

**IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA**

- (1) NOT REPORTABLE
- (2) NOT OF INTEREST TO OTHER JUDGES
- (3) REVISED.

CASE NO:44009/2015

9/2/2018

In the matter between:

W A P M

FIRST PLAINTIFF

M M

SECOND PLAINTIFF

and

THE MINISTER OF DEFENCE

DEFENDANT

JUDGMENT

THOBANE AJ,

[1] In late January 2014 the 20 years old second plaintiff was at University where she was a student helping out first year students when she felt pain and started throwing up. Concerned at what was happening to her she went to her family doctor, a Dr. Du Plessis who advised that she should go for a sonar or an ultrasound. On 04 February 2014 she underwent an ultrasound

evaluation/assessment at Dr. De Beers, De Jager.

[2] The findings of the ultrasound were to the effect that a gallstone was present in the gallbladder of the second defendant and further that there was no sign of acute chronic cholecystitis.

[3] On 05 February 2014 she presented herself at 1 Military Hospital and was seen by a Dr. Maree who advised that she had a gallstone and that there was no other way of removing it other than surgery. The medical personnel arranged that she come for an operation to remove the gallstone on 27 March 2014.

[4] On 26 March 2014 she checked into 1 Military Hospital. She was admitted and taken to a ward. She was then informed that she needed to go for an X-Ray and an ECG. She went for such tests and was brought back to the ward.

[5] It was further explained to her that she was about to undergo an operation in terms of which three incisions would be made to her abdomen. In the event all failed, so it was explained, they might need to make a large cut on her abdomen. The Doctor that explained all this was a Dr. N.P. Skosana whom she did not know. The doctor did not explain any risks or consequences related to the operation. She further did not explain that there could be possible bleeding. Nothing was said to her about a possible infection.

[6] On 27 March 2014 she went for the procedure. Her gallbladder was removed. After the operation she woke up in the ward in pain on the right to the middle of her abdomen. She tried to summon nurses using the bed button but it was not functional. She threw up a few times and cleaned up herself. A nursing sister came and told her she needed to go to the bathroom to take a shower. She walked to the bathroom but was in too much pain to shower.

[7] On 28 March 2014 a young man whom she could not tell whether or not was a doctor as he wore neither a white coat nor did he have a name tag, came to ask her how she was doing. He did not examine her but asked if she wanted to go home. She was thereafter discharged and given prescription for pain and anti-vomit meds. Her mother fetched her from the hospital and took her home. On arrival she went to her bedroom to sleep. Her condition did not improve. She was continuously nauseous and in pain. She returned to the hospital on 29 March 2014. She felt very tired, in pain and with yellowish eyes. She had been throwing

up and her waste matter changed color.

[8] On 1 April 2014 she went back to the hospital and was admitted. Blood samples were taken and it was said she needed to go for an ERCP. An appointment set for 14 April 2014 was arranged for her. She was allowed to go home and was collected from the hospital by her mother. She got weaker, threw up a lot, could hardly eat and could not walk or talk. Her father phoned around to arrange an ERCP.

[9] On 7 April 2014 she was taken to UNITAS Clinic where Dr. Bond performed the ERCP. He found that there are clips inside her and that she needed to have emergency reconstructive surgery. She was referred to Dr Van Niekerk for such surgery.

[10] On 8 April 2014 she was examined by Dr. Van Niekerk. He told her that he needed to make a large incision and take a piece of her intestine to make a "pipe" as her "pipe" was cut during the operation. This happened and she was thereafter in high care for about three days with a urine pipe, a tube in her stomach and one in her nose. She was uncomfortable and in pain and recuperated only after 10 days.

[11] During cross examination she stated that when she initially went to 1 Military Hospital on 5 February 2014 it was not an emergency. She went there because of her symptoms. When she was given a date for the operation she asked if there was any other earlier date but was told that there was none. On 26 March 2014 when she was admitted and was being prepared for the operation, she was only told that they were going to perform a gallbladder laparoscopy. The consequences of the operation were not explained to her and she also did not ask about them. She disputed that on 27 March 2014 before the operation, a doctor explained consequences of the operation to her. It was put to her that a nurse on duty Ms. Ramokoka was present when Dr. Skosana explained the consequences of the operation to her also that Dr. Mathobeng confirmed that consequences were explained on 27 March 2014. When she was admitted on 1 April 2014 and given the date of 14 April 2014 she did ask about an earlier date but was told that her condition was not serious. She then requested a home pass while she awaited the date. She appreciated that removal of the gallstone relieved her of her pain and accepted that 1 Military Hospital may have paid for

her reconstructive surgery.

[12] Dr. Bastion Hendrik Pienaar was called to testify as an expert. His qualifications and expertise were placed on record. He started off by explaining a few things to lay the foundation for his testimony. He explained that a gallbladder was a sac like organ underneath the liver. He explained its significance in the human body and how it functions. He tendered his evidence with the use of diagrams prepared before hand. He also made reference to his report. He stated that there were areas in the anatomy where the surgeon, in respect of gallbladder removal should not have gone. He stated that the area where the hepatic artery as well as the hilar plate was situated was a no go area. He stated that a vessel sealing device ought not to have been used. The second plaintiff suffered a severe injury in that her entire bile duct system was removed and her arterial system injured severely. He stated that the anatomy ought to be properly identified however if there are difficulties, opening up the patient might be the only option.

[13] He stated further that he had a discussion with a Dr. Limbos who was initially contracted by the defendant to prepare a medico-legal report for them. He was advised by him that he had arrived at the same conclusion as him on negligence. He did not see his report but stated that he was informed by Dr. Limbos that he was prepared to come and testify if called. He stated that according to the surgical report there were three doctors involved in the surgery. This was not unusual. The report shows the names of Dr. Cassim, Dr. T. Mathobeng and Dr. N.P. Skosana. He took the liberty of contacting the HPCSA and came to learn that Dr. Cassim was just a medical practitioner and not a registrar.

[14] The bleeding that appears to have taken place seems to have been severe. This is in line with the severity of the injury caused to the second plaintiff. He stated that he had performed over 10 000 operations to remove the gallbladder as a surgeon. In his experience the length of the procedure is approximately 15 minutes. At most it could be 30 minutes. In the case of the second plaintiff the procedure took 2 hours and 25 minutes. This time line in his opinion is "unacceptable". He believes that when there was bleeding, the

surgeons tried to stop it with clips. The use of clips was not in keeping with what a reasonable surgeon would do, namely, open the patient up to stop the bleeding. He stated further that from a reading of the medical records, there was acute cholecystitis.

[15] Concerning informed consent he stated that the surgeon who was scheduled to operate should deal with informed consent so as to be able deal with the risk associated with the procedure as well as the concerns of the patient, if any. Informed consent should not be handled by a nurse. On perusing the records nowhere does it appear that Dr. Mathobeng obtained informed consent. If it was obtained it would have been recored in writing by either him personally or a junior doctor. In his opinion there was negligence because the patient's bile duct system was removed. Even if she had consented, she could not have possibly consented to removal of her bile duct system. The duty of a medical practitioner is to avoid causing injury or damage to the patient. It is totally unacceptable, so he testified, to obtain verbal consent in these circumstances.

[16] During cross examination he stated that the usage of a seal was unacceptable. If a doctor uses his discretion to choose a device over another then should things go wrong he must take responsibility. He stated that a tissue sealing device costs about R5000-00 whereas the correct instrument which is unipolar and reusable costs about R300-00, to use the former would be more wrong even if costing was to be factored. It was put to him that the defendant's expert was of the view that the injury did not emanate from negligence but that there could have been inflammation that obliterated the area where the injury took place. It was further put to him that the surgeon in charge of the operation was Dr. Mathobeng even though records reflect Dr. Cassim. It was further put to him that Dr. Mathobeng obtained "informed verbal consent" from the second defendant. That Dr. Mathobeng was teaching other junior doctors who were assisting him. It was further put that Dr. Mathobeng will testify that when the second defendant was admitted on 1 April 2014 she had "jaundice illness", and that he gave the second plaintiff reasonable treatment. Further, that during the operation there was bleeding which he clogged to stop. Importantly it was put to him that after the operation Dr. Mathobeng was unaware that there was an injury

until the reports of Ors. Van Niekerk and Bond showed that there was an injury. He disputed that the operation was a complex operation, that being the version of Dr Mathebeng. He reiterated that Dr. Mathebeng had no business allowing an untrained person to do the operation. He further stated that the incidence of 4% of operations that go wrong do not absolve negligence. Lastly he stated that there were two major problems from the operation. Firstly, that the operation was conducted at the incorrect region and secondly an incorrect instrument was used, this of course quite apart from his view that a trainee had no business performing the operation.

[17] Dr. Thabo Jeffrey Mathobeng testified that he is the head of surgery at 1 Military Hospital. He has been based at 1 Military Hospital since 1 July 2010. On average he performs 120 to 130 surgical procedures per annum. He remembers that he was consulted by a junior doctor who wanted guidance about how to proceed with a patient. He then became interested in getting involved. The practice is that a day before surgery a patient is seen with the view to preparing for surgery. The patient is also made to meet the anesthesiologist. He remembers that on 26 March 2014 he met the patient who was in the company of her mother. He took particular interest in her as she was their youngest patient with gallstones. On 27 March 2014 although he does not remember details, but as a matter of practice with all patients that are wheeled into theatre, he interacts with them to allay their anxieties and also confirms the procedure with them. On 27 March 2014, although he does not remember specifically, it would not have been different.

[18] With specific reference to this patient he could not recall specifically if the consent was signed however at the door of the theatre there is an nurse and a doctor, so he stated, who confirm the details of the patient as well as the procedure to be performed. Concerning the risks of the operation, the patient is informed about those the day before. Regarding the informed consent any of the three doctors on duty signs it. In this instance it appears to have been Dr. N.P. Skosana. He explained that the consent was in the form of a booklet. They sometimes make copies thereof. In response to a question as to who obtained informed consent in respect of the second plaintiff, he stated that he can answer

with reference to what is common practice. In general he does it himself. During the operation he remained responsible although the practitioner that performed the procedure was Dr. Cassim. According to him the operation went well. The adhesions were easy to deal with and the bleeding after the artery was cut was also dealt with. He stated that he could not remember who cut the cystic duct but he accepts that as the most senior he would have done so. He does not remember specifically who did the cutting however he would have identified it and informed Dr. Cassim where to cut.

[19] When bleeding was encountered, the options available were either to apply a clip or to coagulate. The discretion is affected by what is easy to do in order to stop the bleeding. In this instance bleeding was stopped. After the procedure bleeding or leaking was not identified, suspected or noted. It was only a few days after the operation that the patient came back with obstructive jaundice. They then proceeded to arrange for further intervention and treatment. Because they use outside service providers they have no control over the allocation of dates. In this instance the patient was given the date of 14 April 2014. Since some time had lapsed since her discharge from hospital they thought it better to admit her so they could observe her to avoid liver damage. On the operation itself, it would be speculation on his part if he were to venture an opinion as to what went wrong which resulted in the wrong area to be severed. With the benefit of hindsight however it is clear that given that Dr. Bond found a clip on the bile duct, what they thought was a cystic duct was clearly not.

[20] He stated during cross examination that Dr. Cassim was a Chief Medical Officer in the employ of the defendant and that he was neither a surgeon nor a specialist. However she was able to exercise care and to perform her duties with the requisite skill. During the procedure, she was being told where to cut by him. This is how training takes place. It was unfortunate that it all resulted in the operation taking place in the wrong area and a wrong instrument being used. As a surgeon that trains juniors you give instructions and take charge. Dr. Skosana was responsible for the camera that was inserted in the belly button. He, together with Dr. Cassim were in possession of two instruments each, interchangeably. He accepts that the injury that the second plaintiff sustained, gleaned from the report

of Dr. Van Niekerk, which resulted in an injury to the right hepatic duct, clot and common duct injury, took place in the no go area.

[21] With regard to what caused the bleeding he stated that all that one could do was to speculate and ameliorate. He is sure that he identified the anatomy correctly despite the fact that the hepatic artery was severed causing vascular compromise to the liver. He nevertheless believes that the operation was carried out with a high degree of care. He accepts however that something went wrong during the operation, but was not prepared to accept that it amounted to negligence to allow a junior doctor such as Dr. Cassim to perform the procedure. When it was put to him that in his evidence in chief he did not state that he explained the risks of the procedure to the second plaintiff, he stated. that usually he prepares a sketch on a piece of paper. He could not recall if *in casu* he did the same thing, however it is something that he does as a matter of practice. It is irregular, so he testified, for a nurse to obtain a consent. It has to be done by a doctor.

[22] He stated that clinical records showed that the anatomy was normal. Nothing called for the administering of antibiotics. There was also nothing that militated for open surgery. He disagreed with Dr. Scharf's observation, (Dr. Scharf being the defendant's own expert witness), that the anatomy was abnormal. There was also no sign that the second plaintiff was suffering from Merizzi's syndrome. He stated that it was unusual to disclose to a patient that the surgeon who was going to perform the surgery was a trainee. The senior surgeon remains responsible. Dr. Cassim was part of a team of three, therefore she should not be singled out for criticism, but was a critical part of the team. There was no duty to explain to the patient that the surgeon was not a specialist. What unfolded and the complications that arose was not anticipated, in his view.

[23] Dr. Georg Scharf is an expert witness called by the defendant. He is a specialist surgeon who is well travelled. His qualifications and experience were placed on record. He stated that two weeks before the trial he was contacted by the defence team who indicated that they had no expert readily available to give evidence. He agreed to be of assistance and was provided with various reports

including the report of Dr. Pienaar. He is of the opinion that the injury to the second plaintiff was unavoidable due to a change in anatomy as well as Merizzi's syndrome. He stated that 1-4% of these operations result in bile duct injury and that modern technology was to blame. In his view the injury was as a result of distorted, abnormal or a variation in anatomy. The injury was therefore unforeseeable, unpreventable and unexpected. He readily and viciously attacked the use of strong language in the report of Dr. Pienaar. He disputed that there was negligence on the part of the doctors that performed the operation. Despite holding the view that there was no negligence, as a doctor, father and grand father, he was of the view that the second plaintiff should be compensated.

[24] With reference to the sketch he prepared for the court he indicated that he was of the view, and this was noted on the sketch, that there was a variant of Merizzi's syndrome present. Having gone through all the records, he was of the view that there was no negligence on the part of the defendant.

[25] In cross examination he was referred to the fact that Dr. Mathobeng disputed that the anatomy was abnormal as well as the fact that there was Merizzi's syndrome. He insisted that Dr. Mathobeng was wrong and that his belief that the anatomy was normal was equally erroneous, that he did not in good faith see it. He conceded that he had expressed his opinion without regard to the summons. It was put to him that the following had been conceded and therefore that the premise of his report was wrong; *locus standi*, legal duty, vicarious liability, nature of the injury, casual connection between the injury and operation, the sequelae, that the no go zone was operated on, that not only the bile duct but also the hepatic duct was severed. In spite of all the above being brought to his attention, he remained adamant that abnormal anatomy was encountered.

[26] He was taken to task about bias. It was suggested to him that he was biased and that he was doing a defence report as opposed to an expert report. He stated that he agreed to be retained when he was informed that the defendant could not secure an expert to testify on its behalf. He then realised that the defence was embarrassed and he then agreed to be roped in after reading the plaintiff's expert report. In fact after reading the report he was upset. He was taken through the joint minute and some of the issues with which he initially did

not agree were raised with him. He deviated from his initial posture on various issues when referred to objective facts and evidence presented.

[27] Dr. Nazira Cassim, testified that she obtained her medical qualification in 1997 and started working for 1 Military Hospital in 2012. She confirmed that she was involved in the operation of the second plaintiff together with Dr. Mathobeng and Dr. Skosana. Preoperatively she never interacted with the patient. She believes that Dr. Skosana is the one that interacted with the patient and obtained her consent. She was however part of the medical team. She could not recall specifics preoperatively but was prepared to accept what was contained in the documents in terms of which Dr. Skosana and some nurses obtained the informed consent. With regards to the operation, the senior doctor identifies the anatomy. Because she was not a surgeon she was assisting in terms of grasping, moving the camera and using the forceps. Her role was not that of operating, she was simply following instructions. The operation went well and she vaguely remembers bleeding from the artery. She could not comment about the duration of the procedure. After the patient had been discharged she remembers that she came back again and presented with jaundice.

[28] During cross examination she stated that she had read the clinical notes in preparation of her testimony. She stated further that she is not a specialist but was only a medical officer and a general practitioner. She was referred to the testimony of Dr. Mathobeng in terms of which she was the one doing the cutting. She could not remember specifically if she did the cutting however if she did on the day, it was on instruction of Dr. Mathobeng with whom the anatomy was first identified and confirmed prior to any cutting. She would have deferred to Dr. Mathobeng as he was the senior doctor. In this instance she is not aware if the risks of the operation were explained. She did not observe any abnormal anatomy which explained why it was absent from the surgical notes. There was also no sign of Mirizzi's syndrome. When told that as part of the medical team they were negligent, she indicated that the anatomy was clearly defined and that she simply followed instructions from Dr. Mathobeng.

[29] Mpho Obakeng Ramokoka testified that she is a registered nurse at 1 Military Hospital. She is currently working at midwifery but enrolled for nursing in

May 2010. In May 2014 she got registered as a nurse. She explained in general terms the procedure before an operation is undertaken, specifically how the patient's consent is obtained. On 27 March 2014 she was in the company of another registered nurse, Ms. Jele, when Dr. Skosana explained the procedure and the risks thereof, they thereafter signed the document in each other's presence. The consent is in the form of a booklet and of late they sign a portion thereof and leave out other portions.

[30] Dr. Aliyah Marais testified that she is a medical officer in the Surgical Department of 1 Military Hospital. On 5 February 2014 she saw the second plaintiff as an outpatient. She came in with a referral letter. She took her history according to which the patient had abdominal pain since December 2013. The patient went for ultrasound which showed presence of a gall stone. She considered protocols and consulted Dr. Mathobeng. After analyzing her condition which was not acute, they decided to book her for selective procedure on 27 March 2014. Generally she explains the procedure to the patient. She explained both laparoscopic as well as open surgery. She explains about bile duct injury and bleeding. Also that the anatomy might be abnormal or there might be adhesions in which event they may need to resort to open surgery. As far as she knows an operation can not be done without signed consent, which is usually done during preoperative visits. It is done by a doctor in the company of two nurses.

The law and evaluation

Informed consent

[31] It is trite that for a patient to voluntarily assume risk, in the context of a medical procedure, informed consent ought to be given. The informed consent is as explained in **Castell v De Greef 1994 (4) SA 408 (C)** at 426F- H. If a medical practitioner's treatment is wrongful because there is no informed consent, he will be liable to the patient in delict if his wrongful conduct was perpetrated with fault (*do/us or culpa*) and caused the harm of which the patient complains. It is common cause that the second plaintiff did not sign all the consent forms. She contends that there was no information provided to her explaining the procedure

as well as the risks involved. If the risks were explained she would have chosen nevertheless less to proceed with the procedure comfortable in the knowledge that all will be done to ameliorate the injury, if any. She was however adamant that *in casu* the risks of the procedure were not explained.

[32] On its part, the defendant agrees that not all the consent forms were signed by the second plaintiff. Various reasons are advanced by various witnesses called by the defendant for the anomaly. The reasons range from sheer omission to a change in informed consent obtaining procedures. The defence witnesses were all in agreement that the risks of the procedure were explained to the second plaintiff. It did not matter to them the exact date of such explanation. Even those witnesses who did not interact directly with the patient prior to the procedure were adamant that the risks were explained. For example Dr. Cassim relied on the fact that in general terms details of an operation which includes the risks are explained preoperatively. She could not provide specifics in relation to this matter. A similar approach was adopted by Dr. Mathobeng. He stated that he usually takes the patient through the procedure and in certain instances he prepares a sketch of what he was about to do. Ms. Ramokoka testified that in fact the informed consent portion of the form is no longer used as it ought to be. She stated that it was constructed in the form of a booklet and that they no longer complete the entire "booklet". They complete one portion and staple the portions together. This, she argued, explained why the second plaintiff did not sign the consent to operate part. The doctor that completed the consent form and who, on the defendant's version, explained the risks to the second plaintiff is Dr. Skosana. She was not called to testify. With the exception of Ms. Ramokoka no explanation was proffered why the consent to operate was not completed and signed even if the informed consent is obtained verbally.

[33] In **Castell v De Greet 1994 (4) SA 408 (C) at 425H-I** Ackermann J said:

"For consent to operate as a defence the following requirements must, inter alia, be satisfied:

- (a) the consenting party "must have had knowledge and been aware of the nature and extent of the harm or risk";*
- (b) the consenting party "must have appreciated*

and understood the nature and extent of the harm or risk";

(c) the consenting party "must have consented to the harm or assumed the risk";

(d) the consent "must be comprehensive, that is extend to the entire transaction, inclusive of all its consequences".'

[34] Written consent, signed by all the parties concerned and of course witnessed by a nurse, is a safety net for the defendant. It assists both parties in the event of a dispute. In the context of this case, and in light of the requirements stated above, I can not conceive of a situation where a medical practitioner would explain the risk that the anatomy might not be identified properly thus resulting in an operation taking place in the wrong area. Even less, that there was a risk that the so called "no go area" would be operated. Even if such an explanation were to be given it would have to be accompanied by further elucidation why the surgeon would end up in the "no go" zone. In light of the above and in the absence of the evidence of Dr. Skosana, particularly because according to the defendant's amended plea the consent was given verbally, I can arrive at no other conclusion than that there was no informed consent.

The defendant's pleaded case

[35] In answer to the contention that the defendant undertook responsibility on examination and treatment of removal of the gallbladder of the second plaintiff, the defendant initially pleaded as follows;

"The defendant denies the plaintiffs' allegation that the defendants' employees undertook and accepted responsibility on examination and treatment of removal of gall bladder on the second plaintiff",

As it later became clear, the defendants abandoned this line of defence. The duty of care was no longer in contention at the trial of this matter. However there appeared to be a conflation between the duty of care as well as the legal duty.

The manner in which the defendant pleaded and therefore pitched its case, gives the impression that consent extinguishes the duty of care. The same submission was made during argument. Having regard to the defendant having belatedly admitted that a particular duty of care was owed by the doctors and nurses to second plaintiff, and as that duty is certainly recognized in law, it follows that a breach of that duty (since it is no longer disputed) for the purposes of liability is wrongful. See: **Minister of Law & Order v Kadir [1994] ZASCA 138; 1995 (1) SA 303 (A) at 317.**

[36] The conflation of the duty of care as well as the legal duty, made its way into the address to court, by the defendant's counsel. On the one hand there seemed to have been an acknowledgment that the defendant was under obligation to provide the second plaintiff with the best care at its disposal and within its resources. Further that this obligation extended beyond the facilities of the defendant. This observation is made in the context of the defendant having pleaded as follows; *"the defendant exercised continued skill, care, diligence to the second plaintiff by even funding treatment at a hospital of her choice"*¹. The defendant further pleaded as follows; *"A high degree of care and skill was applied on the second plaintiff's treatment, but the risk manifested themselves."* The defendant on the mere reading of the pleadings accepts that a certain level or degree of care, skill and diligence was required in the surgery, and on its version the obligation was met in that such skill, care and diligence was exercised. It can be taken as proven, in light of the defendant's plea, that it was expected of the defendant to exercise reasonable care, skill and diligence in the performance of the procedure.

[37] In **Trustees for the Time Being of Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd (545/2004) [2005] ZASCA 109; [2007] 1 All SA 240 (SCA)**, the following was said by Brand JA;

"[11] It is sometimes said that the criterion for the determination of wrongfulness is 'a general criterion of reasonableness', i e whether it would be reasonable to impose a legal duty on the defendant (see eg Government of the Republic of South Africa v Basdeo and another

¹ Amended plea para 8 line 9-11.

1996 (1) SA 355 (A) 367E-G; Gouda Boerdery BK *supra* para 12). Where that terminology is employed, however, it is to be borne in mind that what is meant by reasonableness in the context of wrongfulness is something different from the reasonableness of the conduct itself which is an element of negligence. It concerns the reasonableness of imposing liability on the defendant (see eg **Anton Fagan 'Rethinking wrongfulness in the law of delict' 2005 SALJ 90** at 109). Likewise, the 'legal duty' referred to in this context must not be confused with the 'duty of care' in English Law which straddles both elements of wrongfulness and negligence (see eg **Knop v Johannesburg City Council [1994] ZASCA 159; 1995 (2) SA 1 (A) 27B-G; Local Transitional Council of Delmas v Boshoff 2005 (5) SA 514 (SCA)** para 20). In fact, with hindsight, even the reference to 'a legal duty' in the context of wrongfulness was somewhat unfortunate. As was pointed out by Harms JA in **Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA (SCA case 459/04 9 September 2005, para 14)**, reference to a 'legal duty' as a criterion for wrongfulness can lead the unwary astray. To illustrate, he gives the following example:

'[T]here is obviously a duty - even a legal duty - on a judicial officer to adjudicate cases correctly and not negligently. That does not mean that the judicial officer who fails in the duty because of negligence, acted wrongfully.' (See also **Knop v Johannesburg City Council** *supra* 330-E.)

[38] The court continues;

[12] When we say that a particular omission or conduct causing pure economic loss is 'wrongful' we mean that public or legal policy considerations require that such conduct, if negligent, is actionable; that legal liability for the resulting damages should follow. Conversely, when we say that negligent conduct causing pure economic loss or consisting of an omission is not wrongful, we intend

*to convey that public or legal policy considerations determine that there should be no liability; that the potential defendant should not be subjected to a claim for damages, his or her negligence notwithstanding. In such event, the question of fault does not even arise. The defendant enjoys immunity against liability for such conduct, whether negligent or not (see eg **Telematrix (Pty) Ltd** supra para 14; **Local Transitional Council of Delmas** supra para 19; **Anton Fagan** op cit 107-109). Perhaps it would have been better in the context of wrongfulness to have referred to a 'legal duty not to be negligent,' thereby clarifying that the question being asked is whether in the particular circumstances negligent conduct is actionable, instead of just to a 'legal duty'. I say this in passing and without any intention to change settled terminology. As long as we know what we are talking about. When a court is requested, in the present context, to accept the existence of a 'legal duty', in the absence of any precedent, it is in reality asked to extend delictual liability to a situation where none existed before. The crucial question in that event is whether there are any considerations of public or legal policy which require that extension. And as pointed out in **Van Duivenboden** (para 21) and endorsed in **Telematrix** (para 6) in answering that question*

'... what is called for is not an intuitive reaction to a collection of arbitrary factors but rather a balancing against one another of identifiable norms. '"

[39] The question that inadvertently arises is whether such reasonable care, skill and diligence was exercised. Dr. Cassim who was a surgeon in training, is the one that, on the defendant's version, performed the operation under supervision of Dr Mathobeng. Dr Mathobeng confirmed that he was in charge and would all the time, during the surgery, confirm the anatomy with Dr Cassim. If that were the case, one must infer that Dr Mathobeng identified the anatomy, confirmed it with Dr Cassim who in turn proceeded to effect the necessary cut or

incision. It is hard to apply a test about what a reasonable trainee surgeon would have done in these circumstances as no evidence was led by any of the parties as to the standard of a reasonable trainee surgeon. The posture adopted by Dr. Pienaar is that a trainee surgeon had no business performing a surgery of this nature. In addition, he is of the view that the duration of the procedure, which was approximately two hours, was inordinately long.

[40] Dr Mathobeng stated that he was in charge of the surgery and that Dr Cassim was under his direct supervision. The procedure of which Dr Mathobeng was in control requires skill. Skill which Dr Mathobeng appears to have had at the time but which Dr Cassim had not acquired owing to her being a trainee. The level of skill whether residing with Dr Cassim or Dr Mathobeng, ought not to have resulted in the transection of the biliary tree. This applies whether one goes with the level of skill of a trainee (Dr Cassim) who is under specialist supervision or the skill of the specialist himself (Dr Mathobeng). It was common cause during the trial that the operation or in particular the transection took place at the "no go area". There ought to be an explanation, in my view, from the defendants, why the "no go area" was operated on, in light of the common cause fact that the operation took place at a place where it ought not to have. It is accepted that Dr Cassim was not a qualified surgeon. Nevertheless, some skill was expected from her. Dr Mathobeng testified that there is a need to train doctors and that the case of the second plaintiff presented such an opportunity. It is my view that the level of skill required of any specialist, even in training, is high. It would be wrong to lower the level of skill expected of a trainee, to a level where it must be accepted that there was a higher risk of injury or of the procedure going wrong. The only reasonable conclusion the court can arrive at, given that the defendant's witnesses have proffered no explanation why the wrong area of the anatomy was operated, is that the doctors who performed the procedure were negligent. If the anatomy was correctly identified, as contended by Dr Mathobeng, and if Dr Mathobeng, an experienced surgeon, was in charge and gave instructions to Dr Cassim, who was a trainee lacking in experience, to "cut" where directed, then why was the wrong area of the anatomy "cut"? Dr Cassim stated that she "cut" where directed by Dr Mathobeng. There has not been an explanation forthcoming, still why the anatomy seemed to have not been properly identified. It

is insufficient to state, as Dr Mathobeng did, that it is unfortunate that the surgery took place in the no go area.

[41] I would be remiss if I do not make reference to the expert testimony tendered by both parties. The plaintiff's case was that they have been made aware that the defendant procured a report from their initial expert and that in terms of this report, there was an unfavorable comment about the conduct of the doctors that performed the surgery. Simply put, the plaintiff procured services of an expert, was supplied with an unfavorable report, ditched the expert and procured another expert but importantly did not disclose the first report to the plaintiff. The plaintiff's expert only became aware when he made contact with the defendant's expert. It is well known that experts are there to assist the court. I found myself troubled by the fact that the defendant was dismissive of the fact that the plaintiffs were aware that there was a report procured which seemed to have been suppressed by the defendant, which report was supportive of their claim.

[42] The duty of an expert witness is well settled in our law. In **Schneider NO and Others v AA Another 2010 (5) SA 203 (WCC)** Davis J quoting: Zefferdt, Paizes & Skeen *The South African Law of Evidence* at 330, citing the English judgment of **National Justice Compania Naviera SA v Prudential Assurance Co Ltd (The 'Ikarian Reefer' [1993] 2 Lloyd's Rep 68** at 81, set out duties of an expert witness thus:

"(1) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation.

(2) An expert witness should provide independent assistance to the court by way of objective, unbiased opinion in relation to matters within his expertise...An expert witness should never assume the role of an advocate.

(3) An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinions.

(4) An expert witness should make it clear when a particular

question or issue falls outside his expertise.

(5) If an expert opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional ones.,,

Davis J foreshadowed the duties of an expert witness and stated the following;

"In short, an expert comes to court to give the court the benefit of his or her expertise. Agreed, an expert is called by a particular party, presumably because the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with as objective and unbiased opinion, based on his or her expertise, as possible or a particular case. An expert is not a hired gun who dispenses his or her expertise for the purposes of a particular case. An expert does not assume the role of the advocate, nor gives evidence which goes beyond the logic which is dictated by the scientific knowledge which that expert claims to possess."

[43] On Dr Scharf's own testimony, he got involved in the matter at the very last hour, because he thought the defendants were embarrassed to find themselves at a trial at which they did not have an expert witness. For a start therefore, the premise from which Dr Scharf moved and ended up being involved in this case was the incorrect one. An expert would want to get involved so as to be of assistance to the court on an issue which required his/ her expert knowledge.

[44] On numerous occasions during cross examination, Dr Scharf was alerted to the fact that it was expected of him to tender unbiased evidence. Counsel for the plaintiff repeatedly told him when posing questions, that the question was meant to show that he was biased in his testimony. For example he stated that he was opposing a particular proposition or opinion simply because it emanated from Dr Pienaar, whom he readily and openly stated that he was not in good

terms with. In this regard, when pointed at numerous proposition he stated that he opposed them on the basis that they originated from Dr Pienaar. However once it was shown that the propositions were extracted from objective facts, he immediately aligned himself therewith and stated " I thought it was Dr Pienaar who said that".

[45] The nature of Dr Scharf's belated involvement further impacted on the conduct of the trial in some other respects. The case commenced without the requisite joint pre-trial minute, explanation in respect of its absence, on the part of the defendants, was inadequate. Eventually when the joint minute was presented it still had areas of disagreement which clearly should have not been classified as such. This became apparent when Dr Scharf conceded, in contrast to what was in the joint minute, to numerous questions or issues he disagreed with in the joint minute. This I find unacceptable.

[46] The testimony of Dr Scharf has offered no assistance whatsoever to this court. On the one hand he contends that there was no wrong done by the defendants and on the same breath submits that he was of the view that the second plaintiff should be compensated for what happened to her. He also insisted that the anatomy was not properly identified and was adamant that there was Merizzi Syndrome symptoms despite the testimony of not only Ors Cassim and Mathobeng but also Dr Pienaar.

[47] An expert that does not concede to even the most basic of propositions renders himself less reliable as an expert and fails in his/her duties as an expert. Dr Scharf was one such witness.

[48] In relation to Dr Cassim, A medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner in his or her field. See ***Mitchell v Dixon 1914 AD*** at 525. In deciding reasonableness the court will have regard to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. A greater degree of skill is expected of a specialist than a general practitioner and if a general practitioner undertakes work that requires specialist skill, which the practitioner concerned does not have, he or she would be negligent. See ***LAWSA Vol 17(2)*** at para 44. Failure to operate at the correct location of the

anatomy is potentially injurious and even fatal This is not in dispute. The injury suffered by the second plaintiff was therefore foreseeable. There has been no explanation forthcoming why, if the anatomy was correctly identified, the biliary tree was obliterated. When all the evidence is considered the conclusion of negligence is irresistible.

[49] I am satisfied that the second plaintiff has discharged the onus resting on her.

[50] I therefore make the following order;

1. The defendant is liable for all the second plaintiff's proven damages;
2. The defendant is ordered to pay the second plaintiff's costs together with the qualifying costs of Dr Pienaar.

SA THOBANE
ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA