



Republic of South Africa

**IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)**

Case No: **13724/14**

In the matter between:

FARIEDA CLARKE

Plaintiff

and

MEC FOR HEALTH WESTERN CAPE

First Defendant

PREMIER OF THE WESTERN CAPE

Second Defendant

JUDGMENT DELIVERED ON 8 MARCH 2018

KUSEVITSKY, AJ

Introduction:

[1] The Plaintiff, Ms Farieda Clarke brought an action against the First and Second Defendants (“the Defendants”) arising out of injuries allegedly sustained by her when she underwent a laparoscopic cholecystectomy which was converted into an open cholecystectomy on 30 November 2011. It is not in dispute that the surgeons who performed the operations did so during the course and scope of

their employment with the Defendants. The Plaintiff alleges that during this operation, the surgeons negligently and in breach of their duty of care, caused an injury to the Plaintiff's colon which, injury later resulted in the perforation of the Plaintiff's colon on 3 December 2011.

- [2] It is the Plaintiff's case that the injury was either as a result of a diathermy injury caused by the surgeons, *alternatively* a serosal injury to the right colon, which injury it is claimed the surgeons failed to notice and/or repair.
- [3] The Defendants' defence is that a serosal injury is an acceptable consequence of a laparoscopic cholecystectomy surgical procedure, which was converted to an open cholecystectomy by means of the Kocher's Incision. Secondly, they state that it is standard teaching and procedure at Groote Schuur Hospital to use scissors when dividing adhesions to the bowel, or in close proximity to any hollow organ. Diathermy is therefore, not used for purposes of dissection in these circumstances. They further state that at no stage during either the laparoscopic cholecystectomy, or the open cholecystectomy, was a diathermy utilised in such a way that it could have caused injury to any part of the colon.
- [4] The trial proceeded on both merits and quantum. Before dealing with the evidence presented, it is important to set out the factual matrix.

The background

- [5] During July 2011, Plaintiff presented at Groote Schuur Hospital and was admitted on 15 July 2011, where she underwent an Endoscopic Retrograde Cholangio-Pancreatogram which is a procedure to examine the pancreatic and bile ducts. During her admission and on 20 July 2011, she was diagnosed with

acute cholecystitis, which is an inflammation of the gall bladder usually associated with gall stones. She was scheduled for a laparoscopic cholecystectomy on 30 November 2011, and subsequently booked for admission on 29 November 2011.

- [6] On 29 November 2011, Plaintiff was examined and diagnosed with cholecystitis. She signed an informed consent form which was part of the hospital records on 29 November 2011, in respect of a laparoscopic cholecystectomy with the option of converting to an open cholecystectomy.
- [7] On 30 November 2011, Plaintiff underwent a laparoscopic cholecystectomy which was performed by Dr Petrus Salomon Rautenbach, a Registrar of the Department of Surgery and Dr Colin McGuire, a post-fellow Senior General Surgeon Registrar at Groote Schuur Hospital.
- [8] During the procedure, the laparoscopic cholecystectomy was converted into an open cholecystectomy by means of a Kocher's incision. It was not disputed that Drs Rautenbach and McGuire called in Mr Suleiman Hoosen Bhaila to assist. Mr Bhaila is a Registered Specialist Surgeon with registered sub-speciality in gastro-enterology and Head of General Surgery in the Metro-West Area which included Groote Schuur Hospital. His experience (and why he is not referred to as "*Dr*" becomes evident later on).
- [9] The surgeons then performed a sub-total cholecystectomy on the recommendation of Mr Bhaila. A sub-total cholecystectomy refers to the removal of only a portion of the gall bladder. During the open procedure, a 3mm tear of the duodenum was noted and repaired and a pencil drain was inserted via a Morrison's pouch.

[10] According to the hospital notes, the Plaintiff was stable on 1 and 2 December 2011. On 3 December 2011, at around 10h15am, faecal material was noted in the pencil drain and Dr Kloppers was informed. At 11h20am, Plaintiff was taken to surgery. An injury to the hepatic flexure of the large bowel was diagnosed and treated surgically on 3 December 2011, by means of a right hemicolectomy and ileostomy with a transverse colon mucous fistula. A colostomy bag was inserted.

[11] On 6 June 2012, Plaintiff underwent a reversal of the ileostomy and the colostomy bag was removed.

[12] Plaintiff alleges that had it not been for the 4cm perforation of the colon, it would not have been necessary for her to have undergone the two further surgeries, and that the injury to the colon which caused the delayed 4cm perforation was as a result of the negligence of the surgeons who conducted the surgery on 30 November 2011.

The issues:

[13] It is common cause that the first basis of the Plaintiff's claim¹ for negligence was based on the premise that the surgeons who conducted the surgery of 30 November 2011, lacked the qualification and competence to perform the surgery, and to this end, relied on a medico-legal report of Dr David Stein which was dated 09 June 2014. In this report, Dr Stein stated the following:

"The laparoscopic cholecystectomy was performed on 30-11-2011. The surgeon was Dr.B Rautenbach (Surgical Registrar) assisted by Dr.

¹ Paragraphs 4.1 and 4.3 of the Plaintiff's Amended Particulars of Claim

C McGuire and a Mr. Bayki. (Probably a student or intern.)... The operation was obviously very difficult and only a sub-total cholecystectomy (a partial removal of the gallbladder) was performed...At no stage was a senior consultant surgeon called in to help with this difficult operation.”

[14] He further stated in this report that the decision to only do a partial cholecystectomy due to the difficulty of the operation was acceptable, however, he questioned the expertise of the surgical team, and suggested that the procedure may have been completed had a fully qualified specialist surgeon been involved with the operation.

[15] Subsequent to the filing of this medico-legal report, Prof PC Bornman, expert for Defendants and Dr Stein compiled a joint minute. In terms of this joint minute, Dr Stein conceded that the surgeons and in particular Dr Bhaila, who conducted the second part of the surgery on 30 November 2011, were all suitably qualified and had the necessary expertise to perform the surgery. When Dr Stein was questioned about this, given that his report was the very basis of Plaintiff's claim, he stated as follows:

“Yes I didn't know who these people were at the time of this original report but since then I have altered my opinion.”

[16] What is immediately striking is that Dr Stein sought to rely on the inferred incompetence (lack of expertise and medical judgment as referred to in his report) of the surgeon who performed the operation and impute this opinion, without verification, into a cause of action. The Plaintiff rightly conceded in argument that this ground was no longer in dispute.

[17] On the 14 September 2016, Prof PC Bornman filed his expert report on behalf of Defendants. His view was that injuries to the duodenum and colon, and in

particular, the missed injury of the colon was considered an acceptable complication, even in experienced hands where there are dense adhesions and inflammation between the gallbladder to the adjacent duodenum and hepatic flexure of the colon as a result of previous attacks of acute cholecystitis. He was of the view that there was a real possibility that the perforation of the colon did not occur during the operation of/on the 30 November 2011, but that it developed during the early post-operative period as a result of an injury to the serosa of the colon with associated ischaemia.

[18] On the 12 October 2016, Dr Stein and Prof Bornman compiled a Joint Minute. It is evident that it was at this meeting that the possibility of a diathermy injury was first raised, and accordingly, Dr Stein was of the view, as recorded in the Joint Minute, that although the cause of the delayed perforation remained speculative, on a balance of probabilities it was as a result of a diathermy injury in the vicinity of the colon.

[19] On the 8 March 2017, the Plaintiff amended her Particulars of claim, still relying on Dr Stein's June 2014 report. Paragraphs 3.5 and 3.6 of the amendment reads as follows:

“3.5 During the laparoscopic part of the procedure alternatively during the operation, the surgeons caused a diathermy injury to the hepatic flexure (right colon) and failed to notice or repair the diathermy injury to the right colon.

ALTERNATIVELY

During the operation the surgeons caused a 4cm serosal injury/ischaemic damage to the hepatic flexure (right colon) and failed to notice or repair the serosal injury / ischaemic damage to the right colon.

3.6 As a result of the diathermy injury alternatively serosal injury to the right colon which was not timeously identified and repaired during the operation, the Plaintiff suffered a delayed 4cm perforation of the right colon during or on 2 December 2011.”

[20] As I have mentioned above, that report solely laid the blame of negligence at the doorstep of the supposedly inexperienced surgeons. Dr Stein in that report, notably also stated that it was not possible to decide whether the damage to the colon or duodenum was done prior to the decision to convert to the open procedure “but the timing of when the damage occurred, *is not too important as the main problem occurred because the tear in the colon was not seen at the open operation.*”

[21] As mentioned before, Dr Stein and Professor Bornman prepared a Joint Minute wherein the following was agreed relating to the colon perforation:

- 21.1 Without having first-hand information on what transpired during the cholecystectomy on 30 November 2011, both doctors can only surmise as to the timing and nature of the colon injury;
- 21.2 Bearing in mind the Plaintiff's clinical course after the cholecystectomy, the perforation did not occur at the time of the cholecystectomy, but sometime thereafter, probably on the morning of 3 December 2011 when her clinical condition deteriorated;
- 21.3 An iatrogenic perforation of the colon during the difficult cholecystectomy, as was the case here, is an acceptable complication as long as this is recognised and repaired at the

time. It is very unlikely that Prof Bhaila, who was called for assistance, would have missed a perforation;

21.4 It is not always possible to identify a partial thermal, or serosal injury to the colon at the time of the cholecystectomy, especially when there is severe inflammation at the site where the colon is adherent to the gall bladder.

21.5 The cause of the delayed perforation of the colon remains speculative but that on a balance of probability, it could have been either the result of a diathermy injury in the vicinity of the colon, or a serosal injury/ischaemic damage when the colon was dissected free from the inflamed gall bladder. If the injury was caused by diathermy this would probably have occurred during the laparoscopic phase of the operation.

[22] They also agreed, that during the performance of a cholecystectomy, every precaution should be taken to avoid a thermal injury to an adjacent viscus, i.e. colon and duodenum. If such an injury can be proven, then it can be regarded as a technical error and, depending on the circumstances, be construed as an act of negligence.

[23] A faecal fistula following a cholecystectomy is a rare complication.

[24] Dr Stein also admitted the following statements made by Prof Bornman in relation to his report dated 14 September 2016. He agreed that:

24.1 In addition to the dense adhesions between the gall bladder, the liver, and transverse colon, the gall-bladder was also adherent to the duodenum.

24.2 The Plaintiff was doing well post-operatively until the morning of 3 December 2011. Until then she was afebrile, her abdomen was soft and

there was minimal bloodstained drainage from the abdominal drain. On the morning of 3 December 2011, she spiked a temperature, she was tender in the right upper quadrant, and faecal material was noticed in the abdominal drain. The Plaintiff was then taken to theatre without delay.

24.3 Dr McGuire was already qualified as a specialist surgeon; that Dr Rautenbach was assisted by Dr McGuire, who at the time was a qualified specialist surgeon with sufficient experience to assist with the performance of an laparoscopic cholecystectomy, and when it became apparent that the operation remained difficult to complete after they converted to an open operation, Drs Rautenbach and McGuire called in the Head of the Emergency Surgical Unit, Mr Bhaila to assist with the operation. It was under his guidance that the decision was taken to modify the operation to a sub-total cholecystectomy. The latter operation is the recommended operation in the setting regardless of the surgeon's experience to avoid *inter alia* a major bile duct injury.

24.4 To convert the laparoscopic procedure to an open operation is a perfectly acceptable one. It would be difficult to determine at what stage the duodenum and colon injury occurred. Dr Stein conceded that the timing of the injuries are not important as the main problem is that the colon injury was missed at the time of the operation on 30 November 2011. 24.5 The questions that remain, are whether the injuries to the duodenum and colon, as well as the missed injury to the latter can be construed as an act of negligence.

24.6 Injuries of this nature is an acceptable complication, even in/with experienced hands, when there are dense adhesions/inflammation between the gall bladder to the adjacent duodenum and hepatic flexure of the colon.

24.7 The fact that the Plaintiff was significantly overweight with a BMI of 33.3 (height 1.5m; weight 75kg) added to the difficulties in performing the operation.

As for the missed colon injury, even this may be difficult to detect in the presence of severe adhesions/inflammation and obesity. What also needed to be considered is that a complete laceration of the colon may not have occurred at the time of the operation on 30 November 2011. (“my emphasis”)

24.8 Injury to the serosa of the colon may occur during the dissection of the inflamed gall bladder which can then result in a delayed perforation on an ischaemic basis.

24.8 In addition, a distended colon, which is a normal post-operative event, may also contribute to the perforation under the circumstances. It is noteworthy that the Plaintiff’s observations during the first two post-operative days appear to be uncomplicated. Her abdomen was soft and there was minimum serosanguinous draining from the abdominal drain. It was only on day three that her abdominal pain increased and only then faecal material was noted in the abdominal drainage bag.

[25] The Defendants argued that based on the concessions made by Dr Stein in the joint minute, Dr Stein’s first report could be of no assistance to the Plaintiff. They further pointed out that Dr Stein did not file a supplementary report subsequent to receiving the report of Professor Bornman, and it was therefore, Plaintiff that had to make out a case for negligence based on Dr Stein’s oral evidence.

[26] The oral evidence that was procured from the experts, Dr Stein and Prof Bornman, relates specifically to whether it is more probable that the cause of the delayed perforation of the colon was the diathermy injury or the serosal injury.

[27] The issues in dispute therefore, seem to be specifically related to the cause of the injury to the Plaintiff’s right colon during the surgery of 30 November 2011, that led to the delayed 4cm perforation, i.e. whether the injury was as a result of a

diathermy injury or a serosal/ischaemic damage. It is the Plaintiff's case that the injury to the colon was due to a diathermy injury.

[28] I will firstly deal with the evidence of the witnesses that testified in relation to the merits of the matter. Each party relied on the expert evidence of one independent expert witness and in the case of Defendants, an additional witness Mr Baila was called who was one of the surgeons who performed the initial operation of the 30 November 2011.

SUMMARY OF THE EXPERT EVIDENCE:

Evidence of Dr David Stein:

[29] Dr Stein started his career in 1954 and was employed as a general surgeon at Somerset Hospital where he became chief of surgery before his retirement from that position. He did not examine the Plaintiff, and his opinion is based solely on the hospital records. His evidence related to his opinion on the operation of 30 November 2011, and specifically to express his opinion on the cause of the perforation of the Plaintiff's colon on 3 December 2011. His view was that the injury to the colon was either caused by a diathermy injury or a serosal injury. With regards to his evidence surrounding a possible serosal injury, Dr Stein conceded during cross-examination that he could only surmise as to when this injury would have occurred as it was possible that the injury to the serosa of the colon might have occurred during the dissection of the gall bladder which can result in a delayed perforation on an ischaemic basis. He stated that this was not a routine cholecystectomy, but a rather difficult one. If it was a serosal tear or injury, surgeons generally do not comment on it as small serosal tears are not considered a problem. If the injury was as a result of a serosal tear, then under these circumstances, it was

acceptable to have either caused or missed a non-penetrative injury to the colon. He also testified that it was not always possible to identify a partial thermal, or serosal injury to the colon at the time of the cholecystectomy, especially when there is severe inflammation at the site where the colon is adherent.

[30] With regards to the use of diathermy, Dr Stein opined that diathermy was used during the laparoscopic stage of the dissection. He was of the view that while the surgeon was attempting to do the gallbladder removal, that he found this difficult and that is when the surgeon left a little wall of the gallbladder behind. This was known as a subtotal cholecystostomy where the surgeon, whilst he was doing the gallbladder removal decided that it would be too difficult and dangerous to proceed. Diathermy, he says, would have been used during the laparoscopic portion of the dissection as there would not have been a way in which the surgeon would have known that it could not be removed. His evidence was that the surgeon tried to remove it, but found that he could not and then decided to convert it to an open cholecystectomy.

[31] Dr Stein was of the view that some of the damage to the colon may have been caused prior to the open procedure, and that the probable damage was the diathermy burn during the laparoscopic procedure because then diathermy is used extensively.

[32] He expressed the view that the higher likelihood is probably the burn injury because damage to the serosal tissue to the bowel is commonly seen and surgeons often just used to leave it. He testified that these days some people do repairs, but that is not uncommon unless it is very large. When asked about the statement in the joint minute that *“if the injury was caused by a diathermy, this would probably have*

occurred during the laparoscopic phase of the operation", he testified that both he and Prof Bornman both agreed that if it was due to a burn – however, they are not saying that it did occur – but that these are possibilities. However, neither of them were there at the time of the surgery so they could only speculate.

[33] When asked about his report stating that the large tear in the colon was not seen or repaired during the first operation, Dr Stein testified that there was no tear present at that stage. He stated, "*Well there wasn't one almost certainly there wasn't one*". This was canvassed with him again during cross-examination and he again acknowledged that there was no perforation at the time of the first operation. The surgeon did not see a tear in the colon, so they did not repair anything, stating "*what is there to repair if it was not seen*". There was no hole in the colon at that stage, i.e. into the lumen of the colon. He conceded that at the time that he did his report, he had not considered the serosal damage. He said it was what he discussed with Prof Bornman that he thought it was always due to the burn, but he agreed with Prof Bornman that it could have also been due to serosal damage. He conceded that there was no tear in the colon to see, and there was therefore nothing to repair.

[34] Dr Stein testified that they were speculating between two causes and only two causes, not that there were no causes. They concluded that the delayed perforation was caused either, by the burn which was not identified, or the serosal injury.

[35] During cross-examination, he was referred to his report of 9 June 2015, where he did not mention that diathermy was a possible type of injury, but only that there was an injury. He maintained that the cause of the delayed perforation remained speculative and that there two possible causes. He could not say for sure if the

delayed perforation was due to the burn, or the serosal injury. It was either the burn that was not identified or the serosal injury which was not properly identified. He conceded that a serosal tear would have been caused when the gall bladder was dissected from the colon. He also noted that the diathermy injury in the laparoscopic phase would not have been caused necessarily by dissecting the gall bladder from the colon, but rather an accidental burn, i.e. if a surgeon places his foot on the pedal that can cause a diathermy hook to burn the colon for whatever reason. He conceded that it was not always possible to identify a partial thermal or serosal injury to the colon at the time of the cholecystectomy.

[36] There was specific reference to the joint minute of the experts wherein they stated that an iatrogenic perforation of the colon during a difficult cholecystectomy is an acceptable complication as long as this is recognised and repaired at the time. Dr Stein testified that both he and Prof Bornman agreed that the cause of the delayed perforation remained speculative, but on the balance of probability, Dr Stein held the opinion that it was more likely to have been a diathermy injury in the vicinity of the colon. Prof Bornman held the opinion, that it was more likely to have been serosal damage when the colon was dissected free from the inflamed gallbladder.

[37] As to the probable cause of a perforation of the colon three days post operation, Dr Stein held the view that there was no complete laceration at the time of the operation, but some injury must have occurred. He stated that both, he and Prof Bornman agreed that the only two possibilities are a burn which was not noticed at the time. When tissue gets burnt, the tissue dies (necrosis) and the heat changes the protein. He is of the opinion that such a burn will not be noticeable in the large bowel that is inflamed.

[38] Referring to the second probable cause, Stein testified that an injury to the serosa of the colon may occur during the dissection of the inflamed gallbladder, but stated that they occur quite often and usually they are not repaired unless there is a very big tear, a very big dissection of the serosa and the underlying muscle, then it must be repaired.

Evidence of Prof PC Bornman:

[39] Professor Bornman testified that he was a semi-retired surgeon currently working predominantly at the University of Cape Town Private Academic Hospital. He was appointed as a consultant surgeon with the Department of Surgery at Groote Schuur Hospital in 1977, and had been there up until his retirement in 2008. He then took up various positions amongst others as Head of the HPB Surgical Unit which includes all forms of surgery on the liver, pancreas, and gallbladder. Prof Bornman reviewed the hospital records of the Plaintiff to provide an opinion with regards to the Defendants' liability. Prof Bornman agreed that this was a very difficult surgery, and stated that the Plaintiff suffered from gallstone cholecystitis with associated dense adhesion. These were situated between the liver, transverse colon and the second part of the duodenum. This, he said was a very common problem that surgeons saw in State hospitals where patients for various reasons presented late and where they have had several previous attacks of cholecystitis, as was the case with Plaintiff. He agreed with Dr Stein that where there were a few adhesions, the operation would generally be easy and straightforward. However, in this instance, the Plaintiff had an inflamed gallbladder and that it was adherent to the liver, the transverse colon and the duodenum.

[40] Prof Bornman also presented slides and video footage on PowerPoint to show the court what a laparoscopic cholecystectomy procedure entailed, although the footage was not of the actual surgery under discussion.

[41] Prof Bornman then sought to demonstrate a dissection on a very inflamed gallbladder without the use of diathermy. However, when Dr Stein testified he indicated that diathermy was in fact used after the blunt dissection to divide the cystic duct during the video clip. Whilst in that video it was evident that the gallbladder was very inflamed, and that diathermy was in fact used to free one thick adhesion. When asked in that instance at what stage would the procedure be converted to an open cholecystectomy, he answered that it would not, as it was a standard laparoscopic cholecystectomy. He stated that if the surgeons could not have identified the cystic duct or secure the safety clips, only then would one convert it because then the surgeons would be constantly concentrating on not damaging the common duct. Essentially Prof Bornman testified that diathermy was only used when it was safe to do so, and it was not done where one was working close to vital structures, or where the colon was adherent to the gall bladder. In the Plaintiff's case, there were dense adhesions between the gall bladder and the colon and also between the duodenum and part of the gall bladder, so the gall bladder was adherent to the colon and to the duodenum as is evident from the operation note.

[42] He testified that in this instance, the surgeons were concerned that they could not clearly identify the anatomy due to this inflammation process around the gall bladder which also involved the colon, so they decided to do an open procedure. They would use more of a blunt dissection technique which they would have also attempted initially with the laparoscopic procedure. The surgeons felt that it was not

going to be safe to do a standard removal of the gall bladder and opted for the sub-total cholecystectomy.

[43] Regarding the cause of the colon injury, neither he, nor Dr Stein could tell exactly what caused the delayed perforation. There were two possibilities, either a diathermy injury, or a serosal injury that caused ischaemic damage.

[44] When asked where he thought the perforation might have occurred, he was of the view that in order to mobilise the gall bladder, the surgeons had to first separate the bowel, then the colon and thereafter the duodenum from the gall bladder. It was during this dissection he assumed a blunt dissection was done when there would be a serosal tear to the colon and a more complete laceration of the duodenum which was recognised. He emphasised how difficult the surgery must have been that there were actually two injuries that occurred during the procedure and that, that can happen quite easily as have happened to him during these procedures.

[45] The important thing, he said, is to recognise and to correct it when you recognise it at that time - which is not always possible. The cause of the delayed perforation remains speculative and that they just don't know what the cause was. It was either a diathermy or a serosal ischaemic damage.

[46] Regarding whether the diathermy will be used in the standard procedure at Groote Schuur Hospital, Prof Bornman testified that they teach not to use a diathermy where there are adherent structures and where there is inflammation.

[47] Regarding the comment in the joint minute, that if the injury was caused by a diathermy, this would probably have occurred during the laparoscopic phase of the operation. Prof Bornman's evidence was that if the diathermy was used during that early stage of the laparoscopic operation then he would accept that it was probably more likely the cause of the injury, but as he testified before, there was no evidence that this had been used and this is not the practice. The technique that they used in the video was blunt dissection and not diathermy to separate the colon or whatever is attached to the gall bladder. This is just not done.

[48] Regarding Dr Stein's evidence that there must have been a burn because there was no obvious tear on the colon, that the delayed perforation could only have been caused by a thermal burn, Prof Bornman's evidence was that if a diathermy touches the bowel and if it is a normal bowel, then it turns white for lack of a better term. If a diathermy is used and there is a lot of inflammation and often during the dissection there can be a bit of bleeding, then one could get charring of the skin. He pointed out that they knew that in this case there was a lot of bleeding and it was quite a difficult operation, so it would be extremely difficult to pick up any form of injury, or that kind of injury that he and Dr Stein are saying happened.

[49] As regards why the injury was not present or visible at the time, Prof Bornman explained the difficulties in identifying injuries of this nature in the presence of severe inflammation between the gall bladder and the colon in this matter and of course duodenum. Both he and Dr Stein had agreed that this is an acceptable complication.

[50] Commenting on Dr Stein's evidence that it is less likely that a perforation will occur if there is a small serosal tear as opposed to a large serosal tear, Prof Bornman's stated that they accept that the larger the serosal tear the higher the risk

there would be of a perforation, but that did not mean that a small tear could not perforate as well since the pathology was the same.

[51] Regarding the injury, Prof Bornman was of the view that it was most likely due to a serosal tear and the reason for that is that the diathermy is not used for that dissection of freeing the colon from the gall bladder and is the classic injury that you get if you use blunt dissection to separate the inflamed colon from the gall bladder or *vice versa*. Regarding Dr Stein's evidence that a diathermy could have accidentally touched the colon, Prof Bornman testified that it is difficult for him to reconcile that kind of injury with a delayed perforation and the size of the delayed perforation that was found at the second operation. While it is possible, he cannot reconcile these two possibilities. He accepted that there was no evidence of any diathermy used in this case and that it is just speculation.

[52] He stated that the eventual management with regard to the appropriate process and protocol that should have been followed regarding the duodenum and colon was that it was handled according to what one would expect of a qualified team of surgeons managing this complication. It is a serious complication and he thought that all the steps were taken and that the timing thereof was appropriate.

[53] Regarding the issue of negligence, based on the fact that the cause of the injury that led to the 4cm delayed perforation is speculative, despite having sympathy for the Plaintiff about her suffering for these complications that occurred, his view was that these are to him quite acceptable under the circumstances and it cannot be construed as being negligence.

[54] His belief is that it was caused during the blunt dissection, or whatever procedure was done during the mobilisation of the colon from the gall bladder and

that it was not caused by a diathermy or at least there is no proof that it was caused by a diathermy.

[55] Regarding what entails a serosal injury, Prof Bornman testified that the serosal layer and the muscular layer of the colon are both thin and he agreed that if there is a tear of the serosa it is more often than not, that the muscle layer is also separated, or there is a tear. This happens often he said, but it did not mean that it will necessarily perforate. Some form of injury must have been present to cause the delayed perforation three days later. However, there was no injury present so they did not repair. They did not see it, this is why they did not repair it. One cannot repair something that you have not seen. He stressed that an unidentified serosal injury to the colon that most likely caused the delay perforation is an acceptable complication of a cholecystectomy. It is also acceptable not to identify it because even in the full thickness, perforations under those circumstances can be missed.

Evidence of Mr SH Bhaila

[56] Mr SH Bhaila is a registered surgical gastroenterologist. He explained that the reason why he is not referred to as “Dr” is because once one has completed a fellowship from one of the Royal colleges in the United Kingdom, in his case from the Royal College of Surgeons of Glasgow, then one automatically reverts back to being called “Mister”. He was the head of General Surgery in the Metro West Area which included UCT and Groote Schuur Hospital. He conducted the open cholecystectomy surgery that was performed on the Plaintiff on 30 November 2011. When it turned out that Drs Rautenbach and McGuire could not continue with the laparoscopic cholecystectomy, they called for Mr Bhaila’s expertise and he attended at the surgery to assist with the open cholecystectomy.

[57] With regard to the use of diathermy, Mr Bhaila testified that diathermy is not used at the beginning of a procedure but right at the end. When surgeons make the four holes to do the laparoscopy, diathermy is not one of the ports that is inserted at the start. They initially insert the Maryland which is a blunt instrument for dissection. He stated that there is often no reason to use a diathermy and to say one would use it on adhesions in the laparoscopic situation is not correct. He did not think anyone ever does that because the instrument is not designed to bring down adhesions. He would use blunt dissection, or sharp dissection but not a diathermy.

[58] When the laparoscopic procedure was converted into an open procedure, Mr Bhaila was referred to the operation form, and he questioned whether, based on the operation notes, that there would have been enough time to use a diathermy. Based on these notes, which were completed by the theatre sister, he testified that the anaesthetist started at 8am to put the patient under general anaesthetic and only gave the surgeons permission to start the surgery at 8.25am. At 8.25am, the surgeons took over and the scrub sister would start to prep the patient's abdomen, cleaning it and draping it. That process he says, takes five to ten minutes so it would be 8.30 to 8.35am. The checking of the equipment takes another five to ten minutes. They would then insert the first port and have to be very careful not to cause damage, so that takes five to ten minutes to set up and get the port in, which would take it up to 8.45am. Once the camera is in they have to wait because they have to distend the peritoneal cavity so that the interior abdominal wall is pushed away from everything so that the gut is not hit. They then run gas through the telescope which takes about two to three minutes, and that takes it up to 8.47 to 8.48am. They then insert the operation port and the gall bladder retractor port and that takes two to three minutes so it would take one upto 8.50am.

[59] Mr Bhaila was then referred to the anaesthetist record, and he testified that at 09h00, the anaesthetist recorded that the laparoscopic cholecystectomy was converted from a laparoscopic to a laparotomy where they use a Kocher's incision. He concluded that during this phase of preparation, by the time the laparoscopy was all set up, which would have been around 8.50 am, the surgeons would have had about 2 to 5 minutes to explore, but not much longer than that, and they soon realised that this method was not going to work laparoscopically. He concludes that in that 7 to 10 minutes before the laparoscopy was converted, it would have been impossible to use a diathermy because that instrument is used mainly for gall bladder dissection. He testified that at most, they would have used the Maryland, an instrument to dissect and which is like forceps, which they would put through the operative port. They would have tried or used the suction or irrigation tube to try to tease things away and conceded that it would be suicide to use diathermy at that stage as they would not know what they were burning. He could not see the diathermy being used in the 7 to 10 minutes before the laparoscopic cholecystectomy was converted. It was too short a time, and in any event, it was not at a stage where they could have used a diathermy. He concluded that based on the time factor and the theatre records and given the fact that diathermy usually occurs right at the end when the gall bladder is removed, diathermy would not have been used prior to the conversion.

[60] During cross examination he however, conceded that by the time that he had scrubbed in, the Plaintiff's bowels were already exposed, that is to say after the laparoscopic part was commenced and abandoned and after the Kocher's incision was made, that the surgeons were alone in theatre for a better part part of an hour prior to his arrival. He therefore could not factually testify as to what they did during the laparoscopic phase.

[61] It was also conceded that factually, Mr Bhaila could not testify as to whether diathermy was used or not, as he was not present. He did admit that diathermy was present in the theatre but stated that it would be rare to use it until the very end of a laparoscopic procedure.

[62] Regarding the operation sheet, Mr Bhaila's also noted that there were very dense adhesions to the liver, transverse colon and the second part of the duodenum. These dense adhesions to the liver were as a result of the Plaintiff's recurrent attacks of cholecystitis. The Plaintiff also had an abdominal hysterectomy which means that both the ovaries and the uterus were removed. That alone, he says, would have caused adhesions, so she was already someone with previous adhesions together with recurrent attacks and would have had more adhesions forming, so these adhesions were dense, which means they are pretty tough.

[63] Regarding the "*retrograde dissection of the gall bladder from the liver*", Mr Bhaila explained that he was called in at that point because the surgeons were unsure about the anatomy in the area of the common bile duct. If they could not see the cystic duct and they could not safely clamp it and cut and clean the gut in a clean fashion, they would start at the other end of the gall bladder, the balloon end and they would start to dissect towards the common bile duct which is much safer and this is what he guided them through. They would reach a point where they would now say they need to stop because they do not know where the cystic duct is and if they go any further they could harm the Plaintiff as they put a clamp across and cut out the gall bladder, which is why it was a sub-total as pointed out by Prof Bornman. This ensured that they did not harm the common bile duct.

[64] A pencil drain was inserted to be safe and according to Mr Bhaila, it is not standard practice in a cholecystectomy to insert such a drain but under the circumstances of the Plaintiff's surgery it was deemed prudent and standard.

[65] He testified that he would have recommended the subtotal cholecystectomy to them in order to avoid harm to the common bile duct. They left the gall bladder remnant behind in order to avoid injury to the common bile duct. He testified that there was an iatrogenic injury to the duodenum of 3mm which was recognised and repaired. Iatrogenic means an injury caused by the surgeon.

[66] As to when the injury to the duodenum would have occurred, he thinks it was most likely that there were the dense adhesions and the gall bladder had to be separated from both the colon and from the duodenum. In the process a tiny hole in the duodenum in the second part was made, recognised and closed.

[67] Regarding whether, they at any stage noticed a tear in the colon, Mr Bhaila's evidence was that if they saw the duodenum injury, they would have started questioning themselves about any other injuries. Because of all the blood, in order to do their investigation they would wash the abdomen thoroughly using litres of normal saline until they can see that the fluid is clear. They would have washed the colon. He testified that with four sets of eyes focussed on this area being him, Dr McGuire, Dr Rautenbach and the scrub sister, they looked and also placed a pencil drain in that area, the Morrison's Pouch, which is right below the liver close to the hepatic flexure of the colon. With all the adhesions, it would be very difficult to identify things. They washed it, cleaned it and got it all clear and he did not smell anything untoward because faeces would smell. He accepted the evidence of Prof Bornman that the injury might have been there and that they could have missed it, but stressed that with all of the adhesions, it would have been possible to have missed it.

[68] He testified, that there might have been a serosal tear of the colon, but that this would have been almost impossible to identify with the amount of dense adhesions present. If they had seen a hole in the colon, they would have immediately looked at it and there would have been options on how to repair it and whether it was safe to do so. It has been accepted by Dr Stein that the perforation of the colon was delayed and Mr Bhaila accepted that, saying that the injury was not there.

[69] With regards to the teachings at Groote Schuur Hospital regarding the use of diathermy, his evidence was that they are taught to stay far away from a diathermy if they are not sure where they are, especially if they are close to vital structures, nerves, arteries, veins, gut and spleen. They do not fiddle with a diathermy unnecessarily and use blunt instruments instead in order to avoid harm and that they also use blunt instruments gently. Mr Bhaila stated that diathermy would have been used during the open part of the surgery and said that they could have used it to do the retrograde dissection safely.

[70] Regarding when and how the colon injury was caused, Mr Bhaila's evidence was that the fact that both the duodenum and the colon were injured, suggested that the surgeons dissected the gall bladder off both the colon and the duodenum in order to separate them so that there was ease for removing the gall bladder without harming any structures. The duodenum injury perforated and they repaired it the moment they realised that there was a perforation. These injuries (colon and duodenum) would have occurred at the time after they converted from the laparoscopic surgery to the open surgery and it is most likely that it occurred during the open surgery.

[71] The colon injury, unlike the duodenum injury, never perforated until three days later. This suggests that it was a serosal injury which exposed the mucosa that had not perforated at the time of the surgery. In this case, they never saw the tear. He accepted Prof Bornman's evidence that if even a small serosal tear could end up being a large serosal tear due to perforation.

[72] During cross-examination, Mr Bhaila conceded that diathermy was present through-out the surgery. He could not however, factually testify as to what happened during the laparoscopic phase. He conceded that diathermy is in fact used at Groote Schuur Hospital for laparoscopic as well as open cholecystectomies. According to him it is also used if it safe to do so during dissection. He however, emphasized that they must be careful when using diathermy when working close to organs and the gut, and specifically the colon. He testified that if you were dissecting with a diathermy it would be wrong and that it might compromise the bowel which might then manifest later and that an unintended diathermy injury to a colon is a mistake and it should not happen.

[73] Mr Bhaila agreed that there must have been an injury to the colon sometime between 08:00 and 10:40 on the day of the first operation. He could only testify factually that he did not observe an injury during the second part of the operation where he was present. He testified that if you go looking for damage, you might see a diathermy injury but you might miss it too.

[74] In this matter, the court is clearly faced with two conflicting opinions. Plaintiff bears the onus on a balance of probabilities to show that the injury was either as a result of a diathermy injury caused by the surgeons, *alternatively* a serosal injury to the right colon, which injury, it is claimed the surgeons failed to notice and/or repair.

[75] Insofar as the alternative claim relating to the serosal injury, both Dr Stein and Professor Bornman agreed during their testimony and in the joint minutes, that if it was a serosal injury or ischaemic damage, then this type of injury was an acceptable consequence of a very complicated and difficult surgery. Under the circumstances of dense adhesions and inflammation, such an injury would not be considered negligent. In light of this concession, the only aspect which the court has to establish, is whether, the Plaintiff has on a balance of probabilities proved, that the surgeons negligently used a diathermy in the circumstances as claimed.

[76] As mentioned before, the respectively experts, both eminently qualified in this field, have two opposing views. It is trite that a court faced with conflicting opinions of experts in highly scientific or technical issues, must determine whether and to what extent the opinions advanced by the experts are founded on logical reasoning or has a logical basis.²

[92] In **Mitchell v Dixon** the following was said with regard to medical negligence³:

“A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not. The burden of proving that the injury of which he complains, rests throughout on the Plaintiff. The mere fact that the accident occurred was not *prima facie* proof of negligence.”

[93] Where there were two mutually exclusive versions, the court has to make one enquiry: is it more probable than not that the diathermy injury caused the delayed 4cm perforation? If the court finds that it is more probable than the serosal injury,

² Michael and Another v Linksfeld Park Clinic (Pty) Ltd and Another 2001 (3) SA 1188 (SCA) paras 36 and 37. Louwrens v Oldwage 2006 (2) 161 (SCA) para 27

³ 1914 AD 519 at 525

then the burden is discharged. If the probabilities are equal, then the burden is not discharged.

[94] Ultimately the question is whether the onus on the party, who asserts a state of facts, has been discharged on a balance of probabilities and this depends not on a mechanical quantitative balancing out of the pans of the scale of probabilities but, firstly, on a qualitative assessment of the truth and/or inherent probabilities of the evidence of the witnesses and, secondly, an ascertainment of which of two versions is the more probable. See **Maitland and Kensington Bus Co (Pty) Ltd v Jennings 1940 CPD 489 at 492** where Davis J stated⁴:

'For judgment to be given for the plaintiff the Court must be satisfied that sufficient reliance can be placed on his story for there to exist a strong probability that his version is the true one....

*As to the degree of probability that is sufficient for plaintiff to discharge the onus, the remarks of Denning J in **Miller v Minister of Pensions [1947] 2 All ER 372 (KB) at 373** cited in **Ocean Accident and Guarantee Corporation Ltd J v Koch 1963 (4) SA 147 (A) at 157D** is applicable. If the acceptable evidence is such that I can safely say*

*'I think that it is more probable than not' the burden is discharged, but if the probabilities are equal, it is not.'*⁵ ("My emphasis")

[77] In **Medi-Clinic v Vermeulen**⁶ the Supreme Court of Appeal held that what is required in the evaluation of the expert's evidence is to determine to what extent:

⁴ The South African Bank of Athens v 24 Hour Cash CC (unreported judgment) A3027/2016 (GLD) at pg 4

⁵ Ibid Para 9 at page 5

⁶ 2015 (1) SA 241 (SCA) at 243 para 5

“Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently.”

[78] An important observation was made in the matter of **F M v Member of the Executive Council, Department of Health, Eastern Cape**. In that case a plaintiff, who had also undergone a laparoscopic cholecystectomy, sustained two perforations to her common bile duct as a result of which bile leaked into her abdominal cavity causing her to become very ill. Revelas J, referring to a *dictum* by Brand JA from Buthelezi v Ndaba⁷, commented as follows:⁸

“After all, as Lord Denning MR observed in Hucks v Cole [1968] 118 New LJ 469 ([1993] 4 Med LR 393):

'With the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong.'

Or as Scott J said in Castell v De Greef 1993 (3) SA 501 (C) at 512A – B:

'The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the error is one which a reasonably competent practitioner might have made, it will not amount to negligence.'

[79] Ultimately, what this court has to decide, is whether it was more probable than not, that the surgeons used a diathermy when it was unsafe to do so, and that the diathermy injury caused the delayed 4cm perforation to the Plaintiff's colon which led to the second and subsequent surgeries and *sequelae*. Before I evaluate the evidence, I should perhaps point out, that this is not the case pleaded on the papers.

⁷ 2013 (5) SA 437 SCA at para 15-17

⁸ At p 23

According to paragraph 3.5 of Plaintiff's Particulars of Claim, it is alleged that *during the laparoscopic part of the procedure alternatively during the operation, the surgeons caused a 4cm diathermy injury to the hepatic flexure (right colon)*. This is not as I understand the issue to be on strictly speaking the Plaintiff's claim should be dismissed on this basis alone.

[80] The second issue to be established is whether, the failure by the surgeons to notice, or repair the diathermy injury was negligent. Both parties presented independent expert evidence. In addition thereto, the Defendants presented the evidence of Mr Bhaila, who, as I mentioned previously, conducted the second stage of the open cholecystectomy and would be classified as an eye witness expert.

[81] Ms Ellis for Plaintiff, submitted that with regard to his evidence, that because he was called as a factual witness, the only evidence that the court should consider is his evidence of fact, and of what transpired in his presence on the particular day of the surgery.

[82] Ms Mahomed for Defendants argued that the question which arises here is whether this matter turns on expert evidence or lay evidence, particularly, where there are mutually exclusive versions. In this regard, I was referred to the case of **Abdo NO v Senator Insurance Company**⁹ where a court was faced with two mutually destructive versions, with expert and eye witness evidence on both sides. The following approach was adopted from **Putzier v Union and SWA Insurance Co Ltd 1793 ECD (unreported)** where Addeleson J was faced with such a problem and held that:

"...unless the opinion of the experts is either uncontroverted or incontrovertible, the evidence of the eye witness should be examined

⁹ 1983 (4) SA 721 E at 725D-726A

first. If such eye witness/es are unacceptable, the Court is bound to decide, if possible, which of the opinions of the various experts is preferable and to found its judgment on such opinion. On the other hand, where a choice can be made on a balance of probabilities and on the accepted principles between two sets of eye witnesses, the Court should first make a provisional assessment of which of the versions of the eye witnesses is acceptable. In this regard, where the onus is on the Plaintiff and where there is a dispute between the experts, if the eye witnesses favour the Plaintiff, the evidence of the Defendant must be shown to have displaced that of the Plaintiff's eye witnesses; but, if the eye witnesses favour the Defendant, the Plaintiff must show that the evidence of his experts must be accepted in preference to the experts and the eye witnesses of the Defendant. If, at best, the Court is left in doubt as to whether the experts for the Plaintiff have advanced opinions preferable to those of the Defendant, then it seems that the Plaintiff would have failed to displace on the findings made in respect of the eye witnesses and would have consequently failed to discharge the onus on him." ("My emphasis")

[86] I was also referred to the matter of **Motor Vehicle Assurance Fund v Kenny**¹⁰ where the court held that direct and credible evidence of what happened... must carry greater weight than the opinion of the expert, however experienced he may be, seeking to reconstruct the event from his experience and scientific training. Strange things often happen... and it is practically impossible for anyone...to give a minute and detailed description of the incident in question. An expert's view of what might probably have occurred must give way to assertions of the direct and credible evidence of an eyewitness. It is only where such direct evidence is so improbable that its very credibility is impugned, that an expert's opinion as to what may or may not have occurred can persuade the court to his view. The Defendants argued, that as the evidence of an expert witness is inevitably based on reconstruction, it cannot

¹⁰ 1984 (4) 432 (EC) at 436H-437B-reference made to **Mapota v Santam Versekeringsmaatskapy Bpk 1977 (4) SA 515 AD at 527-528**

conceivably bear the same weight as direct, eyewitness testimony of the event in question¹¹.

[87] Direct and credible evidence regarding what occurred during an incident carries greater weight than the opinion of an expert irrespective of his experience. A court is required to weigh up all the evidence before it and decide whether the Plaintiff has discharged the onus of proof on a balance of probabilities¹².

Did the surgeons cause a 4cm diathermy injury during the operation of the 30 November 2011?

[88] All the witnesses agreed that this was a difficult procedure. It was also not disputed that Drs McGuire and Rautenbach, both qualified specialist surgeons, had opted to convert the procedure from a laparoscopic cholecystectomy to an open procedure when it became apparent that the operation would be difficult to complete. There is also no evidence that there was a 4cm diathermy injury at the time of the first injury. However, the likely scenario preferred by all of the experts was that there was some sort of injury and that it ultimately perforated into a 4 cm tear.

[89] This would also support the contention by all, that in all likelihood, the injury was not of such a nature that was seen on the 30 November 2011. It is very unlikely that Mr Bhaila, knowing that there had been an injury to the duodenum and having repaired it, would not have looked for other possible injuries. In fact, his evidence was that knowing that there was this injury, they would have questioned themselves about the possibility of other injuries. With four pairs of eyes, the probabilities are unlikely that they would not have done so. In fact, Prof Stein conceded that if Mr

¹¹ *Van Eck v Santam* 1996 (4) SA 1226 CPD

¹² *Vervoeidingskommissaris v Multilaterale Motorvoertuigongelukfondse* 1998 (3) All SA 155 EO

Bhaila did not see the injury, there was nothing to repair, and that it was unlikely that Mr Bhaila would have missed the injury. Mr Bhaila himself testified about what a surgeon was faced with during such an operation, and thanks to the video footage, the court was also apprised of what the inside of a person's bowel looked like, especially in a patient who had severe adhesions.

[90] Dr Stein conceded that the injury could have been small or big, but he reiterated on several occasions that all he and Prof Bornman could do, was to speculate as to what would have happened. His approach to the merits of this matter was questioned by the Defendants. They argued that his evidence should be considered together with his report of 9 June 2014, wherein he makes no reference to a diathermy being used, or being the cause of the injury. In fact, in the report, his whole basis of the negligence revolved around the incompetence of unskilled surgeons who conducted the surgery. Based on this it was argued, that Dr Stein could not rely on his report to prove negligence. They argued further, that it was clear from the evidence procured at trial, that Dr Stein was trying his best to assist the Plaintiff, and that in the circumstances, it is doubtful whether his opinion could be accepted. Defendants further argued, that despite what Dr Stein testified in court about his views of the cause of the delayed 4cm perforation, he did not categorically say that the diathermy was the most probable cause of the injury. He conceded on more than one occasion that both he and Professor Bornman could only speculate, and that both causes are equally possible / plausible. Thus, given the above, the Defendants argued that his evidence could not be accepted.

[91] Given this concession, a court is thus faced with seeking answers from the surgeon that was present. Could a diathermy have been used in the circumstances as claimed. Mr Bhaila testified that it would have been suicide for surgeons to have used diathermy under circumstances where there were dense adhesions. He stated

that the teachings at Groote Schuur hospital went against the use of diathermy under those circumstances. During cross-examination, when it was put to him that he was not present at the first stage of the operation and he could not testify as to what had happened. This argument, to my mind, is flawed. Even if Mr Bhaila was not present at the first stage of the procedure, the evidence before this court is that the surgeons, following protocols and procedures, chose to convert the laparoscopy to an open procedure. It would be highly improbable that they would not have followed protocol and teachings prior to that and used diathermy in circumstances that were unsafe. It was Mr Bhaila's evidence that diathermy is only used at the end of the process, once all of the structures have been neatly pinned away and the common bile duct identified. The evidence is that the surgeons had not reached that stage, hence their decision to convert the procedure. To view these stages as separate and as isolated events to my mind is not appropriate. Mr Bhaila testified what organs which were burnt – looked like. Had there been an injury to the colon, he would also have smelled the faecal material. He also testified that there would have been no time to have used the diathermy. But ultimately, when all of this, viewed cumulatively is taken into account, the probabilities weigh heavily against diathermy having been used during the first part of the operation.

[92] As to the second part of the operation, Mr Bhaila is a factual eye witness. He admitted that diathermy was present during the open phase of the surgery. He testified that diathermy was not used during the open phase of the operation and that the more likely scenario the injuries occurred when the duodenum and colon was being dissected from the gallbladder. He impressed upon the court as being a very good witness, making the necessary concessions where necessary. I therefore have no hesitation accepting his evidence.

[93] The Plaintiff's claim is based upon negligence, that is, upon the absence of that reasonable skill and care which the law requires under the circumstances.¹³ The Plaintiff must prove some definite act of negligence.¹⁴

[94] On every point in which negligence was suggested, the evidence was in favour of the Defendants that being the expert qualifications of the surgeons; the agreement that if they did not see ask anything, then nothing could be repaired; the concession that if it was a serosal injury that it would be an acceptable complication; and the concession that it was unlikely that Mr Bhaila would have missed an injury during the open phase of the operation.

[95] Both experts testified that they were merely speculating as to what might have happened. There are no reasonable grounds on the available evidence for finding that the surgeons were negligent during the operation of 30 November 2011. In fact, the evidence suggests that every effort was taken to ensure that the most conservative approach was taken during her operation when they were experiencing difficulty. The evidence also suggests they followed protocol and procedures by converting the laparoscopic cholecystectomy to an open procedure. In following these protocols and procedures, one would question why they would then deviate from the teaching when both experts and Mr Bhaila testified that diathermy is not used when it is not safe to do so. And most importantly, cognisance must be taken of the admission made in the joint minutes that it was unlikely that Mr Bhaila would miss a diathermy injury.

¹³ See *Mitchell v Dixon* 1914 AD at 525

¹⁴ (*Ibid* at 521)

[96] In **FM v Member of the Executive Council**¹⁵, **Department of Health, Eastern Cape**, Revelas J held that:

“The human body and its reaction to surgical intervention are far too complex for it to be said that, because there was a complication, the surgeon must have been negligent in some respect. Logic dictates that there is even less room for application of the maxim in a case like this, where it has not even been established what went wrong; and where the views of experts are all based on speculation — giving rise to various but equally feasible possibilities — as to what might have occurred.”

[97] The court also referred to the **Medi Clinic** case *supra*, and held that where experts hold opposite views, the following was stated:

“Experts may legitimately hold diametrically opposed views and be able to support them by logical reasoning. In that event it is not open to a court simply to express a preference for the one rather than the other and on that basis to hold the medical practitioner to have been negligent. Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently.”

[98] Mr Bhaila’s evidence was clear, concise and uncontroverted. Given the time that the anaesthetist administered to the Plaintiff by the surgeons which was at 8:25am to the time that they actually commenced the laparoscopy, which was at approximately 8:50am to the time that they converted to an open cholecystectomy at 9:00am. Factually speaking, there is no way that the diathermy would have been inserted into one of the ports for the purposes of dissection at that stage, especially since it is common cause that the Plaintiff had severe adhesions. Dr Stein’s evidence regarding an adhesion being loosened by way of a diathermy in the video, was under circumstances where the cholecystectomy was a normal one and where the

¹⁵ Case No. 273/2013 at para 40

entire procedure was done by way of laparoscopy with no conversion to open surgery. In this case, there was insufficient time between commencing the laparoscopy and converting it to an open cholecystectomy to have utilised a diathermy. The conversion was done during the exploration phase and not dissection stage. There could therefore not have been an “*accidental*” burn of the colon by the diathermy at the laparoscopic phase. Mr Bhaila also testified that during the open cholecystectomy, only when all the vital organs had been safely dissected from the gall bladder by means of blunt dissection, then they would have used a diathermy to remove the gall bladder. The diathermy, if it was used at all, would only have been used right at the end of the open cholecystectomy to remove the gall bladder after it was safe to do so. This was admitted by Dr Stein as well.

[99] Dr Stein admitted that since he was not present at the surgery, he could only speculate as to time that the injury to the colon occurred and the cause of the injury. Accordingly, the lay evidence of Mr Bhaila together with the evidence of Professor Bornman, the Defendant’s expert, both favour the Defendant’s defence that a diathermy was not used at all during the laparoscopic phase of the surgery, or the open cholecystectomy for the purpose of dissecting the vital organs from the gall bladder.

[100] It was submitted that Dr Stein could not support his own contentions that a diathermy was definitely used at the laparoscopic phase and that the diathermy possible caused an “*accidental*” burn of the colon during this time. As such, this creates doubt as to whether Dr Stein’s version can be sustained particularly given Mr Bhaila’s evidence read with the note from the anaesthetist as to how quick the laparoscopy was converted into the open cholecystectomy as well as from the operation note. It is clear that what transpired at the open cholecystectomy phase of the surgery, is that the surgeons attended to dissecting the colon, the duodenum and

the liver free from the gall bladder before conducting the retrograde removal of the gall bladder. There is no note to suggest that any dissection or removal of the gall bladder took place during the laparoscopic phase of the cholecystectomy. I am therefore of the view that Plaintiff has not discharged the onus of proving that the surgeons used diathermy in a manner which caused a diathermy injury to the hepatic flexure or right colon of the Plaintiff.

Was it negligent to have failed to notice or repair the diathermy injury?

[101] This question can only be answered if I find that on the balance of probabilities, that Plaintiff has proven that the injury was in fact caused by a diathermy injury to the right colon. Since I have found this not be the case, it is not necessary for me to deal with this aspect. In any event, it was already accepted by Dr Stein that in all likelihood, Mr Bhaila would not have missed an injury during the open surgery. In the circumstances, the onus has not been discharged in this regard.

[102] I am therefore of the view that the Plaintiff has failed to discharge her onus of proving that diathermy was used during the procedure of 30 November 2011.

[103] Since no negligence on the part of the Defendants employees could be established, it is not necessary for me to deal with the evidence of the Plaintiff and the remaining witnesses who were called in support of an assessment on *quantum*. Lastly, The Plaintiff in this instance also sought to take issue with consent, or rather the lack thereof in the second operation. The question of informed consent is attached to the requirement of wrongfulness in the Aquilian action. Since negligence

is a requirement, where no negligence has been proven, the question of wrongfulness does not arise.¹⁶

[104] Consequently, the following order is made:

The Plaintiff's action against the Defendants is dismissed with costs.

KUSEVITSKY, AJ

Acting Judge of the High Court

¹⁶ FM supra at para 44 ; Castell v De Greef 1994 (4) All SA 63 (C) at 426 D-H