and cystocele. The definition of "prolonged labour" provided by Professor Korda is that it is a "labour that goes on for about 18 to 24 hours after the commencement of regular contractions". Dr Han does not challenge this definition. The only dispute is when Ms Cheng's first stage of labour started. Professor Korda says that it should be 9pm on 2 May 2020 when Ms Cheng was 3cm dilated, while Dr Han's view is that it began at 10.40pm on 2 May 2020 when the artificial rupture of the membrane was performed. The first stage of labour ended around 9.35am on 3 May 2020.

39 Professor Korda claims that for the first stage of labour, the mean duration is 8.5 hours, the median duration is eight hours, and the mode duration is six hours. Mr Kamalacumar submits that regardless of whether Ms Cheng's labour was 11 hours or 12.5 hours, it was well over seven to eight hours and was therefore prolonged. Ms Kuah argues that Professor Korda has not provided any literature or medical guideline that explains why Ms Cheng's first-stage labour, even if it was accepted to be 12.5 hours, was prolonged. Further, Ms Kuah points out that Professor Korda had also agreed that once the cervix had dilated to 10cm, there was no more indication for a caesarean section.

Professor Korda even agreed that a progression from 4cm dilation to 10cm dilation can occur spontaneously within 20 minutes.

40 Regardless of whether the first stage of labour had been 11 hours or 12.5 hours, Dr Khoo's decision to proceed with the natural delivery when Ms Cheng had dilated to 10cm was reasonable and appropriate. First, it cannot be said that any first-stage labour exceeding the mean, median and mode duration is necessarily prolonged and thereby requires a caesarean section. Second, it is Professor Korda's own view that Dr Khoo's conduct from 9am on 3 May 2020 up to the cancellation of the emergency caesarean section was consistent with a reasonable and competent obstetrician and gynaecologist.

41 Overall, it is clear to me that Dr Khoo was not negligent as his diagnosis, treatment and care of Ms Cheng are supported by a respectable body of medical opinion. Dr Khoo's experts had directed their minds to the comparative risks and benefits of the medical procedures in this case and their opinion is defensible. As for Dr Khoo's advice to Ms Cheng, I find that he did not withhold any material or relevant information. Dr Khoo's management of Ms Cheng's labour and delivery does not constitute the tort of battery either. Accordingly, Royal Clinics of O&G Pte Ltd cannot be held vicariously liable for Dr Khoo's actions and has not breached its contract with Ms Cheng.

42 Finally, I shall consider the claim in which Ms Cheng says that she suffered pain and suffering and loss of amenities in respect of the RVF. Although this is a matter for the assessment of damages, which is irrelevant here because Ms Cheng has failed to prove her case, I would like to make clear that any such damages would have been limited in any event. This is because based on Ms Cheng's medical history, she showed significant improvement within

one month after the diagnosis of her RVF and she underwent a successful repair surgery on 28 October 2020. Associate Professor Tang Choong Leong also confirmed on 5 January 2021 that Ms Cheng's wound had healed, and she could resume her normal activities, except that she was advised against any future vaginal deliveries. As for Ms Cheng's alleged urinary incontinence and faecal urgency, she has merely reported experiencing such symptoms but there has never been any medical diagnosis of either condition.

43 Further, regarding Ms Cheng's uterine and bladder prolapse, Mr Kamalacumar submits that the vaginal birth had caused it. This is likely to be true, as Dr Lee Lih Charn and Dr Aswini Balachandran, who are both urogynaecologists consulted by Ms Cheng, explained that uterovaginal prolapse is a common condition after vaginal birth. Dr Yvonne Chan, an obstetrician and gynaecologist consulted by Ms Cheng, was also of the opinion that the uterine prolapse could have been caused by "constitutional laxity and weakness of the pelvic tissues" following a vaginal childbirth. However, as explained earlier (see [40] above), I do not think that Dr Khoo's decision to proceed with the natural delivery was inappropriate. It thus follows that Ms Cheng's claim for damages for her uterine and bladder prolapse must fail.

44 Ms Cheng also claims S$36,000 for her loss of earning capacity. She says that she "had no choice but to resign" from her role at the funeral service company as she took frequent medical and hospitalisation leave after the incident. This caused her relationship with her manager and brother-in-law, Mr Daniel Wong, to deteriorate. Mr Daniel Wong was not called to testify. However, Mr Daniel Wong had clarified through an email response to Mr Kamalacumar that Ms Cheng's medical condition "was in no way related to the company's decision" to terminate her employment. The company was

restructured in January 2021 and, consequently, her position no longer existed. She was offered another "redesign role" by Mr Daniel Wong, which she rejected. More importantly, Ms Cheng was able to earn the same or higher income in the various jobs she tried out after she left the funeral service company. The reason she left those jobs was not due to any disability or long-term effects from the injury sustained during her delivery, but because she found that the roles were "mundane", "not as meaningful" or "not a good fit" for her. She is now a homemaker, but she admits that she can work and has been looking for a new job. There is thus no loss of future earning capacity at all. I will not deal with the details of the rest of Ms Cheng's claims for damages, except to state that many of these expenses (*eg*, her medical expenses for her antenatal consultations) would have been incurred even if she had not sustained the injury during delivery.

45 For the reasons above, I find that Ms Cheng has failed to prove her case and the action is dismissed. I will hear submissions on costs at a later date.

- Sgd -
Choo Han Teck
Judge of the High Court

Cumara Kamalacumar, Celestine Luke Tolentino and Daniel Soo (Selvam LLC) for the claimant;
Kuah Boon Theng SC, Kee Shu'en Theodora and Kimberly Chia Wei Xin (Legal Clinic LLC) for the defendants.