



REPUBLIC OF SOUTH AFRICA

30/98

**THE SUPREME COURT OF APPEAL
OF SOUTH AFRICA**

Case No: 290/95

In the matter between

ABRAHAM MENDEL BROUDE

Appellant

and

WILLIAM ANDREW McINTOSH

First Respondent

THE ADMINISTRATOR OF THE TRANSVAAL

Second Respondent

CORAM: HEFER, EKSTEEN, NIENABER, HOWIE *et* MARAIS JJA

DATE HEARD: 9 and 10 March 1998

DELIVERED: 27 March 1998

JUDGMENT

MARAIS JA

MARAIS JA:

In coldly clinical terms this is an appeal against the dismissal of an action for damages suffered as a consequence of a paralysis of the left side of the face caused by the allegedly negligent conduct of a surgeon employed by the Transvaal province who performed an operation upon appellant's left ear in September 1991. In human terms it is a sad tale of high hopes, good intentions, dashed expectations, much anguish, and ensuing recriminations culminating in lengthy, stressful, and expensive litigation. The resolution of the litigation was more than ordinarily difficult. There were conflicts of fact on both major and minor issues. Some of the evidence given in support of appellant's case was manifestly or demonstrably unreliable. So too was some of the evidence given in support of the case for respondents. A pre-existing undercurrent of professional and personal hostility towards the respondent surgeon on the part of his counterpart, who was the principal professional champion of appellant's cause,

was plainly evident. Subsequent surgical intervention many months later by a Swiss surgeon not called to testify, far from providing clear answers to what had caused the paralysis, raised yet more conundrums. The learned trial judge (Botha J) did his best to arrive at firm conclusions and in many respects was able to do so. However, in the final analysis he found himself unable to conclude that it had been established by appellant on a balance of probability that negligence on the surgeon's part had been proved and he granted absolution from the instance with costs.

Summarising the history of the matter as neutrally as I can, it amounted to the following. Appellant is a medical doctor who has spent most of his professional life practising medicine either privately or as an employee of a hospital. He was born on 30 March 1931 and was 60 years of age at the time of the operation. In 1969 his left ear began to trouble him. He experienced deafness and tinnitus (noises in the ear) and protracted bouts of giddiness. In the same year

he underwent an operation in Germany. It left him permanently deaf in the left ear but alleviated the tinnitus and the vertigo to such an extent that for 20 years he had no need of further intervention.

In 1989 there was a recurrence of vertigo and tinnitus with accompanying nausea. He was referred in 1990 to first respondent, Professor McIntosh, who is an ear, nose and throat surgeon. He is head of the relevant department at the Johannesburg hospital and a professor in the faculty of medicine of the University of the Witwatersrand. Conservative treatment followed but brought little relief. In March 1991 a decision was made to operate. The operation was performed by first respondent at the Johannesburg General Hospital on 4 September 1991.

The operation which first respondent set out to perform was a cochlear vestibular neurectomy. It is a designedly destructive operation and has as its object the severance of both the cochlear and the vestibular nerves. The

vestibular nerve is severed and excised to counteract vertigo. The cochlear nerve is severed but not necessarily removed to counteract tinnitus. Inasmuch as the cochlear nerve plays a role in the hearing function its severance would not have been appropriate if plaintiff had still been able to hear in his left ear. I interpose here that no criticism was made of first respondent's decision to recommend and perform this particular operation rather than a less invasive operation known as a labyrinthectomy.

The operation entails gaining access to the inner ear structures by making appropriate incisions, sculpting away with a rotary burr part of the mastoid bone behind the ear, passing through the labyrinth and part of the cochlea (and *en passant* destroying them *pro tanto*) and arriving at the internal auditory canal. This is a bony structure with an internal lining of dura which is a very thick tough tissue. The bone of the canal is shaped down until it is so translucent that one can see through it to the structures behind it. The underlying dura is exposed by lifting

the remaining film of bone. The dura is then opened and the nerves which are to be severed are exposed to view. They are visualised microscopically at a very large magnification by the surgeon. Absent any anatomical abnormalities the nerves are easily seen and distinguished from one another both by reason of their colouration and by reason of their physical location and the courses which they take. In close proximity to the vestibular and cochlear nerves is the facial nerve - indeed these three nerves make contact with one another for some of their respective lengths. The vestibular nerve has two branches both of which are severed and a segment of each removed. The cochlear nerve is incised and may or may not be removed. To close the opening through which entry was gained, a sheet of fascia (fibrous tissue which holds structures together and envelopes muscles) taken from the patient's body is placed in such a way as to cover the opening in the internal auditory canal. To hold it in place and provide a soft tissue seal so that cerebrospinal fluid which fills the canal does not exude or leak out, an

appropriate quantity of body fat harvested from the patient is eased into the cavity before the incision in the patient's skin is sutured. That at any rate is how first respondent said the operation should be done and there is no disagreement amongst the medical witnesses about that.

The operation was over by 10.25 on 4 September and after spending some time in the recovery room appellant was taken to the ward in the latter part of the morning. His wife was waiting to see him. The appearance of his face at this juncture and when he was visited again towards evening, and whether there were indications of facial palsy (paralysis) visible, were major issues at the trial. What passed between first respondent and appellant and his wife on the latter occasion was also in dispute.

According to first respondent the appearance and function of appellant's face after he awoke from the anaesthetic in the recovery room was normal. Later that day when he saw appellant in the ward there were no clear

signs of even a partial palsy. All that he observed was "a possible sluggishness of movement in places". According to appellant's wife, Mrs Broude, she noticed when appellant was wheeled into the ward that "his face looked strange" in that his mouth looked "skew". She said that appellant passed his hand across his face and asked her whether his face was skew and she replied in the affirmative. Later on in the afternoon she met first respondent in the ward which was a general ward. Appellant asked first respondent whether his face was skew and first respondent affirmed that it was. First respondent allegedly patted her on the shoulder and laughingly said: "Mrs Broude, if you were in America you would already be at the lawyer's offices". According to first respondent he said no such thing. Appellant and his wife also said that first respondent told them that appellant's face would return to normality within three to four weeks. First respondent's version was that when he did discuss the palsy (and it was not on that occasion) he said it would resolve itself in three to four months but that he could have said that it might

resolve itself earlier within a matter of weeks.

First respondent did not dispute that by the next day (5 September) some clinical signs of a left facial palsy were visible. On that day appellant was tested by means of electroneuronography to establish the status of his facial nerve. The test (referred to as an ENOG) showed a 60% degeneration of the nerve. Just how many such tests were carried out between then and appellant's discharge from the hospital on 9 September was disputed but it is at least common cause that on 19 September (by which time appellant had been re-admitted to hospital in circumstances to be related) another ENOG was carried out and that it showed a 100% degeneration of the nerve.

During appellant's first stay in hospital there was a leakage of cerebrospinal fluid through the surgical wound and through the nose. The occurrence of such a leak is not uncommon and is not necessarily or even probably indicative of negligence. Appellant was anxious to go home and after discussion

with first respondent during which appellant was told to stay in bed and to do whatever had to be done "to look after" himself as appellant put it, he was discharged on 9 September. The contemporaneous clinical note made at the time reflects that there was still an "occasional" leak. First respondent observed with some justification that this was an indication that it was a resolving leak and that further surgical intervention was both unnecessary and unwise. While at home appellant suffered from a stuffy and irritating nose. On 11 September he blew his nose and experienced an excruciating headache. He claimed he had not been told not to do so. That was disputed. He rushed back to hospital and remained there until 20 September. Again, so appellant said, his discharge was "by negotiation and discussion". He was to be strictly confined to his bed, take antibiotic cover, and report back regularly to the department. The leakage of cerebrospinal fluid continued. First respondent's attitude was that it would stop of its own accord. Appellant decided, so he said, to take a second opinion and consulted Dr Davidge-

Pitts on 7 October. Appellant was advised to wait for a few more weeks. He also communicated with Dr Hamersma during October. He was reluctant to be involved but advised him to keep in contact with first respondent, to be conservative and to follow first respondent's advice. By 23 October the leak had stopped and appellant returned to work on 28 October.

On 29 October appellant consulted an ophthalmologist, Dr Kuming, about problems he was experiencing as a consequence of not being able to open and close his left eye because of the palsy. As time went by and no improvement in his facial condition appeared to be taking place, appellant's anxiety increased. He experienced difficulty in making contact with first respondent (the reasons why are in dispute). On 28 November 1991 appellant wrote to first respondent. The letter was mainly reproachful. It was said that the facial palsy was still present and the question was posed whether the facial nerve had been either partially or completely severed. Surprise and disappointment was expressed that neither first

respondent nor his department had made contact with appellant. However, first respondent was thanked for everything and the operation was said to be "in a final analysis" a "success" and "the nursing, medical and hospital" were said to have been "superb".

First respondent claimed not to have received this letter until long after it was written, citing his lengthy absence from South Africa as one of the reasons why he did not receive it sooner. He admitted that he did not reply to it but said that he was due to see appellant soon after he had seen the letter and intended to discuss it with him then. As a fact they did not see one another again.

On 30 January 1992 appellant consulted a neurologist, Dr Levy, who was well known to him. Clinical examination failed to disclose any observable functioning of the left facial nerve. An electromyographical test (known as an EMG test) was performed to assess whether any function was present. According to Dr Levy mild volitional activity in certain of the facial muscles was noted. No

stimulation of the facial nerve was possible. Dr Levy concluded that there did appear to be some return of function and suggested that a further EMG test in six weeks time might be of some value. He said in evidence that the volitional activity reflected when the EMG test was done was inconsistent with total severance of the nerve and that for the message to have reached the muscle from the brain stem via the facial nerve meant "that there must have been some continuity" and that whatever lesion there might be was a "partial" one. He said that clinical recovery of a facial nerve can be very delayed and that electrical recovery often precedes clinical recovery. However, there is sometimes no functional recovery. A further test was carried out on 1 July 1992 but the findings were not recorded and Dr Levy was quite unable to recall what they showed.

Appellant claimed that he had been told by Dr Levy that the result of the first test was equivocal and that nothing could be deduced from it. Dr Levy's response to that was that the result of the test may have been equivocal as an indicator of

returning function but that it was not equivocal as an indicator of continuity of the nerve.

Before returning to Dr Levy on 1 July 1992 appellant consulted Dr Hamersma during February 1992 after an arranged meeting with first respondent did not take place on 4 February. Dr Hamersma examined appellant and subjected him to electrical testing. He told appellant that the facial nerve was dead and that there was no response. He questioned appellant about his interaction with first respondent and having learnt that first respondent had told appellant to await developments, he advised him to "err on the conservative (side) and give it its best shot seeing that (first respondent) had never ever indicated any kind of concern" and that "we should wait up till nine months". He also told him that he might need an operation and that he should consult another ear, nose and throat surgeon, Dr le Roux, and a neurologist, Dr de Klerk.

On 5 March 1992 Dr Kuming performed a tarsorrhaphy operation on

appellant. It entails suturing the corners of the eye lids together in order to protect the eye without depriving the patient of the use of the eye. Had appellant been able to open and close his left eye this operation would not have been required.

On 19 May 1992 appellant consulted Dr le Roux who sent him to a physiotherapy practice conducted by Ms Melanie Jacobs in the same building in order to undergo a nerve excitability test (known as a NET). The test was conducted by one of her assistants, Ms van der Merwe. According to Ms van der Merwe, she had no difficulty in performing the test. The apparatus was not out of order and appellant was not told to come back on another day. According to Dr le Roux, the result indicated that the nerve was alive and had a chance of recovery and that it had not been severed. A strange feature is that Dr le Roux testified initially that he had not asked for the test to be done but conceded when confronted with a note written to Ms Jacobs that he had done so. However, he said he had received no report on the result of the test. When asked why he had

not asked for the report when it was not forthcoming, he was quite unable to explain why he had not done so. He claimed to have seen it for the first time in court. Equally strange was appellant's evidence that the apparatus was not functioning, that he returned on another day to be tested, and that the person conducting the test was still "not very impressed with their apparatus" but said "they have got some result and that they would report to Dr le Roux".

Dr le Roux advised appellant that he should consider going to see Dr Fisch, a renowned surgeon in Zurich, with a view to surgical exploration of the nerve and a primary nerve repair. Dr de Klerk shared that view. In the result appellant was operated upon by Dr Fisch in Zurich on 19 September 1992. Dr Fisch was unable to repair the nerve and instead performed a facial nerve hypoglossal anastomosis. The operation entails severing the nerve to the tongue in the neck and then connecting it to the facial nerve where it exits from the brain stem at the base of the skull. The muscles of the face are thereby enervated and

the patient is trained to use the tongue to create facial movement. However, it will not restore emotional expression and while it will be possible to close the eye, secretion of the eye does not return and the eye remains dry. The operation was successful.

Appellant underwent yet further operations in South Africa in 1993 to improve his facial appearance but it is unnecessary to describe them. What was found during the operation in Zurich and what inferences could be drawn from what was found was the subject of much debate. Dr Hamersma was present at the operation and described what was found. Dr Fisch did not testify but his note of the operation was translated from German into English and placed before the trial judge by consent of all the parties as being a correct exposition of what he did and what he found. The parts of it around which debate centred were these:

"5. Behind the foramen meatal, a huge neuroma bulged out of the opened

internal auditory canal. This neuroma was removed by tympanioplasty scissors, without escaping of fluid.

6. Removal of bone over jugular bulbus in the area of porus acusticus internus. This had not been reached by previous operation. Exposure of back, upper and lower surfaces of the internal auditory canal. The facial nerve was traced inside the scarred auditory canal. A few millimetres before the foramen meatal, the nerve loses itself inside scar tissue. The scar extends over the entire internal auditory canal.
7. Opening of the meatal dura in the area of porus acusticus internus. Here too an atrophied facial nerve was to be found. Even after removal of dense scar tissue from the internal auditory canal, it was still impossible to identify a proximal stump of the facial nerve, with any certainty. It would appear that, after the previous operation, dense scar tissue in the internal auditory canal compressed the facial nerve and led to development of a scar-neuroma.
8. In view of the fact that facial paralysis had persisted for one year and the patient's facial muscles had a very flaccid appearance, we decided to proceed with a hypoglosso-facial-anastomosis.

9.

Review: The cause of the facial-nerve-lesion during the previous operation remains unclear. It is possible that the internal auditory canal was, to a large extent closed by tissue which, as a result of post-operative swelling of facial nerve graft within the inner auditory canal was compressed and, as a result, regenerated nerve-fibres were unable to establish contact with the meatal foramen. Whether the 6 weeks of liquorrhea also were (also) responsible, remains an open question."

I mention that the facial nerve graft referred in the passage sub-headed "Review"

appears in the German as "des Transplantates der N. facialis" and that was rendered as "the transplanted tissue" in Dr Hamersma's translation of the report.

What was thought to be a neuroma was shown on histological examination to be "scar tissue with parts of a peripheral nerve". (A neuroma is the new growth of tissue which usually follows upon the severance of a nerve and it is something quite distinct from scar tissue.) The reference to "liquorrhea" is a reference to the leakage of cerebrospinal fluid which occurred in September 1991.

The claim for damages was founded upon first respondent's conduct before, during, and after the operation. I shall deal with each in turn. The claim based upon first respondent's conduct prior to the operation rested upon his alleged failure to apprise appellant of the risks attending the operation and of the existence of an alternative operation. The claim was advanced in two ways in the pleadings. First it was alleged that first respondent had "wrongfully failed to obtain the (appellant's) real or informed consent to the operation and the first

(respondent) accordingly committed an assault on (appellant) in operating on him on the 4th of September 1991". Secondly, and in the alternative, it was alleged that in "treating the (appellant) and in carrying out the operation (first respondent) acted in a negligent and unskilful manner" in that he "failed to inform the (appellant) prior to carrying out the operation of the risks and hazards involved and he failed to inform the (appellant) of alternative operative treatment available".

Pleading a cause of action such as this as an assault to which the patient did not give informed consent is of course a familiar and time-honoured method of doing so. However I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this court when an appropriate case arises. To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has

explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent.

It seems to me to be inherent in the notion that even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle of law of which I am aware by which the characterisation as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not. Events occurring *ex post facto* can logically have no bearing on the question. It is no answer to say that if the

undisclosed risk does not eventuate no damage will have been caused. That has nothing to do with the characterisation of the medical practitioner's act in intervening surgically as lawful or unlawful. I mention this merely by way of example to explain why I consider that the validity of causes of action framed in this manner *in circumstances similar to those which are said to exist in this case* requires re-examination. (I emphasise the latter qualification; I leave aside cases in which *mala fides* is involved such as cases of deliberate fraud and deliberate misrepresentation of what is entailed in order to obtain consent which would otherwise not be forthcoming.) However, re-examination would be inappropriate in the present case. The matter was not argued and even if it be assumed in favour of appellant that the cause of action based upon an allegation of assault is conceptually sound in law, I agree with the trial judge's conclusion that the evidence does not bear it out.

The omission to inform appellant of the risk of leakage of

cerebrospinal fluid was of no significance. The leakage was not proved to be causally related to the onset of the facial palsy and appellant did not claim that if the risk of leakage had been mentioned to him, he would have refused to consent to the operation. Appellant's evidence as to the alleged failure of first respondent to inform him of the risk to the facial nerve and of the availability of the alternative operation (labyrinthectomy) was rejected by the trial judge. He pointed out that appellant had signed a document in which he consented specifically to a translabyrinthine vestibular neurectomy and in which he acknowledged that the nature and possible effects of the operation had been explained to him. He referred to appellant's own use of the expression "labyrinthectomy" in a letter which he wrote on 5 April 1991, which was of course prior to the operation, and to appellant's concession that he may have been told that the translabyrinthine vestibular neurectomy would provide a "one stop" solution to both his vertigo and his tinnitus. The learned judge considered that the reference to the latter operation

providing a "one stop" solution to both problems suggested that a comparison was made with another operation which would not achieve both objects. He noted that appellant had sought to explain his use of the word "labyrinthectomy" by claiming that he thought it was a synonym for a translabyrinthine vestibular neurectomy but observed that appellant must have heard the word "labyrinthectomy" from first respondent. He found that appellant was at the end of his tether, was looking to first defendant to do whatever he could to eliminate or alleviate his problems, and was amenable to whatever surgical intervention first respondent recommended. He added that appellant had never said that if he had been informed of the risk to the facial nerve and of the alternative operation, he would not have consented to the operation which was performed. The highest that appellant had put it was that he might not have consented. He drew attention to the fact that when appellant's letter of demand was sent it made no mention of any failure by first respondent to inform appellant of the risk to the facial nerve and the availability of an alternative

operation. He also considered it to be improbable that first respondent would have failed to inform appellant of these matters. One might add that it is also somewhat improbable that appellant would have been disinterested in such matters given the fact that he was a medical practitioner with some knowledge of the anatomy of the area in which the operation would be performed. No good reason exists to differ from the trial judge's view that this cause of action was not made out. The same applies to the alternative cause of action based upon an alleged negligent failure to inform appellant of these matters. This conclusion makes it unnecessary to decide upon the correctness of the approach to questions of this kind taken by the full bench of the Cape Provincial Division in Castell v De Greef 1994 (4) SA 409(C).

The remaining allegations of negligence levelled at first respondent relate to both the manner in which first respondent performed the operation and the manner in which he dealt with appellant after the operation. The negligent

conduct during the operation was pleaded originally as consisting of, firstly, the severance of the facial nerve and, secondly, the failure properly to close the operation site and the aditus (entrance) to the antrum (cavity). The latter allegation was not persisted in at the trial and no more need be said about it. During the trial appellant amended his pleadings to include an allegation that, if the facial nerve was not severed, it was negligently damaged in some other unspecified way. A request for particulars elicited the reply that "the nature of the damage was - bruising, stretching, tearing, crushing, cauterising, compressing or interference with the nerve's blood supply resulting in an alteration to the anatomical structure of the nerve and interference of (sic) the electrical conduction of impulses through the nerve", and that appellant was unable to be more specific. In response to the question when and how the damage should have been diagnosed, appellant replied that the "damage should have been diagnosed and recognised when the damage arose at the operation, but certainly when the (appellant's) face exhibited signs of

paralysis". As to how and when the damage should have been repaired, appellant replied: "Either by nerve suturing or grafting and if that was not possible, by hypoglossal facial anastomosis, as soon as possible."

The trial judge concluded that the evidence did not establish on a balance of probabilities that the facial nerve was severed during the operation. That conclusion rested upon a number of subsidiary findings and considerations which, if correct, amply justify it. Those findings and considerations were these. The facial nerve must have sustained some injury during the operation. Severance could not be deduced solely by invoking the *res ipsa loquitur* doctrine because there were other potential causes of damage to the nerve which did not entail severance. An immediate and complete post-operative palsy (which would have been a concomitant of a severance) had not been established by the evidence. The direct evidence of first respondent that the facial nerve was not severed or otherwise observably damaged, corroborated as it was by the evidence of Dr

Vasek, who was present as an observer but bore no responsibility for the operation, could not be justifiably rejected. Dr Levy's evidence that the facial nerve showed signs of life when tested electrically on 30 January 1992 was incompatible with severance. That evidence was acceptable evidence and Dr Hamersma's attempt to pass the result of the EMG test off as equivocal, or as what a "dumb neurologist" found, was impliedly rejected. The result of the NET test performed at the rooms of Ms Melanie Jacobs at Dr le Roux's request showed that there was regeneration of the nerve taking place and, when confronted with it, Dr le Roux was constrained to concede that it pointed to non-severance. The Swiss surgeon, Dr Fisch, was not called by appellant to give evidence and his report of the operation which he performed contained no explicit statement that the facial nerve had indeed been severed at the previous operation. That Dr Fisch may have assumed at the time that severance had occurred was possible because he searched for nerve ends to unite or join by way of a graft and found a mass of scar tissue

which he mistakenly thought was a neuroma. The fact that the tissue was found on histological examination to be scar tissue and not a neuroma, made severance improbable. The very existence of the scar tissue, which would have taken time to form post-operatively, and which could have put additional pressure on the nerve, was an indication that the nerve might not have been cut initially. It could not simply be assumed, in the absence of evidence by Dr Fisch, that he tested the nerve for viability before performing the operation which he did, when so many unanswered questions attended what he found. His inability to identify a proximal nerve stump could also be interpreted as supporting the notion that there was in fact no severance. The report was consistent with Dr Kassner's interpretation of it as indicating that the facial nerve was found embedded in the scar tissue. (Dr Kassner is an ear, nose and throat surgeon who was called to testify by respondents.) At best for appellant, Dr Fisch's report was to the effect that the cause of injury to the nerve was not clear and that the nerve may later have been

compressed by developing scar tissue. The learned judge rejected the evidence of Dr Hamersma that the cochlear nerve had not been severed by first respondent (and by implication the insinuation that the facial nerve had been mistakenly severed instead). Finally, the learned judge considered that the result (60% degeneration) of the ENOG test done on 5 September 1991, while not conclusive, also tended to show there had been no severance.

While some of these considerations are of questionable probative value, in the main the findings are justified by the evidence. There are yet further considerations pointing away from the nerve having been severed during the operation. Appellant's case was predicated upon the proposition (for which there was a good deal of support in the evidence) that if the facial nerve had been severed during the operation, first respondent would have been aware of it. If that is so and if the facial nerve had indeed been severed, it is in the highest degree unlikely that first appellant would have ignored it and simply continued with the

operation as if nothing untoward had happened. The swift onset of total palsy would have been the inevitable consequence and he would have had to deal with it. The injury to the nerve would not have been something which would go away if left unrepaired and undisclosed. Moreover, it would have been extremely difficult to conceal successfully such a mishap from the other medical personnel participating in the performance of the operation. Once the cumulative impact of these findings and considerations is measured, I am left in no doubt that there is no preponderance of probability that the facial nerve was severed during the operation. It is worthy of mention that Dr le Roux, appellant's own witness, said that he did not think that one could really prove that it was severed.

Counsel for appellant's alternative contention was that whatever the precise cause of the palsy was, the onset of the palsy was so immediate and complete that it had to be inferred, as a matter of probability, that it could only have been caused by some unspecified negligent act on the part of the surgeon

which caused damage so severe that the act must have been closely akin to severance in its traumatic impact. To that contention I now turn.

Foundational to the argument was the premise that the onset of the palsy was immediate and its extent complete in the sense that all the muscular functions of the left side of the face controlled by the facial nerve came to an end within hours of the completion of the operation. That is not what the trial judge found. It is so that he rejected first respondent's euphemistic evidence as to the appearance of appellant's face when he saw him in the ward later on the day of the operation. It is also so that he accepted the honesty of the evidence given by appellant's wife and members of her family regarding the appearance of appellant's face. However, he did not regard their evidence as sufficiently reliable to warrant concluding that there was indeed a "sudden complete" palsy on 4 September 1991. After referring to their evidence as to the "skewness" of appellant's face and the details allegedly observed, he stated that allowance had

to be made "for the telescoping of impressions that stretch over a period". He plainly had in mind the fact that appellant's face looked progressively worse as the months went by and that the only photographs of his face which were available at the trial were those taken when its appearance was at its worst. No photographs taken very shortly or even relatively shortly after the operation were produced.

The members of the family differed to some extent from one another in describing the details of what was observed. Appellant's wife, when asked to compare the appearance of appellant's face then with its appearance in the photographs, was unable to do so. All she could say was that it was not as bad as was depicted in the photographs. When asked whether his appearance improved or deteriorated after his discharge from hospital in September 1991, she replied: "I do not know. Maybe I was just too emotionally involved, I do not know." She added that she saw it "on and on and on and it always seemed grotesque to me". The trial judge referred to the fact that the members of the family had no previous experience of

diagnosing a paralysis and that Dr Kassner had testified that it requires some experience to do so and particularly to assess the degree of a paralysis - a proposition for which there was support in the medical literature. He opined that the worst appearance of appellant's face would be the one most likely to be imprinted on their memories. He referred to the evidence of both first respondent and Dr Vasek (which he felt unable to reject) that when appellant was clinically examined in the recovery room after the operation for signs of facial weakness, there were none. He considered that their evidence that if appellant had displayed a virtually immediate complete facial paralysis, prompt action would have been taken to deal with it, was in accord with probability. He thought that first respondent's remark about recourse to law in the United States of America in such circumstances and a remark overheard by appellant's daughter-in-law to the effect that the palsy would take longer to resolve than appellant had initially been led to believe, was inconsistent with any belief on first respondent's part that appellant

had sustained a severe surgical injury to his facial nerve and had experienced an immediate and total paralysis. He attached some significance to the fact that in February 1992 appellant himself described the condition as a partial (meaning transient) facial palsy and that when he solicited a letter from first respondent describing his condition and it was described as such, he accepted it without demur. He recalled (wrongly) that Dr Kassner had testified that a paralysis manifesting itself within 4 hours of an operation "could still be consistent with a delayed onset". (As a fact Dr Kassner gave no such evidence; it was the evidence of Dr Vasek which could be interpreted as supporting such a proposition.) In the result he concluded that what the evidence of appellant and his family did show was that when he was first seen in the ward on 4 September 1991, there was a "visible deformity that made an abrupt and unpleasant impression", "something which disturbed them", and which was "a far cry from the hardly discernible sluggishness to which first (respondent) testified". The overall conclusion was

that “(o)n all this evidence it cannot be accepted as proven on a balance of probabilities that clinically a sudden complete palsy was present when Mrs Broude saw her husband in the ward”. Again, some of these factors are not particularly cogent when viewed in isolation but in their totality they provide sufficient justification for the conclusion reached.

The evidence of Dr Hamersma is of pivotal importance in appellant’s case. The trial judge’s mainly unfavourable assessment of him as a witness is fully borne out by the evidence. He was found to be deserving of credit for his readiness to champion the cause of the appellant but lacking in objectivity because of his professional animosity towards first respondent which pre-dated the operation which first respondent performed upon appellant. A disturbing aspect of his evidence was the zeal with which he sought to persuade Dr Fisch to include in his report an unequivocal statement to the effect that the cochlear nerve had not been cut despite the fact that the factual foundation for such a statement was

slender. His motive for doing so was to enable it to be argued that the facial nerve had been mistaken by first respondent for the cochlear nerve and mistakenly severed. A perusal of his evidence shows him to be a forceful and at times excitable personality who was intent upon dredging up anything he could think of which might reflect adversely upon first respondent's performance of the operation, his conduct after the operation, and his credibility. Anything which appeared to militate against his own thesis of severance of the facial nerve or damage so serious as to be akin to severance was dogmatically derided as being of no consequence. The neurologist who conducted an electromyography (EMG) test and found signs of life in the nerve inconsistent with its severance was "dumb". Aspersions were cast upon the competence of the physiotherapist who performed the electrical nerve excitability (NET) test upon appellant and found activity in the nerve. It will be recalled that the latter was a person in the practice to which appellant had been referred for testing by one of his own witnesses, Dr

le Roux, and that the former was Dr Levy, whom appellant chose to consult.

Groundless allegations of a lack of provision of aftercare by first respondent, the validity of which could easily have been proved or disproved by reference to hospital records, were eagerly espoused by him and repeated in a letter sent to Dr Fisch. A reckless allegation was made in a letter to Dr Fisch to the effect that the appearance of appellant's face was the cause of appellant's son's suicide.

Appellant had said no such thing. His attempt to pass off as simply an example of voluntary and informal peer review a letter written to Dr Fisch in which he solicited his help in bringing pressure to bear upon respondents to compensate appellant and in which he referred to first respondent as a surgeon who commonly avoided his complications, who frequently had facial palsies, who was a show-off and a liar, who touted for work at the medical aid societies and underbid his colleagues, plainly lacked candour. While Dr Hamersma was a very knowledgeable and experienced surgeon and there was much in his evidence

which made good sense and accorded with the evidence of other medical witnesses and medical literature, there were too many manifestations of a lack of objectivity to enable one to repose any real confidence in him as a witness. His dogged persistence in advancing the contention that first respondent had negligently **severed** the facial nerve during the operation, knew that he had done so, yet failed to lift a finger to make amends, was, in the face of the countervailing *indicia* and the inherent improbability of such behaviour, illustrative of unjustifiable obstinacy and cast a pall of doubt over the value of his evidence on other contested issues.

Counsel for appellant contended that Dr Hamersma's evidence, namely, that the appearance of appellant's face as testified to by members of appellant's family, was consistent only with an immediate and total facial palsy, had not been challenged in cross-examination and that therefore all subsequent reasoning should proceed from that premise. The fact of the matter is that Dr

Hamersma's opinion is dependent upon the accuracy of the descriptions of appellant's facial appearance on the day of the operation. The trial judge, for good and sufficient reasons, was not prepared to find that their descriptions were accurate in every respect and I am unable to justify declining to accept his finding on that issue.

Counsel for appellant frankly conceded that if that finding could not be successfully assailed (that it had not been proved that an immediate and total left facial palsy had set in after the operation), he would find it very difficult, if not impossible, to convince the court that it was more probable than not that first respondent must have been negligent in some or other respect in performing the operation. I think that the concession was correctly made. Indeed, even if the immediate onset in of a total (complete) facial palsy had been proved, it would have been questionable whether the inference that first respondent had negligently seriously traumatised the facial nerve during the carrying out of the

operation would have been justified. The medical evidence shows that there are ways in which a facial nerve may be unwittingly damaged, without any want of care on the surgeon's part, to an extent sufficient to cause a paralysis which sets in relatively swiftly but which will pass given time, provided that nothing occurring post-operatively aggravates the damage or frustrates the healing process.

The finding of scar tissue in the internal auditory canal when Dr Fisch operated is a complicating factor. The developing scar tissue could on the medical evidence have compressed the facial nerve to such an extent as to seriously aggravate whatever damage might have been done to the nerve during the operation performed by first respondent. The reason for the presence of the scar tissue could not be ascertained but a number of possible causes for which first respondent could not be held responsible were identified. It may therefore well have been the case that initial damage was unwittingly done to the facial nerve by first respondent notwithstanding the exercise of due care and that, but for the

subsequent development of scar tissue which exacerbated the damage, the palsy might have passed. A speculative suggestion by Dr Hamersma that first respondent may have negligently thrust the fascia with which he covered the opening in the dura into the canal and that it was the origin of the scar tissue found by Dr Fisch, was rightly rejected by the trial judge as highly improbable.

Then there is the inability of any of the medical witnesses who testified (other than Dr Hamersma) to single out any particular potential cause of damage as the most probable cause of such damage as occurred during the operation. When the water is muddied yet more by the further uncertainties surrounding what was found and what was done when the subsequent operation in Switzerland was performed, it becomes increasingly difficult to justify the proposition that it is more probable than not that the initial damage to the nerve was negligently caused.

It is of course so, as counsel for appellant submitted, that what is

probable and what is not, can only be properly assessed by examining the respective cases of appellant and respondents in their totality. It is also so that undue concentration upon what may appear to be weaknesses in the case of each should not be allowed to obscure the probative weight and impact of other evidence which is not open to question. I do not think the trial judge was unaware of those considerations. His judgment provides no indication that he was unaware of them and it cannot be assumed that he was not aware of them.

There is of course another consideration to be borne in mind in cases of this kind. When a patient has suffered greatly because of something that has occurred during an operation a court must guard against its understandable sympathy for the blameless patient tempting it to infer negligence more readily than the evidence objectively justifies, and more readily than it would have done in a case not involving personal injury. Any such approach to the matter would be subversive of the undoubted incidence of the onus of proof of negligence in our

law in an action such as this.

When reviewing the total picture emerging from the evidence, counsel for appellant sought to invest with some significance what the trial judge found to be untrue denials by first respondent of what at first blush might seem to be compromising statements made by him after the operation (the reference to medical malpractice litigation in the United States of America and the long wait for recovery of facial function which would be appellant's lot). It was argued that, when read with the difficulty which appellant said he experienced in getting to see or elicit any response from first respondent after his discharge from hospital, it was indicative of a guilty conscience and a realisation that the operation had not been performed with the necessary care. Some significance was also sought to be attached to the finding that first respondent's description of the appearance of appellant's face soon after the operation was unjustifiably euphemistic.

The trial judge weighed these contentions and discounted the

probative value of the findings on which they were based. He pointed out that the remark about lawyers and the United States of America was equally consistent with a genuine sense of confidence that at worst a transient facial palsy which would soon resolve itself was present. The overheard remark, made on a later occasion, that it would take longer to recover than appellant had initially been led to believe, when objectively regarded, is not indicative of any sense of personal guilt. The difficulties experienced by appellant in making contact with first respondent were not regarded as sinister. The evidence on that issue was rightly held to be inconclusive. The euphemistic description by first respondent of appellant's face was not attributed by the trial judge to a wilful perversion of the truth; instead he attributed it to reconstruction based upon available but incomplete hospital records and assumptions about what would have been done. He pointed to the inherent improbability of first respondent having known all along that he had severely damaged the facial nerve but having refrained from

informing appellant and, more importantly, from having taken any remedial operative action. Recriminations and unpleasant repercussions would be inevitable. Although he did not explicitly say so, I think it is implicit in the trial judge's judgment that whatever reason first respondent may have had for denying making the remarks which he did, the inference that it was because he had a guilty conscience was not justified. It was argued that the learned trial judge's assessment of first respondent's credibility was unduly charitable and that reconstruction and inadequate hospital records could not satisfactorily explain his excessively euphemistic description of appellants's facial appearance soon after the operation. Nor, so it was submitted, could a subconscious repression of any recollection of the statements which he made after the operation satisfactorily account for his denial that he made them. That may well be so, but I do not think that that contributes greatly to the resolution of the question whether first respondent was indeed negligent in his performance of the operation. I find

myself unable to say that the trial judge was wrong in his overall assessment of this aspect of the case.

Something was sought to be made by appellant's counsel of the fact that some of the other members of staff who participated in the operation and who would have seen appellant in the recovery room and later in the ward were not called by respondents. It was argued that an inference adverse to respondents should be drawn. I cannot agree. While those witnesses may perhaps be regarded as falling within respondents' "camp" rather than appellant's, the onus of proof lay upon appellant and not upon respondents. The latter had placed before the court the evidence of first respondent and Dr Vasek both of whom could testify as to what actually happened during the operation and in the recovery room. The persons not called by respondents were available to appellant as witnesses and consultations were held with some of them. They were professional people and in all the circumstances I regard their non-appearance in the witness-box as a

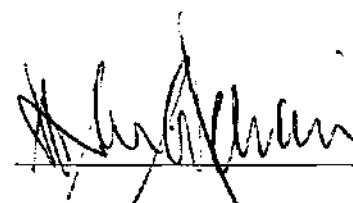
neutral factor.

The post-operative negligence alleged can be disposed of shortly. An allegation that appellant was prematurely discharged from hospital on the fifth day after the operation "in a debilitated and ill condition" was said by appellant himself to be incorrect. An alleged negligent failure to institute any or proper treatment for a "dry eye" condition which often accompanies facial palsy had to be jettisoned when it became quite obvious from contemporaneous hospital records, the authenticity of which was undisputed, that appellant's evidence in support of that allegation was quite wrong. An allegation that there was a negligent failure to close the cerebrospinal fluid leak was simply not shown by the evidence. It stopped of its own accord as both first respondent and Dr Davidge-Pitts had predicted it would. An allegedly negligent failure to properly monitor appellant's condition by regular check-ups or examinations was not established. As the trial judge correctly observed, the preponderance of evidence was that it

was expected of a public hospital patient to report back after his discharge. A report back date had been mentioned upon appellant's first discharge. It was anticipated by his second re-admission to hospital when the cerebrospinal leak worsened. Upon appellant's second discharge there was nothing to be done except to wait. Indeed one may add that despite appellant's later resort to other medical practitioners for advice (including Drs le Roux and Hamersma), no immediate surgical intervention was advised and they too advised appellant to wait and see what developed. By the time surgical intervention was recommended appellant had long since ceased to look to first respondent for treatment and advice. An allegedly negligent failure to inform appellant that he had severed the facial nerve and to determine the site of the damage to the nerve and repair it was not proved because, for the reasons given earlier, a severance of the facial nerve during the operation was not proved.

All things considered, I am unable to conclude that the trial judge has

been shown to have been wrong in granting absolution from the instance. The appeal is dismissed with costs including the costs of two counsel.


R M MARAIS

HEFER JA)
EKSTEEN JA)
NIENABER JA)
HOWIE JA) CONCUR