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IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG.

CASE NO: 2017/10193

(1) REPORTABLE: YES/NO

(2) OF INTEREST TO OTHER JUDGES: YES/NO

(3) REVISED.

DATE 28 August 2025

SIGNATURE

In the matter between:

N[...] S[...] M[...]

Plaintiff

and

WITS HEALTH CONSORTIUM (PTY)LTD
registration number 97/15443/07

Defendant

JUDGMENT

CORAM; YENDE AJ

Introduction.

[1] By agreement between the parties, the issue of liability and quantum have been separated in terms of Rule 33(4) of the Uniform Rules of the Court, thus the matter only proceeded before me on the issue of liability only.

[2] The plaintiff claims for damages from the defendant based on the alleged negligence of the defendant's doctor and /or medical staff at **Khulandoda Male Circumcision Clinic run by Wits Health Consortium (Pty)Ltd,**

situated in Johannesburg, Gauteng Province following a male circumcision he underwent on 1st September 2014 that caused damage and permanent deformity on his manhood- penis.

[3] The plaintiff Mr N S M[...] and adult male person who resides in Nancefield Hostel Pimville, Soweto, Johannesburg. The Defendant is Wits Health Consortium (Pty) Ltd, a company duly registered in terms of the law of the Republic of South Africa, with registration number 97/15443/07 and with registered address and principal place of business at 3[...] P[...] o[...] W[...] T[...], Parktown, Gauteng Province.

[4] The issues to be adjudicated is the liability as to the causation of the plaintiff's permanent deformity of his manhood and whether the alleged damages were as a direct result of the defendant's doctor and/or staff negligence during the plaintiff's circumcision and post the circumcision.

[5] The defendant disputes that its doctors and /or staffs were negligent in their dealing with the plaintiff during the circumcision and post the circumcision. The defendant further denies liability and claims to be protected by the contractual indemnity which the plaintiff signed before he was circumcised by its employees.

[6] In every civil litigation it is trite that parties must plead their case properly and further support their case with evidence that support their pleaded case. I now turn to the proceedings before me.

[7] **Brief relevant Background Facts.**

[7.1] On or about 1st of September 2014 the plaintiff was circumcised by the Defendant's employee/s at Khulandoda Male Circumcision clinic after being recruited by the defendant's employee who were promoting the Defendant's services at a local area.

[7.2] After the circumcision, the plaintiff was discharged and was given medication, pain killers and given information and/or told how he should look

after himself while recovering from the circumcision procedure. He was advised to come for the further observation on the 3rd of September 2014.

[7.3] The plaintiff did present himself at the clinic on the 3rd day of September 2014 and was seen by a nursing personnel member by the name of **S. Bongi** who made the following observations on her medical assessment form: -

[7.3.1] that the wound was clean and healthy,

[7.3.2] the suture line was intact and;

[7.3.3] that the plaintiff is able to pass urine.

[7.3.4] The plaintiff was then ordered to come back to the clinic for further assessment on the 10th September 2014.

[7.4] The plaintiff returned to the clinic on the 9th September 2014 complaining of sever pains, discomfort and swelling on his penis and was seen by medical personnel who introduced himself to the Plaintiff as Dr. Makhudu who carried out the following: -

[7.4.1] it was recorded that the plaintiff came in with the swelling of the penis and;

[7.4.2] that the wound was cauterised and sutured, and;

[7.4.3] covered with antibiotics and pain killers;

[7.4.4] The plaintiff was specifically told that the pains and swelling will subside;

[7.4.5] The plaintiff was then ordered to come back to the clinic for further assessment on the 12th September 2014.

[7.4.6] Accordingly no expert advice was either sought or obtained and/or a referral to an expert/ Urologist was made by Dr Makhudu after having re-opened the wound removed the stiches, drained the clot blood and re - sutured the wound and covered same with the antibiotics.

[7.5] On the 10th of September 2014, seeing that the plaintiff's pain was not subsiding and his condition was deteriorating, the plaintiff's brother called Khulandoda clinic to inform them that his younger brother was experiencing severe excruciating pains on the wound area and was told that the plaintiff must go buy pain killers at a local Click's store and this will help the pain to subside.

[7.6] Later on the 10th September 2014 after a failed attempt to get the clinic to urgently intervene, the plaintiff's condition worsened and this prompted his

brother to urgently call an ambulance which came and stabilised the plaintiff then took him to Chris Hani Baragwanath Academic Hospital on emergency basis (herein referred as “CHBAH”).

[7.7] The plaintiff arrived at “CHBAH” at or about 23h00hrs and was taken to casualty section and put in a room, then assessed by nursing personnel who put on drips to help ease the pains from the wound. The plaintiff was kept at the casualty room until he was admitted at 02h40 on 11th of September 2014. In the early morning, the plaintiff was attended to by the Doctor who recommended that the plaintiff should be admitted and be urgently referred to a Urologist.

[7.8] On or about the 15th September 2014, the plaintiff was seen by an expert Urologist who according to the plaintiff, recommended that the plaintiff should be operated.

[7.9] The plaintiff was then booked for surgery on the 30th of September 2014.

[7.10] On the 30th of September 2014, the plaintiff was operated by a certain Dr. Basienicz assisted by another medical personnel. The plaintiff was then stabilised after the operation and/or surgery and taken back to the ward for admission and further monitoring or observation.

[7.11] The plaintiff was provisionally discharged and/or was given pass out by the medical personnel on the 7th of October 2014 as his conditions was out of danger and recovering well so as to free up the beds for other emergencies and was advised to return on the 17th of October 2014 for further assessments.

[7.13] On the 17th of October 2014 the plaintiff returned to “CHBAH” where he was again admitted and only discharged on the 10th of November 2014.

[8] **Plaintiffs’ testimony.**

[8.1] It is apposite to mention that the plaintiff testified under oath and confirmed that he went for circumcision on the 1st September 2014 at Khulandoda Male circumcision clinic. He stated that he was 23 years old when he went for the circumcision. He mentioned that before the medical staff commenced with the procedure, he was given an anaesthesia injection to take away the pain. When they commenced with the procedure, he could not feel any pain but in the middle of the procedure he started feeling pains

and he informed the medical staff about this discomfort. He mentioned that he could not hold himself and he started crying instead he was told to be patient until the Doctor was finish with the procedure.

[8.2] He further testified that after the circumcision procedure the pain was unbearable, it was difficult for him to walk and he was directed to the recovery room for monitoring until the pain subsided. After a while he was given pain medication, told how to look after the operation while recovering and released to go home the same day.

[8.3] He confirmed that he returned to the clinic as directed on the 3rd of September 2014. He stated that on the 3rd September 2014 he was seen by nursing sister **S. Bongi** confirmed the medical assessment observations as recorded by nursing sister **S. Bongi** except that he was not sure if the dressing was removed around the circumcised area. He confirms that the circumcision procedure was fine and it never had any pains and/or swelling and further that he could pass urine with great ease. After the third day of post circumcision procedure, he was advised to return to the clinic on the 10th September 2014 for further assessment.

[8.4] He testified that he started feeling pains on his private parts and his manhood started to develop swelling. He asked his brother to call the clinic to inform them about the sudden pain and swelling on his manhood. Accordingly, his brother was told by someone at the clinic that he can go to the local Click's store to buy pain tablets and these would help make the pain to subside. In deed they went to purchase the pain tablet at the local Click's store. He took the pain killers and the pain never subside instead the pain and the swelling on his private parts got worse.

[8.5] On the morning of the 9th September 2014 the pain became unbearable and the swelling of his manhood was persisting, thus he decided to present himself at the defendant's Khulandoda Male clinic. He confirms that while at the clinic the nursing sister referred him to Dr Makhudu who after assessed his operation, informed him that he had a blood clot on his veins. He was given an anesthesia injection and after a while Dr Makhudu removed the

stitches, drain the blood that had clot and then re-sutured his operation and thereafter the wound was covered with antibiotics, he was feeling better and he went home.

[8.6] He confirms that when Dr Makhudu re-worked on his circumcision procedure, he did not feel any pains and he was put in the recovery room and later allowed to return home. He testified further that once again he was told to look after his operation and given medicine to help ease the pain and the swelling.

[8.7] He stated that on the 10th September 2014 his operation was getting worse in that the skin on his penis was turning black and, on the area, where he had stitches, cracks were beginning to develop and his operation started to bleed. He told his brother to call the clinic. After a number of calls to the clinic someone answered his brothers call and advise him to continue to take the medical and man up. Later at night he experienced excruciating pains on his operation and his private parts become swollen. He testified that his brother called an Ambulance which arrive and transported him to Chris Hani Baragwanath Academic Hospital "CHBAH" at about 23h00 hrs.

Plaintiff arrives at CHBAH at 23H00hrs on the 10 September 2014.

[9] He confirmed that when he arrived at the "CHBAH" it was around 23h00 hrs, he was taken to casualty ward where a file was opened for him and the hospital personnel then put him in a room not far from the casualty ward where he was given a drip to reduce the pains. He testified that the drip did not help to reduce the pains on his manhood. According to the plaintiff the hospital staff that attended to him, informed him that there were no Urologist at that night time but he will have to wait until the following morning for a Urologist to attend to him.

[10] The plaintiff explained that after a drip was put on him, he was seen by a medical doctor who observed him and told him that he must wait until the morning so as to be seen by a Urologist. He testified that in the morning of the 11 September 2014 he was attended to by a medical doctor who took a

scan of his private parts and he was further taken to another Department which he cannot recall. He re-called that the doctors who attended to him had informed him that the cause of his pains was that his penis had contacted a virus and/ an infection and that was the cause of his conditions. The medical doctors who attended to him had informed him that there is nothing that they can do as the infection and/virus had spread all over his penis to the point that there is nothing they can do. The only thing they can do to help him was to remove his scrotum and the skin of his penis because it was already damaged.

- [11] He testified that it was not long after he was admitted at “CHBAH” that he was booked in a theatre where the Doctors conducted the procedure to remove his scrotum and the skin of his penis. He cannot remember the date when he went to the theatre but he can recall that, that there was a weekend in between and about five days when this operation was done on him.
- [12] He further confirmed that since he was admitted on the 11 September 2014, he did not leave “CHBAH” until he was operated and was given a pass out on the 7 October 2014 as he felt better and returned on 17 October until the 10 November 2014 when he was finally discharged. As to the procedure of removing his scrotum and the skin of his penis he testified that the wound was scaring and a watery substance was coming off from the wound area. He testified that after the initial procedure of removing his scrotum and the skin of his penis there were other procedure that he underwent. While at “CHBAH” the doctors were constantly observing him, he was given sperm cells injections to help boost his wound to heal.
- [13] He testified further that he has been to the theatre for almost three to four times. He recalls that the second time he went to the theatre was when the head of Urologist suggested to him that fat tissue had to be harvest from his stomach in order to boost his sperm cell thus piece of fat – tissue and blood was taken from him.

- [14] He testified that during this period he was not completely healed from the operation but when he was discharged on the 10 November 2014, his condition had improved in that he was feeling better as the pain had subsided and he could walk.
- [15] The plaintiff's elder brother also testified but his testimony could not amplify the plaintiff's testimony save to confirm that on the 10 September 20214 he was asked by the plaintiff to call the clinic when he was experiencing pains on his private part. He testified that he called the clinic and the medical staff advised him to go and buy pain tablets at the local Clicks store to help reduce the pain.
- [16] After returning from Clicks, he left the plaintiff to do his business and when he returned later, he found the plaintiff sleeping he decided to open his trouser to see the operation at that time the plaintiff could not wake up, he got scared and call for an ambulance.
- [17] The ambulance came and the plaintiff was put on trasher and transported to CHBAH. When they arrived at the CHBAH the plaintiff was taken to casualty ward and he was told to return the next day. The next day he returned to CHBAH and he found the plaintiff admitted and the plaintiff told him that he was seen by a doctor who told him that he must be seen by the Urologist.
- [18] As mentioned earlier that the plaintiff's brother testimony could not shed any light as to what had transpired to the plaintiff from the 1st, the 3rd and the 9th of September 2014. The thrust of his evidence is about the events as they unfolded on the 10th September 2014 as adumbrated *supra*.
- [19] It is now apposite now to turn to the expert who testified on behalf of the plaintiff. Dr E. M. Moshokoa, the plaintiff's only expert that was called to testify, is a first African specialist urologist in South Africa with a comprehensive list of qualification against her name namely, *MBChB (Cum Laude)*, *MMed (Urol)* *MEDUNSA*, *FCS (Urol SA)*, *CIME*, *Diploma Laparoscopy (Strasbourg)*: *ORCID org/ 0000-0002-7263-7508*. She has

been practicing as a medical doctor for 26 years but she has been a Urologist for 20 years.

- [20] The defendant called three witnesses. Dr Makhudu, a medical practitioner, Nurse S. Bongi, Dr F.J. Van Wijk a specialist Urologist who hold *MBChB (Pret) MMed (Urol Pret) FCS (Urol SA)*.
- [21] In *Blyth v Van der Heever*¹, the Court in determining the question of negligence considered the following issues:
- ‘(i) what factually was the cause of the ultimate condition of [Plaintiff];
 - (ii) did negligence on the part of [the Defendant] cause or materially contribute to this condition in the sense that [the Defendant] by the exercise of reasonable professional care and skill could have prevented it from developing.’
- [22] In determining whether there was negligence it is apposite to record the areas of agreement between the experts as well as the aspects which the experts conceded by defendant’s witnesses. In the joint minutes between both Drs Moshokoa and Van Wijk, I deemed it fit to restate the relevant agreed joint minutes “*Ad history both experts agree that the plaintiff, Mr M[...] was approached for a circumcision drive that was done in Khulandoda Clinic. They both further agree that he signed the consent form for the procedure and had a circumcision on the 1st September 2014 under local anaesthesia. Both agree that he returned to the clinic after he had a swelling of the penis and? A hematoma was diagnosed. The wound was opened, under local and cleaned and then re-sutured. They both further agreed that he then deteriorated then phoned the ambulance that took him to Chris Hani Baragwanath Academic Hospital. They both agreed that he was consulted by an expert Urologist and was booked for surgery in September 2014.*
- [23] *The experts further both agreed that the Claimant decided to consent for stem injection for the recovery of his wounds. They both agreed that Mr M[...]*

¹ *Blyth v Van der Heever* 1980 (1) SA 191 (A) at 196E

currently complaints of disfiguring of his penis as not having good quality erections and that he also has problems in passing urine and sometimes has to express the urine through compression on the urethra.

- [24] *On examination both the experts agree that examination findings are as described in respective reports. In summary, both the experts agreed that they don't have any information on the technique that was used and the sterile environment in which the treatment was done. They further both agreed that Mr M[...] developed a hematoma, that he was treated under local anesthesia and sutured again. They both agreed that he should have been referred to the Urologist to manage this and reasonably be kept overnight for observation.*
- [25] *Both the experts agreed that there was a time lag before he was re-operated while he was in Chris Hani Baragwanath Academic Hospital. Both experts agreed that the claimant did develop complications afterwards which looked like a clot or an infected hematoma that formed underneath the skin and were or became secondary infected. This caused severe infection of the fascia of the surrounding tissues with the developed into Fournier's gangrene and the full extent of damage due to that.*
- [26] *Both the experts further agree that with secondary intention healing to the defect is covered by fibrotic/ scar tissue. The experts further agreed that he currently has sexual dysfunction, low sensation, and difficult penetration and relationship problems and that relationship problems deferred to a clinical Psychologist. Lastly both experts agreed that the reconstructive part after that is to do skin graft, which is currently accepted to be the standard treatment car. In this case the claimant selected to have stem cells and this caused healing by secondary intention and very severe scar tissue formation."*
- [27] *Dr Moshokoa testified that she compiled her report after perusal of the Hospital records from CHBAH as well as the ID copy of the plaintiff. It was during her testimony during the proceedings that her evidence was led in*

respect of the medical records from Khulandoda clinic. Dr Moshokoa conceded that the anesthesia used on the plaintiff being a combination of macaine 0.5% -2,5ml, the lignocaine 2%- 7.5ml together were the total volume dose of 10ml. She stated that the doses of the anesthesia used during the procedure on the 1st September 2014 was insufficient, this was evidenced by the fact that the plaintiff experienced pains during the circumcision procedure. She stated that the plaintiff should have been give at least 20mls is the dose she prefers administering in her private practice. She found nothing amiss with the ring block procedure use. In essence she did not raise any issue with the method used to circumcised the plaintiff.

- [28] She testified that when the plaintiff presented himself at the Khulandoda clinic on the 9 September 2014 with the swelling penis she would have referred the plaintiff to a urologist and kept the plaintiff for further observation. She however did not challenge and/or question the manner in which Dr Makhudu dealt with the wound of the plaintiff which was to open the wound, cauterized and re-sutured and covered the wound with antibiotics and pain killers.
- [29] Dr Moshokoa confirmed that upon analysing the medical records from the clinic from the 1st September 2014 to 9th September 2014 and the notes recorded therein everything looked ok after the operation.
- [30] Dr Moshokoa further testified that according to her medical experience, on the 9 September 2014 it appears that the plaintiff presented with adverse event which is not expected on a normal circumcision procedure. She stated that at the clinic the plaintiff should firstly have been properly diagnosed, secondly to rate how server his condition was and then manage it accordingly. The clinic failed to document the condition of the plaintiff whether it was an adverse event, secondly it was not rated whether it was server or not, thirdly there was an additional intervention onto this adverse event on which there was no consent form and nothing was recorded as to how much of local anesthesia was given.

- [31] She stated that a reasonable action by the clinic on the 9 September 2014 could have prevented the deterioration of the condition of the plaintiff. She stated that these included *interalia* the general examination and the local examination based on the past examination of the plaintiff. She stated that the information captured on the medical records on the 9 September 20214 was deficient. She stated that treatment on the 9 September 2014 had to change given the adverse event that the plaintiff presented with. On treatment she testified that there had to be a change on the antibiotics, since the wound was no longer clean, it was already contaminated despite being given antibiotics.
- [32] She further stated that on treatment, the procedure that was done which seemed to have been similar to circumstances under which the circumcision was done does not give sterility that is optimal like in theatre and same treatment does not offer better control for the surgeon as compared to when it should have been done in theatre. She further stated that the administering of the local anesthesia already on the wound which was already swollen could be detrimental.
- [33] She testified that the conditions that the plaintiff presented himself with on the 9 September 2014 at Khulandoda clinic could be characterised as hematoma. She stated that the treatment of such condition under local anesthesia and re suturing was not enough accordingly, the plaintiff should have been referred to a Urologist to manage this and be kept overnight for observation. She noted that from her observations of the medical records from Khulandoda clinic the treatment of the plaintiff's condition was not aggressive.
- [34] She testified that from the medical record from CHBAH she could decipher that sonar/ x-ray was taken from the plaintiff on the 11 September 2014 by a Uro-consult after a query on scrotal abscess and was admitted in ward 7. She testified further that from the hospital record from CHBAH it was not clear when the Fournier's gangrene was diagnosed. She testified that the

plaintiff's condition while at CHBAH could have been managed and not reversed as there was already a dead tissue on his private parts.

- [35] During cross-examination, Dr Moshokoa conceded that when she made her report, she did not have the medical record from Khulandoda clinic and that she was never requested to file a supplementary medical report by the plaintiff's legal team. She also conceded that her evidence with regard to the medical record from Khulandoda Clinic never formed part of her report which was discovered to the defendants. This also included her testimony about some operations which she concluded might have been undertaken by the plaintiff at CHBAH which were never pleaded and/or testified to by the plaintiff during his evidence in chief. She further conceded that the procedure on the 1 September 2014 was generally acceptable in public clinics and also conceded that the *Forceps Guided* and *Vicryl Rayoide* was an acceptable method for performing circumcision.
- [36] The plaintiff closed its case at the end of Dr Moshokoa's testimony and never adduce any further evidence by either the doctors and /or medical staff from CHBAH. The defendant counsel then indicated that it will call three witnesses, Nurse Bongji, Dr Makhudu and Dr Van Wijk a urologist expert. Nurse Bonekile Sithebe testified to the effect that she is a professional nurse currently working for South African Blood services since 2010. She testified that on the 1st September 2014 she was employed as a professional nurse by Wits Khulandoda male clinic. She has been involved with the Wits Khulandoda Male clinic since 2011 and left in 2015.
- [37] She testified that at the Khulandoda Male circumcision clinic the facilities were aseptic and all the material used was from CHBAH. She testified that before a patient could be circumcised, she will do a health screening, checking for any abnormalities on the penis and check for any infection, check for blood pressure and the pulse and if they pass the screening a patient would be taken to theatre for the operation.

- [38] She confirmed that before the patient could be assessed they will be given oral information on what was expected from them as well as forms detailing what is expected of them and how they must look after the operation post the circumcision. This form was printed in the various local languages. Once a patient passes the screening he will be taken to the theatre-the circumcision room.
- [39] She testified that on the 1st September 2014 she was at Khulandoda male clinic and she consulted with the plaintiff who came for a male circumcision. The plaintiff went through the normal screening process and was presented with a consent form whose contents was explained to him and thereafter he signed it in front of her and she witnessed same.
- [40] She testified that on the 3rd September 2014 the plaintiff returned to the clinic for the 1st / 48Hrs visit and she personally attended to him. She stated that she assessed the plaintiff and noted the following observations:
- (a) the wound was clean and healing
 - (b) suture lines intact;
 - (c) able to pass urine
 - (d) and the plaintiff to come back to the clinic on the 10 September 2015.
- [41] She stated that after the initial circumcision procedure the patient has to remove the bandage the following day after the circumcision and when he returns to the clinic for the first visit the bandage should have been removed. If the patient has not removed same, she removes it herself and assessed the wound. She testified that when she assessed the plaintiff on the first visit the bandage was already removed and the wound was clean.
- [42] She testified that if there was anything wrong with the circumcision procedure the Standard Procedure was to call the doctor and refer the patient to urology. She testified that on the 9th September 2014 he was not involved with the plaintiff but it was Dr Makhudu.

- [43] Dr Makudu testified under oath and stated that he has been practicing as a medical doctor in South Africa since the year 2006, he is permanently employed by an international NGO, and also runs a private medical practice in the South of Johannesburg. He stated that during 2010 he was employed with PHRU as a project director for circumcision programme -Khulandoda Male circumcision project until the end of December 2014.
- [44] Dr Makhudu stated that he recalled the matter of the plaintiff. He was referred to the medical record from Khulandoda Male circumcision clinic and he confirmed knowledge of same. He confirmed that all patient were required to sign the standard indemnity form prior to be circumcised. No patient could be circumcised without a duly signed consent and/or indemnity form
- [45] Dr Makudu was referred to the medical records from Khulandoda clinic specifically on the 1 September 2014. He stated that anesthesia used on the plaintiff was a combination of macaine 0.5%---2,5ml which is long acting anesthetic, which can stay up to six to eight hours to start working and the lignocaine 2% --- 7.5ml is the short acting anesthetic one which start to function almost immediately and last for a short while , the lignocaine was a lower volume and the macaine was a higher volume and the combination was enough. These volumes of the used anesthesia were in line with - VMMC guidelines developed by WHO which were adopted by South Africa in 2013. The anesthesia used on the plaintiff on the 1st September 2014 was more than sufficient as currently volumes in terms of the present guidelines the ratio is 1:1.
- [46] Dr Mokudu testified that if one were to use more volumes of anesthetic this would distort the anatomy as a result one may end up taking more skin, hence the less anesthesia the better. He testified that on the 9 September 2014 he attended to the plaintiff who presented with a swelling penis. He confirmed that he opened the wound cauterised, re sutured it and covered with antibiotics and gave the plaintiff painkillers. He stated that the condition that the plaintiff presented with was a hematoma swelling on the penis and

that required him to open and re cauterized he further explained that hematoma -Blood clot- is collection of blood under the skin. The decision whether to open or leave it is based on the when you see how big the swelling is or is growing actively, or actively bleeding when you see it.

[47] He testified that his decision to open the wound, cauterise and re -suture was based on the fact that it was not a big swelling and it was not actively bleeding. He stated further that since it was seven days since the plaintiff was circumcised, he covered the wound with two broad spectrum antibiotics to prevent it from having infections the broad spectrum was *Augmentin* and plus *flagella* and the pain killer was *paracetamol*. He confirmed that there was no sign of infection on the wound and averred that if there was any sign of infection they would have immediately referred the plaintiff to urology and send him to theatre. He stated that there was no sign of *Necrotizing Fascialities* or *Fournier gangrene* on the plaintiff's wound on the 9 September 2014 that is the reason he decided to treat the plaintiff himself and not refer him to a urologist as it was not necessary. Dr Makhudu testified that after treating the plaintiff he was advised to come back the clinic on the 12 September 2014.

[48] Dr Makhudu was referred to the plaintiff's medical records from CHBAH on the 11 September 2014 when he was admitted. Dr Makhudu testified that the plaintiff's clinical records from CBHAH on the 11 September 2014 indicates that the plaintiff's wound had Fournier's gangrene and these particular symptoms did not present themselves on the 9 September 2014 when he treated the plaintiff for a hematoma. He also noted that although the CHBAH plaintiff's clinical records refer to the *sceptic circumcision*, according to him these symptoms were a *Fournier's gangrene*. Dr Makhudu further testified that had the plaintiff presented with these symptoms there is nowhere that he could have open the wound, cauterised and re -sutured and covered with antibiotics. He was going to immediately refer the plaintiff to urology and to the theatre immediately because these conditions rapidly progress within hours.

[49] Dr Makhudu was also referred to the **plaintiff's amended particulars of claim and/ version** same restated for completeness of my judgment: -

“4.8 On or about the 11th of September 2014 early morning, the Plaintiff was attended to by the medical personnel who recommended that the Plaintiff should be admitted and must be urgently be referred to a Urologist.

4.9 It was noted that the Plaintiff had swollen penis, discharging puss and blood and scrotum with cellulitis and oedema, slough on wound, necrotic skin and he diagnosed the Plaintiff as having sceptic circumcision. The Plaintiff was admitted on the 11 of September 2014.

4.10 On or about the 15th of September 2014, the Plaintiff was seen by an expert Urologist who according to the Plaintiff, recommended that the Plaintiff should be operated.

4.11 The Plaintiff was then booked for surgery on the 30th September 2014.

4.12 On the 30th September 2014, the Plaintiff was operated by a certain Dr Basienicz (with spelling to be confirmed) assisted by another medical personnel Dr. Si... (whose name is unknown to the Plaintiff and unclear on the medical records.) The Plaintiff was then stabilised after the operation or surgery and taken back to the ward for admission and further monitoring or observation.

[50] Dr Makhudu's immediate response thereto was that in terms of timelines therein the delay was too long to treat the symptoms that the plaintiff presents with at CHBAH because in terms of the guidelines and the recommendations the patient is supposed to be sent immediately to the theatre. Dr Makhudu testified that having admitted the plaintiff on the 11 September 2014 it was too late for the plaintiff to be seen by a Urologist expert on the 15th of September 2014 and thereafter to be operated on the 30th of September 2014.

[51] Dr Makhudu further testified that the clinical records from CHBAH do confirm that the plaintiff was diagnosed with Fournier's gangrene but the clinical records does not specifically state the date when this diagnosis was made.

- [52] Dr Makhudu stated that the **Fournier's gangrene** is caused by a number of bacteria. It attacks the tissues just under the skin and it eats up everything under the skin as the result that everything that is above the skin dies with it within a short space of time. It then becomes dangerous because the dead tissue is also a sight for more infections. The more you leave it the more it eats up the **facia**. The **facia** is the one that the skin is on top. Thus, everything that is on top of the **facia** will die because the **facia** has been eaten up by these bacteria. Dr Makhudu noted further that the **Fournier's gangrene** progresses rapidly from the penis it extends right up to the abdomen hence when it is removed in the theatre all the dead tissues is removed in terms of treatment. He averred that it was imperative that a patient with such a condition has to receive treatment urgently as the condition becomes a ***Necrotizing Fasciitis***.
- [53] Dr Makhudu further confirmed that from the clinical records from CHBAH on the 11 September 2014 it is evident that ***necrotic*** skin ***distal*** to suture was clinically observed and recorded yet the urologist attended to the plaintiff only on the 15 September 2014.
- [54] Dr Makhudu further testified that with regards to the treatment of the plaintiff with ***stem cell*** rather than ***skin graft*** he cannot comment as the same was not the standard way of treatment as same was on a ***clinical trial***. Dr Makhudu further stated that the condition of the plaintiff could have been treated by way of skin graft which was the normal standard of treating such conditions.
- [55] Dr Makhudu confirmed under cross -examination that the plaintiff was assessed and taken vital signs prior to being circumcised. He confirmed further that the plaintiff signed a consent form. He further confirmed that on the 9th September 2014 the plaintiff was assessed and thereafter he attended the plaintiff and treated him for the hematoma. He confirmed that there were no signs of an infection on the wound. He maintained that he opened the wound cauterised, re sutured it and covered with antibiotics and

gave the plaintiff painkillers. This was the best treatment he gave to the plaintiff.

- [56] Dr Makhudu further confirmed that having open the wound after nine days of the actual procedure the decision to cover the wound with antibiotics was a preventative measure to prevent the wound to getting infections. He confirmed that the treatment he administered on the plaintiff was based on the consent form that the plaintiff had duly signed on the 1st September 2014. He maintained that the hematoma he treated on the plaintiff was a swelling only on the penis and there was no swelling on the scrotum. He confirmed that the circumcision procedure in general is done under local anesthesia in what is referred to as surgical clean, sterile environment.
- [57] Dr Makhudu further confirmed that the circumcision on the 1st September 2014 was done under acceptable local anesthesia and the environment was sterile, this he maintained was evidenced by the fact that after three days of the procedure the plaintiff's condition was fine as recorded by Nurse Bongi Sithebe.
- [58] Dr Van Wijk a urologist was called by the defendant and he stated that he is a urologist in private practice for the past 35 years and a part-time lecture at Steve Biko Academic Hospital. Dr Van Wijk testified that he was requested to look at the medical -legal aspects concerning the plaintiff's circumcision that was performed at Khulandoda Male Circumcision clinic on the 1st September 2014.
- [59] Dr Van Wijk testified that upon perusing the clinical records from Khulandoda Male Circumcision clinic he found nothing untoward with the volumes of the anesthesia used during the circumcision. He observed that the time used by to conduct the procedure was normal as it only involved the actual procedure. He stated that the clinical records by nurse Sithebe on the 3rd September 2014 were a clear indication that the nurse had to observe and assess the plaintiff penis before she could make her findings, thus it is impossible that the nurse could have recorded such clinical observation

without physically looking at the wound itself. He confirmed that the clinical records on the 3rd September 2014 were an indication that the circumcision that took place on the 1st September was up to standard hence the observations by nurse Sithebe that -:

- (a) the wound was clean and healing
- (b) suture lines intact;
- (c) able to pass urine

[60] Dr Van Wijk testified that his analysis of the clinical record from Khulandoda Male circumcision clinic on the 9th September 2014 he formed an opinion that the plaintiff presented with symptoms of a hematoma. He stated that no infection was recorded by Dr Makhudu and he confirmed that the manner in which Dr Makhudu treated the wound was an acceptable standard of care that any surgent could have done when presented with such a condition. He confirmed that in the absence of any infection recorded there was no need to refer the plaintiff to a urologist and to theatre. He explained that it is normal to develop a hematoma normally about five to seven days after the initial circumcision due to involuntary erection while the wound heals.

[61] Dr Van Wijk testified that he could not found anything untoward with the manner in which Dr Makhudu dealt with the condition that the plaintiff presented with on the 9 the September 2014 accordingly, that was a normal standard of care performed by any surgeon in the circumstance.

[62] Dr Van Wijk testified that the clinical records from CHBAH on the 11 September 2014 indicated that the plaintiff had developed a purulent discharged and swelling of the scrotum. Dr Van Wijk stated that though the plaintiff was not sure about the exact date of surgery, but he was consulted a couple days by a Urologist on the 15 September 2014 and was booked for surgery on the 30th September 2014.

[63] Dr Van Wijk stated that it is unknown by the plaintiff and from the medical record from CHBAH why the operation was only done so long after he was admitted at CHBAH on the 11 September 2014. He stated that plaintiff told

him that his condition did not stabilize and he was taken to theatre for debridement of the necrotic skin. Dr Van Wijk explained that the clinical records from CHBAH revealed the conditions that the plaintiff present with on the 11 September 2014 was clearly diagnosed as Fournier's gangrene.

[64] He observed that when the plaintiff was admitted on the 11 September 2014 the clinical medical records reveals that some of the assessment included *inter alia* "swollen penis + scrotum cellulitis+ oedema, Septic circumcision wound, necrotic skin distal to suture, no active bleeding". To which Dr Van Wijk stated the condition was a clear Fournier's gangrene and that the plaintiff should have been referred to the theatre and the seen by a urologist immediately.

[65] Dr Van Wijk testified that by that stage the plaintiff had developed *Fournier's gangrene* which was caused by bacterial infection of the underlying fascia leading to necrosis of the overlying skin. He stated that from the medical records from CHBAH extensive debridement of the skin was done, and the plaintiff's left testicle was replaced under the Inguinal skin on the left side and right testicle remained in the part on the scrotum that survived. He observed further that from the medical records from CHBAH there was a problem with time lag before the plaintiff was re-operated while at CHBAH. He stated that it was extremely paramount that while at CHBAH the plaintiff's infection on his penis and surrounding tissue should have been treated aggressively with antibiotic, sometimes intravenous antibiotic. The *Fournier's gangrene* that presented itself required extreme urgent surgical intervention by CHBAH in order to excise all the dead tissue and to clean the wound.

[66] Dr Van Wijk stated that the plaintiff should have been advised about the skin graft and not the stem cells. He stated that the best treatment would have been skin graft which was a normal standard operation and a standard care. The stem cell was on trial stages and it resulted in the severe scarring on the plaintiff's wound. He stated that in the case of the plaintiff, the stem cells will stimulate the growth of the tissue but the underlying tissue is then replaced

by mostly scar tissue and it heals by secondary healing often causes severe contractures.

[67] Dr Van Wijk testified that from the medical records from Khulandoda clinic he found nothing untoward and that standard of care was observed on the 1st, 3rd and the 9th September 2014. He lamented that, though the hospital records from CHBAH it is noted that blood cultures were obtained from the plaintiff but is still not clear where the infection came from.

[68] Dr Van Wijk was subjected to cross-examination but throughout he stood and maintained his report as well as his observation of the medical clinical record from both Khulandoda and CHBAH.

[69] Dr Van Wijk conceded that the plaintiff's condition post the normal circumcision was a very unusual complication of a circumcision. He stated that more aggressive wound care, as well as antibiotics or intravenous antibiotics should have been administered. This could have prevented the severity of the damage to the plaintiffs' perineum and the resulted disfiguration and from the hospital records it is not clear what the delay in debridement at CHBAH contributed to the plaintiff's disfiguration.

[70] The defendant having closing its case I now turn to the defendant's defense. The defendant defends its-self on three basis, being: -
(a) Indemnification;
(b) Novus actus intervenience;
(c) No negligence on the defendant's part.

[71] The defendant averred that the plaintiff signed a consent form that contained an indemnity clause at Khulandoda Male Circumcision clinic. Same was pleaded on its amended plea and sadly, no reply by way of pleadings was received from the plaintiff after the defendant had amended its plea in order to incorporate same as a defence, thus the plaintiff does not challenge such defense on his papers before court. It is common cause that indeed the plaintiff admitted in cross-examination that it is his signature on the indemnity

form and same was duly witnessed by Nurse Sithebe. This was also confirmed by the experts in their joint report that the plaintiff signed the consent form which contained the indemnity.

[72] It trite that exclusionary clauses in the form of hospital exemption clauses are mainly used in the private health care sphere and seek to protect the hospital (or doctor) from personal liability arising from negligence that will cause the patient harm.²

[73] In contracts, exclusionary clauses are called by many names including 'exemption clauses', 'indemnity clauses', 'exculpatory clauses' and 'waivers.

[74] These clauses aim to limit or exclude the liability of hospitals and medical professionals for damages arising from medical procedures, often due to negligence.

Interpretation of exclusionary clauses.

[75] The courts have attempted to protect the public by interpreting exemption clauses narrowly and/or limiting their effect, or even striking them out in the interest of public policy.³

[76] It is also suggested, fairly regularly, that exemption clauses should be construed *contra proferentem*⁴ against the person for whose benefit the exemption is included, and at whose behest it is drafted. However, the guides to interpretation, such as *contra proferentem*, should be resorted to

² See Letzler "The law of contract, the Consumer Protection Act and medical malpractice law" (2012) June *De Rebus* 22.

³ See *Van der Westhuizen v Arnold* [2002] 4 All SA 331 (SCA); 2002 (6) SA 453 (SCA) at [18]. See also *Afrox Healthcare Bpk v Strydom* [2002] ZASCA 73; 2002 (6) SA 21 (SCA) at [9]: In relation to exclusion or exemption clauses such as clause 2.2, the general approach in our law is that such clauses, though valid and enforceable, must be construed restrictively.

⁴ The "*contra proferentem*" maxim is a rule of contract interpretation that dictates ambiguous contract terms should be construed against the party who drafted the contract. This principle aims to discourage vague or unclear language in contracts and places the burden of ambiguity on the party best positioned to prevent it. Essentially, if a contract clause is unclear, the interpretation that favours the non-drafting party will be adopted.

only where the application of the general principles of interpretation fails to yield a clear meaning.⁵

- [77] In the absence of legislation regulating unfair contract terms, and where a provision does not offend public policy or considerations of good faith, a careful construction of the contract itself should ensure the protection of the party whose rights have been limited, but also give effect to the principle that the other party should be able to protect himself or herself against liability in so far as it is legally permissible.⁶
- [78] In *Afrox Healthcare Bpk v Strydom*,⁷ (*Afrox case*) the exemption clause indemnifying the hospital, its employees and agents from all liability for damages or loss of whatsoever nature, including consequential damages or special damages from any direct or indirect injury caused to the patient by act or omission was before court for determination.
- [79] The SCA held that these clauses were the norm, not the exception, and, as such, were sound business practice and not contrary to public policy. Further, the court could not find evidence that the patient was in a weaker bargaining position than the hospital. The court did not deal with gross negligence, but it indicated that even that would not result in an automatic invalidation of the clause.⁸
- [80] The court further dismissed the alternative basis of the claim, that the contract was unenforceable because it is unreasonable, unfair and in conflict with the principle of *bona fides* or good faith. It held that, when it comes to the enforcement of contract terms, the court has no discretion and does not proceed on the basis of abstract ideas, but only upon the basis of crystallised and established legal rules.⁹

⁵ See n2 at [19]. See also Section 4(4)(a) of the Consumer Protection Act 68 of 2008.

⁶ *Id* at [21].

⁷ [2002] ZASCA 73; 2002 (6) SA 21 (SCA).

⁸ *Id* at [13].

⁹ *Id* at [32].

[81] On the further alternative of awareness when signing the contract, the court held that there was no legal duty upon one party to bring an exclusionary clause, pertinently, to the other party's attention. The party is bound by the clause as though he had read and expressly agreed to it.¹⁰

Comparative legal principles in other countries.

[82] In the United States these clauses are generally regarded as invalid in hospital contracts. The courts tend to rely on the common law in its interpretation and application of the law as opposed to statutory guidelines. As the medical profession and medical practices affect public interests, the profession and medical practices are governed by public regulations that involve health, safety and welfare, as well as ethics. Any conduct that would move away from a generally accepted standard of discharging professional duties is frowned upon.¹¹

[83] Section 2(1) of the English Unfair Contract Terms Act 1977 states that: 'A person cannot by reference to any contract term ... exclude or restrict his liability for death or personal injury resulting from negligence'. It was generally accepted in most, if not all, European countries that exclusion clauses were unlawful in respect of medical liability.

The Consumer Protection Act.

[84] The Consumer Protection Act¹² (the Act) states that the common law should be developed 'as necessary to improve the realisation and enjoyment of consumer rights generally'. In the hospital context, the consumers are the patients and the suppliers are the hospitals.

¹⁰ *Id* at [36].

¹¹ See n1 above.

¹² Act 68 of 2008.

- [85] Sections 48¹³ and 49 of the Act regulates clauses which prohibits unfair, unreasonable, or unjust contract terms. The Act aims to prevent exploitation of patients by medical professionals and hospitals through the use of standard form contracts with onerous exemption clauses. The Act further adds scrutiny, requiring that clauses be clear, understandable, and brought to the consumer's attention.
- [86] Examples of unfair, unreasonable or unjust terms include ones that are 'excessively one-sided in favour of any person other than the consumer', as are ones where 'the terms of the transaction or agreement are so averse to the consumer as to be inequitable'.¹⁴
- [87] A term which could, whether or not that is the intention, serve to relieve a supplier of services of the obligation to take reasonable care in any of its dealings with consumers is particularly liable to be considered unfair.
- [88] A party relying on an exclusion of liability or indemnity clause must prove it was brought to the consumer's attention and that the consumer understood its implications. Patients should carefully review all contracts and seek clarification on any clauses they do not understand, especially those limiting liability.
- [89] Patients may still have recourse against hospitals or medical professionals for damages, even if an exclusionary clause is present, if the clause is deemed unfair or not properly disclosed. The courts may also consider public policy when assessing the validity of such clauses, particularly in the context of medical care.
- [90] There are long-standing professional standards of conduct and ethical rules that the medical profession is expected to meet. Failure to meet such

¹³ Section 48(1)(a)(ii) of the Consumer Protection Act prohibits 'terms that are unfair, unreasonable or unjust'. This is supported by section 48(1)(c), which prohibits any agreement that requires a consumer to waive any rights, assume any obligations or waive any liability of the supplier on terms that are unfair, unreasonable or unjust.

¹⁴ Section 48(2)(a) and (b) of the Act.

standards is inarguably proof that the hospital has failed to perform in a manner that the patient is 'generally entitled to expect'. This is a direct breach of the hospital's obligations under the Act. Being an obligation stemming from the Act itself, it cannot be waived and liability for failure to perform properly cannot be excluded.¹⁵

[91] Most exclusionary clauses would contravene the above requirement because, by excluding a hospital's liability, the clause would shield the hospital from its duty under the Act to perform 'in a manner and quality that persons are generally entitled to expect'.

[92] In insisting that the patient accept the provision of waiver in the contract, the hospital certainly exercises a decisive advantage in bargaining. When the patient signed the contract, he completely placed himself in the control of the hospital; he subjected himself to the risk of its carelessness. The hospital, under such circumstances, occupied a status different than a mere private party; its contract with the patient affects the public interest.

[93] Any exclusionary clause that excludes liability for the gross negligence of the hospital would be void on the basis of the provision of section 51(1)(c)(i)¹⁶ of the Act, over and above the general prohibition on exclusionary clauses. Thus, in no circumstances can an exclusionary clause that contravenes the abovementioned provisions be relied on by a hospital to escape liability.¹⁷

[94] Consequently, the effect of the above provisions, specifically ss 54(1)(b) and 51(1)(c)(i) of the CPA, will inarguably render most exclusionary clauses in hospital contracts void.

¹⁵ Section 54(1)(b) of the Act provides that: 'When a supplier undertakes to perform any services for or on behalf of a consumer, the consumer has a right to – the performance of the services in a manner and quality that persons are generally entitled to expect; having regard to the circumstances of the supply, and any specific criteria or conditions agreed between the supplier and the consumer before or during the performance of the services.'

¹⁶ Section 51(1)(c)(i) of the Act prohibits any term in a hospital contract that purports to 'limit or exempt a supplier of goods or services from liability for any loss directly or indirectly attributable to the gross negligence of the supplier or any person acting for or controlled by the supplier.'

¹⁷ Section 51(3) of the Act provides: 'A purported transaction or agreement, provision, term or condition of a transaction or agreement, or notice to which a transaction or agreement is purported to be subject, is void to the extent that it contravenes this section.'

- [95] A term of a consumer agreement is 'presumed' to be unfair if it has the purpose or effect of "excluding or limiting the liability of the supplier for death or personal injury caused to the consumer through an act or omission of that supplier". Thus, the unlimited enforcement of an exemption clause excluding liability for death or personal injury cannot be tolerated and should be set aside.
- [96] It is likely that the Act will entirely revoke the principles laid down by the SCA in the *Afrox* case. This will bring South Africa in line with foreign jurisdictions in regard to medical liability, specifically in respect of exclusionary clauses in hospital contracts. This is especially so when one considers the duty of the courts to take account of foreign and international law when interpreting the provisions of the Act.¹⁸
- [97] It can therefore be argued that it is likely that any type of exclusionary clause, at least where it appears in a hospital contract, will no longer be valid in light of the Act, especially when regard is had to comparative case law dealing with what should be regarded as an unfair, unreasonable or unjust term. Thus, an exclusion of a hospital's duty to provide quality service would almost certainly fall foul of the Act, especially where the hospital is at fault, regardless of whether it is intentional or due to negligence.

Case Law post-Consumer Protection Act.

- [98] To find out whether an indemnity form or contract holds water, one usually needs a court to pronounce on its validity. There are many factors which the court considers, including the nature of the underlying contract or activity and the relevant bargaining positions of each party.

¹⁸ Section 2(2) of the Act.

- [99] South African courts take into account public policy, seen in the light of the Constitution, when determining whether a particular indemnity undertaking is enforceable in certain circumstances and whether negligence or fault on any person's part should exclude the enforceability of that clause in a given case.
- [100] A hospital is reasonably expected to provide quality services by ensuring that patients are treated in a professional manner and in accordance with professional standards that do not cause harm. This view is based on the principle of reasonable expectations. The law should be more willing to protect the reasonable expectations of parties and should give them legal force.¹⁹
- [101] In applying the principles articulated in *Barkhuizen*,²⁰ the court in *Naidoo v Birchwood Hotel*²¹ held that:
- “the plaintiff was a guest in a hotel, and did not take his life in his hands when he exited through the hotel gates. To deny him judicial redress for injuries he suffered in doing so, which came about as a result of the negligent conduct of the hotel, offended against notions of justice and fairness. Public policy, with the notions of fairness, justice and reasonableness, would preclude the enforcement of a contractual term if its enforcement would be unjust or unfair. In the circumstances of this particular case, to enforce the exemption clause would be unfair and unjust. The court could 'not let blind reliance on the principle of freedom of contract override the need to ensure that contracting parties must have access to courts'.”
- [102] The Constitutional Court case, in *Fujitsu Services Core (Pty) Limited v Schenker South Africa (Pty) Limited*²² involves the interpretation of exemption clauses and whether they can exclude liability for theft by

¹⁹ See Mupangavanhu “Exemption Clauses and the Consumer Protection Act 68 OF 2008: An Assessment of *Naidoo v Birchwood Hotel* 2012 6 SA 170 (GSJ)” PER / PELJ 2014 (17) 3.

²⁰ See *Barkhuizen v Napier* [2007] ZACC 5; 2007 (5) SA 323 (CC); (2007 (7) BCLR 691 at [55] and [73].

²¹ 2012 (6) SA 170 (GSJ) at [73] – [74].

²² [2023] ZACC 20; 2023 (9) BCLR 1054 (CC); 2023 (6) SA 327 (CC).

employees. Further, it explores the interplay between contract interpretation, public policy, and the Consumer Protection Act.

- [103] *Osman Tyres and Spares CC & Another v ADT Security (Pty) Ltd*²³ case demonstrates the importance of specifically mentioning negligence in an exclusion clause for it to be effective.
- [104] In *Dutfield v Lilyfontein School*,²⁴ the Court held that the defendants would be indemnified against any claims provided that stringent safety measures were in place. In the event that the defendants failed to ensure that such safety measures were in place, the indemnity would not be operative. The Court found that the defendants had failed to do so. The case was thus decided in favour of the plaintiff.
- [105] The rights to life and bodily and psychological integrity are embodied in the Bill of Rights, and it has been said that compelling a patient to waive these rights in order to obtain medical treatment or to be admitted to a hospital 'would surely be contrary to public policy'.²⁵
- [106] In summary, while exclusionary and indemnity clauses in medical contracts are still permissible, they are subject to the provisions of the Consumer Protection Act. Hospitals and medical professionals must ensure that these clauses are fair, understandable, and properly communicated to patients to be enforceable.
- [107] Even if the exclusionary clauses in hospital contracts do not fall under the blacklist contained in section 51 of the Act, but they certainly fall under the general prohibition on unfair, unreasonable or unjust terms contained in section 48 of the Act, as such, they are void and cannot be relied on by a hospital to escape liability.

²³ [2020] ZASCA 33; [2020] 3 All SA 73 (SCA).

²⁴ [2011] ZAECHC 3.

²⁵ See Carstens and Pearman "Foundational Principles of South African Medical Law." Durban, LexisNexis 2007 at 560-561.

- [108] In essence, the Consumer Protection Act aims to level the playing field between suppliers and consumers, preventing businesses from easily escaping liability through the use of exclusionary clauses. Courts are now more likely to consider the context of the agreement, the consumer's understanding of the clause, and whether the clause is fair and reasonable before upholding it.
- [109] Having outline the law on indemnity I now turn to the second defence by the defendant being novus actus intervenience.
- [110] In cases of medical negligence, the “*novus actus interveniens*” (*novus actus*), Latin for “a new intervening act”, can be a defence, meaning that an independent event occurring after the initial negligent act breaks the causal link between that act and the resulting harm, potentially relieving the initial wrongdoer of liability. Essentially, it argues that the harm was not a direct result of the original negligence, but rather a consequence of this intervening act.²⁶
- [111] This doctrine provides a defence when an intervening act occurs after the initial negligence. If this intervening act is considered sufficiently independent and powerful, it can be deemed to have broken the chain of causation, meaning the initial negligent act is no longer the direct cause of the harm.
- [112] [112] For instance, imagine a patient suffers a minor injury due to a doctor's negligence. The patient is then treated for that injury, but the treatment is also negligent. The second act of negligence (the treatment) could potentially be considered a *novus actus*, meaning the doctor who caused the initial injury might not be liable for the harm caused by the subsequent negligent treatment.

Defence in case of medical negligence.

²⁶ See Neethling and Potgieter “Law of Delict” 8th Edition, Durban, LexisNexis 2020 at 250-251.

[113] In medical negligence, establishing causation²⁷ is crucial. It means proving that the doctor's negligence directly led to the patient's injury or harm. A *novus actus* is not confined to either factual or legal causation only, and can interrupt the causal chain at either point.

[114] In respect of factual causation, a *novus actus* interrupts the nexus between the wrongful act of the initial wrongdoer and the consequences of his act to such an extent that it frees him of the liability of his actions. However, when assessing *novus actus* in respect of legal causation, regard must be had to the aspects of policy, fairness, reasonableness and justice in order to determine whether liability for the initial wrongful act can still be imputed to the initial wrongdoer, and whether the causal chain has been broken.²⁸ Therefore, a *novus actus* disrupts the "directness" aspect of the initial act and the subjective test of legal causation cannot be fulfilled.

[115] It is important to distinguish *novus actus* from contributory negligence. Contributory negligence involves the patient's own negligence that contributes to their injury, while *novus actus* involves an independent intervening act by a third party.²⁹

Key Considerations.

[116] The courts will carefully consider the circumstances to determine if the subsequent treatment was truly independent and severe enough to break the causal chain. The courts will analyse several factors when determining if an intervening act qualifies as a *novus actus*, including:

- a) Foreseeability: was the intervening act foreseeable by the original wrongdoer?³⁰
- b) Independence: was the intervening act independent of the initial negligence?³¹

²⁷ Causation ordinarily consists of two elements that determine whether or not a party can be held liable for the damages caused to another. These elements are factual causation and legal causation. A full and lengthy explanation of both elements can be found in the case of *Groenewald v Groenewald* 1998 (2) SA 1106 SCA.

²⁸ See *Road Accident Fund v Russell* [2000] ZASCA 66; 2001 (2) SA 34 (SCA) at [26].

²⁹ *Novus actus* is often utilised as a defence by initial wrongdoers who wish to prove that their liability is limited or non-existent and should be imputed on another party.

³⁰ If the subsequent event was reasonably foreseeable at the time of the initial wrongful act, it is not to be considered as a *novus actus* capable of limiting the liability to be imputed on the initial wrongdoer.

³¹ It can be occasioned by anyone or anything other than the initial wrongdoer. This general category also includes the injured party him or herself, another third party or even an act of God.

- c) Voluntariness: was the intervening act a voluntary action by the patient or another party?³²
- d) Severity: was the intervening act sufficiently serious to be considered a break in the chain of causation?³³

[117] In order to qualify as a *novus actus interveniens* in the context of legal causation, the plaintiff's conduct must be unreasonable. Reasonable conduct on the part of the plaintiff cannot free the defendant from the imputation of liability. Even unreasonable conduct on the part of the plaintiff will not always absolve the defendant. Whether it will do so, depends on the facts of the particular case.³⁴

Comparative Jurisprudence.

[118] In *Webb v Barclays Bank Plc and Portsmouth Hospitals NHS Trust*,³⁵ the claimant contracted polio as a child which affected her mobility. Whilst working for Barclays Bank she tripped on a protruding stone in their forecourt and injured her polio affected leg. This caused her excessive problems and her consultant advised her that it would be best if she had her leg amputated from above the knee. She went through with the amputation which meant she was wheelchair bound but was still experiencing excessive pain. It turned out the advice of the consultant was wrong and he had not fully discussed the implications of such an operation or sufficiently explored alternative options.

[119] The court held that the doctor's actions did not break the chain of causation but the Bank was entitled to a contribution, under the Civil Liability (Contribution) Act 1978, from the Trust to reflect the proportion of pain, suffering and loss of amenity caused by them.³⁶

³² See *Mafesa v Parity Versekeringsmaatskappy Bpk (In Likwidasie)* 1968 (2) SA 603 (O): "The court held that the fall had been caused by the plaintiff's own carelessness and that the defendant was not liable for the damage caused thereby: the fall was an intervening cause which broke the causal effect of the original negligence.

³³ See *S v Tembani* 1999 (1) SACR 192 (W): The court held that only if the medical negligence was so overwhelming as to make the original wound merely part of the history of the chain of events could it be said that death did not flow from the wound.

³⁴ See *Premier of the Western Cape Province and Another v Loots NO* [2011] ZASCA 32 at [20].

³⁵ [2002] PIQR P8.

³⁶ Practitioners have taken the decision as authority for the proposition that for medical treatment to amount to a break in the chain of causation, the treatment must not only be negligently provided, but grossly negligent.

[120] In *Jenkinson v Hertfordshire County Council*,³⁷ the court did not consider that *Webb* is authority for the proposition that only gross negligence on the part of treating doctors can amount to a *novus actus interveniens*; whether or not medical treatment breaks the chain of causation will be highly fact-sensitive and will depend on all the circumstances of the case, including the nature and extent of the negligence and its foreseeability on the part of the tortfeasor.

[121] In Western Australia, a successful break in the chain of causation absolves the original tortfeasor from liability for the injured party's ultimate loss. This inquiry is also known as the "scope of liability" which is reflected in section 5C(1)(b) of the Civil Liability Act 2002 (WA).³⁸ This inquiry requires the Court to consider whether it is appropriate for the scope of the original tortfeasor's liability to extend to the harm in question and whether liability for the harm should be imposed on the original tortfeasor.

[122] Australian Courts have consistently held that to establish a *novus actus interveniens* capable of severing the chain of causation, the original tortfeasor must establish, on the balance of probabilities, that the subsequent treatment was "grossly negligent", and therefore not a reasonably foreseeable consequence of the original injury. A mere error or lapse of judgment will not possess enough "causal potency" to amount to an intervening act capable of breaking the chain of causation.

[123] In the case of *Aquilina v NSW Insurance Ministerial Corporation* (1994) 157, the negligent driver in a motor vehicle accident was held liable for both the back injuries sustained in the motor vehicle accident and the severe complications of negligently-performed back surgery (including brain damage). This was on the basis that the surgeon's negligence did not amount to gross negligence and the back injuries from the motor vehicle accident carried the risk that some negligent medical treatment might be given.

³⁷ [2023] EWHC 872 (KB).

³⁸Section 5C (1): A determination that the fault of a person (the tortfeasor) caused particular harm comprises the following elements — (a) that the fault was a necessary condition of the occurrence of the harm (factual causation); and (b) that it is appropriate for the scope of the tortfeasor's liability to extend to the harm so caused (scope of liability).

[124] Similarly, in the case of *Liston v Liston*,³⁹ the South Australian Supreme Court held a negligent driver liable for the back injuries sustained in the car accident and a subsequent permanent back disability sustained as a result of an unsuccessful laminectomy. This was on the basis that there was nothing “ultraneous” nor “unreasonable or extraneous or extrinsic” about the surgeon’s decision to perform the laminectomy.⁴⁰

SA Case law on *novus actus*.

[125] I now turn to deal with the defendant’s defense of *novus*, in *MEC Health, Eastern Cape v Mkhitha and Another*,⁴¹ the plaintiff sustained right femur fracture in the accident. When she was transferred from the Nelson Mandela Academic Hospital to the Bedford Orthopaedic Hospital (BOH) to undergo surgery, the fracture was not properly repaired, as there was a large piece of bone that was not aligned in a normal position and as a result thereof, the plaintiff’s knee joint was incongruent.⁴²

[126] The staff at BOH failed to take the necessary x-rays of the plaintiff’s leg, which would have indicated that there was a mal-alignment of her right leg. As a result, the leg healed with a 15-degree angulation, which she alleged was as a result of the hospital’s negligence.⁴³

[127] The court *a quo* found that the substandard medical care did constitute a *novus actus* and that the RAF could not be held liable for the plaintiff’s sequelae even though the injuries were initially caused by the negligence of the RAF’s insured driver.⁴⁴

[128] The court *a quo* dismissed the special plea and held that should it allow the MEC’s special plea to succeed, the court would deny the plaintiff of her common law right to sue the MEC as a result of his staff’s negligence and would limit the damages

³⁹ (1981) 31 SASR 245.

⁴⁰ See *Wright v Cambridge Medical Group* [2012] 3 WLR: The original tortfeasor must prove that the subsequent negligent treatment went beyond the realms of a “failure to take reasonable care”, and must instead, be considered outstandingly bad to amount to gross negligence, capable of breaking the chain of causation.

⁴¹ [2016] ZASCA 176.

⁴² *Id* at [2].

⁴³ *Id* at [7].

⁴⁴ *Id* at [9].

she would be able to claim from the RAF to those that would result due to the less-severe sequelae of the injuries sustained during the collision.⁴⁵

[129] In the Supreme Court of Appeal (SCA), the court held that although the plaintiff would not have been hospitalised but for the collision, the negligent treatment of the plaintiff by the staff of BOH had significantly contributed to the consequences of the injuries sustained by the plaintiff and therefore had broken the causal chain between the collision and the severity of the injuries sustained by the plaintiff. The SCA dismissed the appeal on the basis that the special plea was bad and the appeal had no prospect of success.

[130] When entering the hospital, the duty of care shifts. The hospital itself then had the duty of care to provide the plaintiff with reasonable medical care. It was unforeseeable that the hospital would not have provided the plaintiff with reasonable medical care, that the medical staff would have been negligent when providing the plaintiff with care and would breach their duty of care towards the plaintiff.

[131] When having regard to legal causation, the negligence of the hospital staff severed the chain of causation as the sequelae suffered by the plaintiff is no longer sufficiently closely and directly linked to the motor vehicle collision for liability to be imputed on the RAF.⁴⁶

[132] In *Road Accident Fund v Russell*,⁴⁷ the court held that, even though the deceased's act of suicide may be said to have been deliberate, the weight of the evidence proved, on the probabilities, that the deceased's mind was impaired to a material degree by the brain injury and resultant depression. Consequently, his ability to make a balanced decision was deleteriously affected. Hence his act of suicide, though deliberate, did not amount to a *novus actus interveniens*. The appellant was held liable to compensate the respondent for such damage as she may prove.⁴⁸

⁴⁵ *Id* at [15].

⁴⁶ *Id* at [14].

⁴⁷ [2000] ZASCA 66; 2001 (2) SA 34 (SCA) at [25].

⁴⁸ *Id* at [26].

[133] The question before court, in *S v Tembani*,⁴⁹ was whether an assailant who inflicts a wound which without treatment would be fatal, but which is readily treatable, can escape liability for the victim's death because the medical treatment received is sub-standard and negligent.

[134] The court, in applying *R v Mabile*,⁵⁰ held that an assailant is entitled always to expect that medical attention will be given in good faith, and to hope that it will be given also with reasonable efficiency; but where the latter is lacking and death ensues it does not entitle him to exculpation. The court further found that it would apply this standard also in the case of 'gross negligence', so long as 'gross' is not taken to imply absence of good faith.⁵¹

[135] In *N.G and Others v Road Accident Fund*,⁵² the court held that the lack of medical treatment by the medical staff was not a fresh cause of death. The deceased would have died anyway from the injury even if he had not been taken to the hospital. Consequently, the defendant was held liable for deceased injuries.

[136] It has by now become well settled that in the law of delict, causation involves two distinct enquiries. First, there is the so-called factual causation which is generally conducted by applying the 'but for' test as described by the court in *International Shipping Co (Pty) Ltd v Bentley*.⁵³

[137] Second, is legal causation, in order to determine whether liability for the initial wrongful act can still be imputed to the initial wrongdoer, and whether the causal chain has been broken, regard must be had to the aspects of policy, fairness, reasonableness and justice.

[138] Foreseeability plays a role in determining both negligence and legal causation. Yet, the relative approach does not require that the precise nature and extent of the actual harm which occurred was reasonably foreseeable. It means foreseeability of

⁴⁹[2006] ZASCA 123; 2007 (2) SA 291 (SCA) at [1].

⁵⁰ 1968 (4) SA 811 (R) 816D-E.

⁵¹ *Id* at [30].

⁵² [2023] ZAEQBHC 23 at [15].

⁵³ 1990 (1) SA 680 (A) at 700E-G.

the actual harm as opposed to harm of a general kind. Nor does it require reasonable foreseeability of the exact manner in which the harm actually occurred.⁵⁴

[139] The *novus actus interveniens* test is expressed in terms of an 'abnormal', intervening act or event which serves to break the chain of causation. The normality or abnormality of an act or event is judged according to the standards of general human experience.⁵⁵ Snyman⁵⁶ describes this test as, an act is a legal cause of a situation if, according to human experience, in the normal course of events the act has the tendency to bring about that type of situation.

[140] It is in the nature of mortal wounds that they would normally, in the light of human experience, lead to death. However, the adequate cause test must not only consider the nature of the initial conduct but also whether the initial conduct would, in the light of human experience, including the advent of supervening acts or events, have resulted in the unlawful consequence.⁵⁷

[141] These are the tests which the court should consider before allowing a *novus actus interveniens* defence.

Critical Analysis of Evidence.

[142] *In casu* the plaintiff's head of argument averred that there was negligence on the part of the defendant's medical doctor and staff on the 1st, 3rd and 9th of September 2014. It was further the plaintiff's testimony during the proceedings that on the 1st September 2014 he went for a circumcision procedure at Khulandoda Clinic. When they commenced with the procedure, he could not feel any pain but in the middle of the procedure he started feeling pains and he informed the medical staff about this discomfort. He mentioned that he could not hold himself and he started crying instead he was told to be patient until the Doctor was finish with the procedure. After the circumcision procedure he was given medicine for his wound and a leaflet containing information how he must look after the circumcision.

⁵⁴ See n9 at [13].

⁵⁵ Burchell "Principles of Criminal Law" 5ed (2016) JUTA at 104.

⁵⁶ Snyman "Criminal law" 6ed (2014) LexisNexis at 90.

⁵⁷ See n30 at 110 – 111.

[143] On the 3rd September 2014 he returned to Khulandoda Male Circumcision clinic for a follow up assessment visit, Nurse Bongi saw him and found that everything was in order. There was no recordable Advent Effect about the circumcision procedure of the Plaintiff. He was instructed to return on the 10 September 2014. On the 9th September 2014 a day before the scheduled date the plaintiff presented himself to the Khulandoda Male Circumcision clinic complaining of a swollen penis.

[145] Dr Makhudu, the medical doctor who attended to the plaintiff, according to his own testimony the plaintiff presented with a hematoma. He testified that his decision to open the wound, cauterise and re -suture was based on the fact that it was not a big swelling and it was not actively bleeding. He mentioned that there was no swelling on the scrotum. He stated further that as a preventative measure he covered the wound with two broad spectrum antibiotics to prevent it from having infections the broad spectrum was *Augmentin* and plus *flagella* and the pain killer was *paracetamol*.

[145] He confirmed that there was no sign of infection on the wound and averred that if there was any sign of infection they would have immediately referred the plaintiff to urology and send him to theatre. He stated that there was no sign of *Necrotizing Fascialities* or *Fournier's gangrene* on the plaintiff's wound on the 9 September 2014 that is the reason he decided to treat the plaintiff himself and not refer him to a urologist as it was not necessary. He maintained that the procedure he performed to the plaintiff having assessed the wound was a standard care which is what any reasonable doctor in his position would have done.

[146] On 11 September 2014, the plaintiff was admitted at the CHBAH having being collected from his home by an ambulance on 10 September 2014 at 23h00hrs. Sadly, the plaintiff and/ or his legal team never bothered to call and medical staff and / medical doctor from CHBAH to come and put into perspective and more particularly to testify about exactly what transpired at CHBAH for the time the plaintiff was processed from casualty and later admitted at 02h40 on the 11 September 2014 until he was discharged on the 7 November 2014. Instead, this court had to rely on the

assessment of clinical records from Dr Makhudu and from the two Urologist experts called by the respective parties.

[147] Both Drs Moshokoa and Van Wijk including Dr Makhudu agreed that the clinical records from CHBAH as recorded on 11 September 2014 at 02h40 revealed that the plaintiff had fairly severe complications which included *inter alia*:

1. *Swollen penis and scrotum;*
2. *Septic circumcision wound;*
3. *Slough on wound with minimal discharge;*
4. *Necrotic skin;*
5. *No active bleeding.*

[148] It is apposite to mention that according to the plaintiff's own testimony, he was seen by a urologist on the 15 September 2014, being 4 days after he presented with the above symptoms. He further testified that he was booked for operation of the 30 September 2014, that is 15 days after he had a Uro-consultation. This part of his testimony ties up with the plaintiff's amended particulars of claim.

[149] Both Drs Moshokoa and Van Wijk agreed that from the clinical records from CHBAH it can be deciphered apart from the 15 September 2014, that there was other two (2) procedures that might have followed but there are no clearly determinable dates mentioned from the clinical medical records. The only date that is determinable was the operation date- the 30th September 2014, this was also pleaded by the plaintiff in his amended particulars of claim.

[150] It cannot be disputed by any shred of evidence that the plaintiff as a result of the chain of events while at CHBAH sustained severe and several permanent sequela and disfigurement of his manhood. Apropos the extensive testimony by Dr Moshokoa it is worthy to note that according to her own testimony when she compiled her report she was never placed in possession of the clinical record from Khulandoda Male Circumcision clinic

thus her expert medico-legal report was only based on the clinical records from CHBAH and to some pictures which the plaintiff presented to her, the same not being discovered and/or presented to court during her testimony.

[151] Both Drs Makhudu and Van Wijk testified that the conditions that the plaintiff presented with at CHBAH required that there should have been immediate surgical intervention on the 11 September 2014. The CHBAH should not have waited until the 15 September 2014 in order for the plaintiff to be seen by a urologist let alone to have been booked for surgery only on the 30 September 2014. Whilst Dr Moshokoa could not come out vociferously about the dilatory time-lines at which CHBAH treated the severe condition that the plaintiff presented with having been diagnosed at CHBAH.

[152] As mentioned *supra* no medical staff and/or medical doctor was brought before court by the plaintiff in order to give an account of evidence on behalf of CHBAH as to the accuracy and/or glaring inaccuracies of the clinical records/ documentation and most significantly to explain the time lag and / or lengthy delays in plaintiff receiving immediate treatment.

[153] Although the plaintiff pleaded and testified that there was negligence on behalf of the defendant on the 1st, 3rd and 9th of September 2014. It is apposite to note that although Dr Moshokoa testified that with regard to the anesthesia on the plaintiff being a combination of macaine 0.5% -2,5ml, the lignocaine 2%- 7.5ml a total volume being 10ml, she would have preferred a combination of 20mls because at her rooms she normally prefers to give her patient's at least 20mls for the circumcision procedure. She did not testify that the 10 ml used at Khulandoda on the 1st September 2014 was not a standard nor a recommended volume by World Health Organization standard procedure

[154] In considering the expert evidence, the decision in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*,⁵⁸ the Court said:

"...it is the Court's duty to construe the specification and, on the merits, to draw inferences from the facts established by the evidence. See *Gentiruco's case*, supra at pp. 616D - 618G. There are, however, cases where the Court is, by reason of a lack of special knowledge and skill, not sufficiently informed to enable it to undertake the task of drawing properly reasoned inferences from the facts established by the evidence. In such cases, subject to the observations in the *Gentiruco case*, loc. cit., the evidence of expert witnesses may be received because, by reason of their special knowledge and skill, they are better qualified to draw inferences than the trier of fact."

And

'... the facts or *data* on which the opinion is based. The facts or *data* would include those personally or directly known to or ascertained by the expert witness, e.g., from general scientific knowledge, experiments, or investigations conducted by him, or known to or ascertained by others of which he has been informed in order to formulate his opinions, e.g., experiments or investigations by others, or information from text-books, which are to be duly proved at the trial.'

[155] In *Price Waterhouse Coopers v National Potato Co-operative Ltd*,⁵⁹ the following passage from a Canadian judgment was cited with approval:

"[326] "Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist..."

[327] "As long as there is some admissible evidence on which the expert's testimony is based it cannot be ignored; but it follows that the more an expert relies on facts not in evidence, the weight given to his opinion will diminish".

[328] An opinion based on facts not in evidence has no value for the Court."

[156] It is evident from the testimony of Nurse Bongsi Sithebe that when the plaintiff returned to Khulandoda Male Circumcision clinic that there was nothing untoward and/amiss with the circumcision procedure of the plaintiff. Both Drs

⁵⁸ *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) p at [33]

⁵⁹ *Price Waterhouse Coopers Inc and Others v National Potato Co-operative Ltd and Another* [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) para 99.

Moshokoa and Van Wijk agreed that indeed the clinical records on the 3rd September 2014 from Khulandoda Male Circumcision clinic did not record any advent event nor negligence on the part on the defendant as the wound was well and healing. Interestingly, both Drs Moshokoa and Van Wijk agree that there was time lag from CHBAH in aggressively treating the plaintiff's condition including referring the plaintiff to theatre.

- [157] In *Caswell v Powell Duffryn Associated Collieries Limited*:⁶⁰, it was said "Inferences must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish ... But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture"
- [158] In *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another*,⁶¹ the Court said:
". . . [I]t should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. 40.2. [I]t has been recognized that while the precise or exact manner in which the harm occurs need not be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable."
- [159] Having regard to the issue of factual causation, but for the wrongful conduct of the medical staff and/or medical doctor, would the plaintiff's loss have ensued or not? It was submitted on behalf of the plaintiff that if the wrongful negligent conduct of the medical staff and/or medical doctor was eliminated - and on the assumption that all precautionary requirements were satisfied and carried out – the damage to the manhood of the plaintiff would not have occurred. Having considered all the evidentiary material including the plaintiff pleaded case *in casu*, Factual causation has thus not been satisfied. Our Courts have indicated that a plaintiff is not required to establish the causal

⁶⁰ *Imperial Marine Co v Deilemar Compagnia* 2012 1 SA 58 (SCA) at 70 at par 24.

⁶¹ *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another* 2000 (1) SA 827 (SCA) paras 21-22.

link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss.⁶² *In casu* the plaintiff has not establish that there was any negligent and/or wrongful conduct on the part of the medical staff and/or medical doctors at Khulandoda Male Circumcision clinic.

[160] The plaintiff has failed to establish causation in *casu* in so far as the defendant is concerned. Both Drs Moshokoa and Van Wijk agreed that there was blood cultures obtained from the plaintiff whilst at CHBAH and yet the results thereof were never presented as evidence at court as such it can never be established as to where did the bacteria originate from or what kind of pathology caused the plaintiff harm to his manhood.

[161] It is trite that the determination of negligence ultimately rests with the court and not with expert witnesses. Yet, that determination is informed by the opinions of experts in the field which are often in conflict in many instances. Fortunately, *in casu* the experts are both seasoned, with vast practical experience and are both urologists. To the extent that I rely on an analysis underlying reasoning mostly that is to an extent based on the clinical record from Khulandoda Male circumcision clinic and to a larger extent from CHBAH, there has been agreement on a number of issues by both sides as adumbrated *supra*.

[162] To my displeasure, the plaintiff's legal team never bothered and/or failed to call any medical staff and/or doctor(s) from CHBAH to come and give evidence before court as to what informed the delay in not aggressively treating the plaintiff's condition when he was received from casualty on the 10 September 2014 at 23h00hrs until being admitted at 02h40 on the 11 September 2014. No one was ever called by the plaintiff's legal team from CHBAH to present the crucial evidence as to how many surgeries and/or procedures did the plaintiff undergo and as to what had happened to the blood cultures that were obtained from the plaintiff while at CHBAH.

⁶² Minister of Safety and Security v Van Duivenboden 2002 (6) SA 431 (SCA) para 25

[163] To my earlier statement that in every civil litigation it is trite that parties must plead their case properly and further support their case with evidence that support their pleaded case. I deem it fit that having critically analysed the evidence in toto before me that I need not make my findings on the defence of indemnity, but to make my findings on the plaintiff's pleaded case and the *viva voce* evidence presented before me.

[164] In *Fox v RAF Tlhapi J stated*⁶³:

"[11] Liability depends on the conduct of the reasonable person. The test for negligence was stated in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-G as follows: For the purpose of liability culpa arises if-

(a) A diligens paterfamilias in the position of the defendant –

(i) Would have foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) Would take reasonable steps to guard against such occurrence; and

(b) The defendant failed to take such steps,

Whether a diligens paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstance of each case. No hard and fast basis can be laid down."

[12] It is trite that the onus then rests on the plaintiff to prove the defendant's negligence which caused the damages suffered on a balance of probabilities. In order to avoid liability, the defendant must produce evidence to disprove the inference of negligence on his part, failing which he/she risks the possibility of being found to be liable for damages suffered by the plaintiff."

[165] Dr Van Wijk testified and corroborated the testimony of Dr Makhudu that the *Fournier's gangrene* that the plaintiff was diagnosed with at CHBAH on the 11 September 2014 at 02h40 is an extremely rare complication with circumcision and explained that it rapidly develops and progress within hours. I find that there was *novus actus interveniens* in this matter.

⁶³ *Fox v RAF* (A548/16) [2018] 285 (26 April 2018).

Considering the Plaintiff's own testimony that he was seen by the urologist on the 15 September 2014 and only booked for operation on the 30 September 2015, I find that the CHBAH was negligent in not establishing the *novus*, or at the least the delay in not aggressively treating the *Fournier's gangrene* which was diagnosed on the same day that the plaintiff was admitted at CHBAH on 11 September 2014 at 02h40 contributed to the plaintiff's conditions thus harming him. I find that early aggressive intervention at CHBAH by medical staff and or medical practitioners that treated at him at casualty prior to admission on the 11th September 2014 might have arrested the rapid progression of the plaintiff's condition and made a difference.

[166] The law on the incident on 9 September 2014 is crystal clear given the fact that it is proven on the balance of probabilities that there was no infection or history that there might been infection on the wound. Dr Makhudu testified that the plaintiff presented with a hematoma which was a swelling only on the penis and there was no swelling on the scrotum.

[167] That having been said, Dr Makhudu was under a legal duty to person the procedure he did and to dispense proficient medical care to the plaintiff. The Constitutional Court in matter of *Oppelt v Health, Department of Health Provincial Administration: Western Cape*⁶⁴ held that:

"There is no doubt that the legal convictions of the community demand that hospitals and health care practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability".

[168] The question is if the service rendered on 9 September 2014 by Dr Makhudu at Khulandoda Male Circumcision clinic was not proficient? In *Topham v MEC for the Department of Health, Mpumalanga Province*⁶⁵ it was held that:

- "Professional negligence is determined by reference to the standard of conduct of the reasonable skilled and careful practitioner in the particular

⁶⁴ 2016 (1) SA 325 (CC) at paragraph [54].

⁶⁵ (351/2012) [ZASCA] 65 (27 May 2013).

field and in similar circumstances. A medical practitioner diagnosing and treating a patient is expected to adhere to the general level of skill, care and diligence possessed and exercised at that time by the members of the branch of the profession to which he or she belongs”.

[169] Recently, the test for medical negligence was aptly captured in November 2023 by Joubert⁶⁶ when he discussed the cases of *Chapeikin and Another v Min*⁶⁷ He concluded that:

“a. The existence of negligence for purpose of liability is that fault arises if a reasonable person in the position of the defendant would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and would take reasonable steps to guard against such occurrence; and the defendant failed to take such reasonable steps.

(b) There are two steps, the first is foreseeability- would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring another causing loss. The second is preventability- would that person take reasonable steps to guard against the injury happening,

(c) Negligence must be evaluated in light of all the circumstances.

(d) Because the test is defendant-specific the standards are upgraded for medical professionals. The question for them is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it.

(e) The appellate division noted that this standard does not expect the impossible of medical personnel.

(f) 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

⁶⁶ <https://www.millers.eo.za/OurInsights/ArticleDetail.aspx?ArticleID=3121> accessed on 8 August 2025. Also see Joubert, W: WHEN CONSTITUTIONAL GUARANTEES MEET REALITY IN HEALTH CARE, 29 April 2016, Medical Negligence, De Rebus in 2017 (June issue) DR42, <https://vzlr.co.za/2016/04/29/when-constitutional-guarantees-meet-reality-in-health-care/also> accessed on 8 August 2025.

⁶⁷ (103/2015) [2016] ZASCA 105 (14 July 2016 and Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape (CCT185/14) [2015] 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) (14 October 2015)

bound to employ reasonable skill and care and he is liable for the consequences if he does not.

(g) A practitioner can only be held liable if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply absence of reasonable skill and care on his part, regard being had to the ordinary skill in the profession.

(h) The test is always whether the practitioner exercised reasonable skill and care or put differently, whether his or her conduct fell below the standard of a reasonable competent practitioner in the field.

(i) If the error is one that a reasonable competent practitioner might have made it will not constitute negligence”.

[170] The final conclusion lies in the testimony of Dr Van Wijk when he testified that if he was presented with the similar symptomatic diagnosis of hematoma he would have treated the wound the same manner that Dr Makhudu treated it because in the absence of any infection from the wound the treatment was that of standard care. The covering of the wound with antibiotics as explained by Dr Makhudu was a preventative measure.

[171] I am constraint to arrive at the overwhelming decision that the plaintiff has failed to prove negligence on the part of the medical staff and /or medical doctors of the defendant at Khulandoda Male Circumcision clinic on the 1st, 3rd and the 9th September 2014.

[172] In the premises the following order is made:

Order

[173] The plaintiff's claim is dismissed on the merits with costs.

J YENDE
Acting Judge of the High Court

Gauteng Local Division, Johannesburg

APPEARANCES

For the Plaintiff: Adv M MAKAMU

Instructed by Nkobi Attorneys Inc

For the Defendant: Adv S KROEZE

Instructed by Whalley Van Der Lith Inc

Heard: 22/23/24/25/28/ 29/30 October 2024 & 7/9/ April 2025

Reserved: 9 April 2025

Heads of Argument – Plaintiff's counsel 30 April 2025.

Head of argument -Defendant's counsel 13 May 2025.

Delivered: 28 August 2025

*This judgment was prepared by **YENDE AJ**. It is handed down electronically by circulation to the parties/their legal representatives by e-mail and uploaded on Caselines electronic platform and by publication of the judgment to the South African Legal Information Institute. The date for hand-down is deemed **28 August 2025**.*