

SOUTH AFRICA / JUDGMENT

Batohi v Roux (12476/2012) [2018] ZAKZDHC 56; [2019] 1 All SA 390 (KZD) (16 November 2018) [2018] ZAKZDHC 56

COURT

Kwazulu-Natal High Court, Durban

BEFORE

Vahed

CASE / FILE NUMBER

12476/2012

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IN

THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL

LOCAL DIVISION, DURBAN

Case

No:- 12476/2012

In

the matter between:

CALLEN

RAJ

BATOHI

Plaintiff

and

Dr

PIETER MALAN

ROUX

Defendant

JUDGMENT

Vahed J:

- [1] Surgical operations are undertaken at risk at the best of times, yet countless people undergo them innumerable times because the benefits far outweigh the acceptable risks. Spinal surgery carries with it its own set of risks, no matter how routine the procedure and no matter how skilled the surgeon. With spinal surgery, when something goes wrong the results can be, and often are, devastating. This is such a case.
- [2] The defendant is a practising neurosurgeon in private practice and the plaintiff was his patient. During 2004 the plaintiff experienced left sided sciatica. He consulted the defendant who operated on the plaintiff to repair, inter alia, an intervertebral disc herniation. The operation, according to the plaintiff, was a resounding success and he was, almost immediately, rendered pain-free.
- [3] The problem recurred in 2011. The facts relevant to the recurrence will be canvassed shortly. The defendant performed a revision operation and this did not go well at all for the plaintiff. He sustained nerve damage, resulting in nerve root neuropathy, during this revision surgery and, it is common cause, he suffers from severe L5 neuropathic pain and weakness. This is experienced in his left lower limb, more especially his left foot. It is painful to the touch and is described by the plaintiff graphically as if he is continually standing on a hot burning coal. It is common cause that the condition is irreversible.
- [4] It is common cause that the outcome fell within the unfortunate, but acceptable parameters of the operation undertaken by the defendant. He is not accused of any negligent conduct during the surgery. Notwithstanding that, the plaintiff nevertheless holds the defendant accountable for his present unfortunate condition and seeks damages from him in delict. This, so the plaintiff contends, is because the defendant was negligent in that he failed to allow for a sufficiently meaningful period of conservative treatment before advising the plaintiff to undergo the surgery in question. In addition, the plaintiff complains that he was not sufficiently appraised of the risks attaching to the surgical procedure performed by the defendant.
- [5] The trial proceeded on separated issues. At the commencement, and in response to a joint request from counsel, I directed that in terms of Rule 33(4) of the Uniform Rules of Court the question of the quantum of the plaintiff's damages, i.e. putting a monetary figure to his alleged losses, would stand over for a later determination. All other issues were to be determined in the proceedings currently before me.
- [6] Before dealing with the facts it is necessary to say something more about the plaintiff's cause of action. In his amended Particulars of Claim the plaintiff set out his case as follows:

" 5.

In [performing the operation] the Defendant acted negligently and wrongfully in that he: –

- a) was overhasty in operating when a reasonable medical practice would have required more conservative treatment inter alia physiotherapy, the prescription of appropriate painkillers and adjustment of their dose, the application of a lumbar brace, transforaminal or epidural steroid injections and/or transforaminal radiofrequency ganglionotomy or some combination of these to be tried first before it was reasonable to operate when such treatment failed;
 - b) overlooked the fact that the said conservative treatment or some combination of these was not tried alternatively not tried to a significant degree;
 - c) failed to recommend alternatively direct some combination of conservative treatment;
 - d) misrepresented to the Plaintiff's medical aid in obtaining authorisation for the operation that conservative treatment in the form of painkillers and physiotherapy had been tried unsuccessfully when this was to his knowledge false alternatively he could and should have ascertained that this was false;
 - e) [sub-paragraph “e” was omitted and was not contained in the document.]
 - f) failed in his duty to obtain informed consent to the operation from the Plaintiff in that: –
 - i) he informed the Plaintiff that the operation was simpler than a previous operation he had performed upon the Plaintiff in 2004, when this was to his knowledge false;
 - ii) he failed to inform the Plaintiff of the significant risks from a second operation to the lumbar spine which include inter alia nerve root damage causing paralysis, weakness, numbness or severe increased pain;
 - iii) he informed the Plaintiff that there was little or no risk in the proposed operation and an excellent outcome was to be expected;
 - g) falsely informed of the Plaintiff that the operation required only the removal of scar tissue when in fact it involved the removal of a disk (sic) lesion;
 - h) severed alternatively damaged the spinal nerve in the vicinity of the L5 vertebra.
5. bis

Had the Defendant informed the Plaintiff of the significant risks of this second operation to his spine as set out in paragraph

- 5. f) ii) above, the Plaintiff would not have consented to the said operation alternatively would have sought alternative expert opinion and the said operation would not have occurred.”
- [7] During his opening address Mr Pillay SC, who then appeared for the plaintiff, expressly disavowed any reliance on paragraph 5(h) of the plaintiff's particulars of claim

(i.e. the damage to the spinal nerve) as forming part of the plaintiff's cause of action.

[8] Explaining paragraph 5(bis) of the plaintiff's particulars of claim, Mr Pillay said this during the opening address:

"ADV PILLAY: M'Lord, five, this is new, I understand that, from my learned friend that this has been consented to, this amendment, and the amended page has been placed in Your Lordship's papers. We say that had he been informed, he would not have consented to that operation.

VAHED J: And would have elected to live with the pain?

ADV PILLAY: No. No, M'Lord. We say that he would have sought a 2nd alternative opinion and that this... [intervention]

VAHED J: And the said operation would not have... [Intervention]?

ADV PILLAY: This operation would not have occurred. Now, M'Lord, why that is significant is because there's a very interesting judgment in the House of Lords where a very prominent neurosurgeon was sued for very much, in similar circumstances, although the condition that ensued was far more serious. And the majority, there was a sharp disagreement that the majority said that it was enough on some extended ... approach to causation, that he wouldn't have had that particular operation. It may be that he would have had a similar operation in future, but if there is a small, a significant risk of this adverse outcome occurring at random, as it were, then that was enough to satisfy the requirement of causation.

Now, M'Lord, I stress that that is not our law. There's a judgment, a recent judgment in the Supreme Court of Appeal that goes off in quite a different direction. M'Lord, I accept that that's a difficult issue of fact for the plaintiff, for the Court now to say in retrospect what the plaintiff would have done, but that is the allegation we make."

[9] Both the plaintiff and the defendant gave evidence for their respective sides. In addition, the plaintiff led the evidence of Dr M V Ganesh, a general practitioner he had consulted prior to seeing the defendant. Both the plaintiff and the defendant led the evidence of expert witnesses for their respective cases. In this regard the plaintiff led the evidence of Dr P Miller, and the defendant led the evidence of Dr J J du Plessis, both those experts being neurosurgeons.

[10] The factual background is fairly straightforward and much of it is not in dispute. Those facts which present a particular significance for the purposes of this judgment will be elaborated upon in due course.

[11] The plaintiff was born on 28 May 1965 and was accordingly 49 years old when he testified. During 2004 he described pain radiating all the way through his left buttock and down into his foot. The pain was so serious that he was eventually bent double (as he described it) and could not walk. He described the pain then as being serious. He indicated that it had started in approximately October 2003 and after about 6 months of continually worsening pain he eventually had the operation during 2004. On that occasion he had been admitted to a state

hospital where the application of traction did not bring him any relief. A visit to a chiropractor was unsuccessful and frequent consumption of painkillers eventually brought no relief. Self-treatment with an infrared heat lamp brought no relief as well. On that occasion he did not attempt physiotherapy. Someone mentioned that he see a neurosurgeon and the

defendant's name was mentioned. He saw the defendant who, as indicated earlier, operated and, when he awoke after the operation,

the pain had disappeared. The procedure was uncomplicated. The plaintiff described it as "a miracle".

[12] Around Christmas, 2010 and going on to January 2011 the pain returned, mildly at first. By the first week of February it resembled the 2004 experience of pain starting somewhere in the lower back and radiating through the left buttock down into the leg. This prompted the plaintiff to consult the Malvern Medicross Centre, a group of, inter alia, general practitioners. There he initially saw a Dr Smith on 25 February 2011 who suggested an x-ray and prescribed oral medication

(analgesics and anti-inflammatories). When the pain did not improve he went back and this time consulted Dr Ganesh. According to the plaintiff he saw Dr Ganesh on two occasions, but he may have been mistaken in that regard because Dr Ganesh records seeing him only once, on 3 March 2011. On both the occasions that he consulted the practice (25 February and 3 March) his complaint was identical, i.e. recorded by the doctors as being "... low backache with left sciatica...". Dr Ganesh administered two intramuscular injections, an anti-inflammatory and an opioid analgesic. In addition, he prescribed oral medication, analgesics,

anti-inflammatories and a sleeping tablet, the latter to be taken at night. A simple leg raising test performed by Dr Ganesh (confirmed

later by the experts to be appropriate and accurately performed) prompted him to tell the plaintiff that he needed to consult a

neurosurgeon but the possibility of an operation did not feature in the conversation. The plaintiff was referred to the defendant because he informed Dr Ganesh that he had previously been treated by the defendant.

[13] The plaintiff saw the defendant on 9 March

2011. The plaintiff says that defendant performed a routine examination and took a history. He confirmed that the purpose of his visit to the defendant was to consider the possibility of surgery. He confirmed also that he advised the defendant of his visits to Dr Smith and Dr Ganesh and of the medication they prescribed for him. There is a dispute as to whether he told the defendant that he had had physiotherapy. However, the plaintiff did confirm that while he informed the defendant of the oral medications prescribed for him, he did not tell the defendant that he chose not to take the medication because he had no faith in what had

been prescribed to him. He went on, rather oddly, to assert that had the defendant prescribed oral medication he would have taken same because what was then being prescribed was being suggested by a neurosurgeon as opposed to what

had previously been prescribed by general practitioners. When pressed he could not explain the difference.

[14] The defendant sent him for a Magnetic Resonance Imaging ("MRI") Scan. He returned either that afternoon or the next day for further discussion with the defendant who then had the MRI image displayed on a computer screen in his consulting room. The defendant showed him various things on the projected image of the scan and he confirmed that a bulging disc and scar tissue was highlighted by the defendant. It is fair to say that what stood out in the plaintiff's mind was that the defendant spoke of an operation to remove scar tissue which he, according to the plaintiff, described as a simple procedure. The plaintiff said that his response to the defendant was that he uttered words to the effect "... You have got my back, Doc...". I suppose that what he was trying to convey was that he placed his trust in the defendant based on his 2004 experience.

[15] The plaintiff could recall nothing of the defendant's advice with regard to risk factors of and concerning the operation. As far as he was concerned there was no risk at all.

[16] Dr Ganesh's evidence was largely consistent with that of the plaintiff save, as I pointed out, that he recalls a single consultation with the plaintiff whereas the plaintiff testified to seeing Dr Ganesh on 2 occasions in addition to seeing Dr Smith. Nothing turns on that in my view.

[17] The defendant testified relying both on some aspects of recollection and on his consultation notes which were admittedly terse and "sketchy". His note of his consultation with the plaintiff on 9 March 2011 (supplemented to cater for medical abbreviations) reads as follows:

"9/3/11 Previous L5-S1 discectomy

2004 – Left sciatica

3 weeks ago sudden onset left sciatica buttock ® calf

Numbness occasionally left 2 toes left foot

® sleeping tabs

- analgesics

Exam: Gait – normal

Power – present

Sensation – present

Straight leg raising test positive at 40° on Left

X-Ray } Recurrent disc/scar tissue?

MRI } Disc space collapse

L5-S1 (?? L4-5 initially)

Plan:

- Provisional discectomy next week if not improved
- Discuss risk factors repeat surgery”

[18] On the same day the defendant sent the plaintiff for an x-ray and for the MRI examination. After those were done he saw the plaintiff again either the same afternoon or early the following morning. On a conspectus of all the evidence it is fair to say that the defendant's single consultation note reproduced above is in reality the combined note of the 2 consultations pre and post the visit by the plaintiff to the radiology department.

[19] On 10 March 2011 the defendant addressed a letter to the plaintiff's Medical Aid Society (Spectramed) seeking authorisation for the operation that features in this case. That letter reads as follows:

“This 45-year-old man has been suffering from severe left-sided sciatic pain in the S1 distribution for the past few months. He has not responded to conservative treatment including analgesics and anti-inflammatory agents, as well as physiotherapy. MRI showed a large recurrent disc herniation towards the left at L5–S1. He had a previous laminectomy about eight years ago.

He should be a good candidate for a discectomy at that level, which will serve to decompress the nerve root and hopefully resolve his ongoing pain.

The procedure codes will be... . The patient will be admitted on the morning of the procedure - 14/03/2011.”

[20] The defendant was taxed at length about the terseness of his notetaking and the fact that his letter to the plaintiff's Medical Aid Society contained matters which were at odds with his notes. The letter refers to pain "... for the past few months..." while his note referred to the "... sudden onset [of pain 3 weeks ago ...". The letter also refers to "physiotherapy" as forming part of the conservative treatment that had been tried by the plaintiff without success whereas the consultation note was silent in that regard.

[21] I shall deal with those aspects and others during the discussion that follows later in this judgment.

[22] I do not intend repeating the evidence of the respective expert witnesses. My treatment of their evidence will also emerge from the discussion that follows.

[23] I have already indicated that notwithstanding paragraph 5(h) of the plaintiff's amended particulars of claim, the plaintiff does not persist with the allegation that the surgery itself was performed negligently.

[24] Mr Acker SC who appeared for the defendant has correctly submitted that this has important consequences at the level of informed consent.

His submission continues that absent proof of negligence in the performance of the surgery, the defendant's conduct in not

obtaining the plaintiff's informed consent (if this is shown to have been the case) cannot be classified as wrongful and liability does not, therefore, attach to him on this score. More on this later.

[25] Thus, the material issues which remain on the pleadings are the following, namely :

- (a) whether the defendant was negligent in not treating the plaintiff conservatively in the first instance and before resorting to surgery;
- (b) whether the defendant failed in his duty to obtain the plaintiff's informed consent to the surgery;
- (c) whether any such negligence on the defendant's part contributed to, or was a cause of, any damages which the plaintiff may prove he has suffered (causation).

[26] The onus of proof on all these issues rests on the plaintiff.

[27] The versions of the parties themselves in relation to the matters in issue are irreconcilable.

[28] The test, in such circumstances, has been set out in *National Employers' General Insurance Company Limited v Jagers* 1984 (4) SA 437 (E):

"... [the plaintiff] can only succeed if he satisfies the Court on a preponderance of probabilities that his version is true and accurate

and therefore acceptable, and that the other version advanced by the defendant is therefore false or mistaken and falls to be rejected.

In deciding whether that evidence is true or not the Court will weigh up and test the plaintiff's allegations against the general probabilities. The estimate of the credibility of the witness will therefore be inextricably bound up with a consideration of the probabilities of the case and, if the balance of probabilities favours the plaintiff, then the Court will accept his version as being probably true. If however the probabilities are evenly balanced in the sense that they do not favour the plaintiff's

case any more than they do the defendant's, the plaintiff can only succeed if the Court nevertheless believes him and is satisfied that his evidence is true and that the defendant's version is false".

This approach has been endorsed by the Supreme Court of Appeal in *Baring Eiendomme (Bpk) v Roux* [2001] 1 All SA 399 (A).

[29] In similar vein *Nienaber JA, in Stellenbosch Farmers' Winery Group Ltd and Another v Martell Et Cie and Others* 2003 (1) SA 11 (SCA), said:

"On the central issue, as to what the parties actually decided, there are two irreconcilable versions. So, too, on a number of peripheral areas of dispute which may have a bearing on the probabilities. The technique generally employed by Courts in resolving factual disputes of this nature may conveniently be summarised as follows. To come to a conclusion on the disputed issues the Court must make findings on (a) the credibility of the various factual witnesses; (b) their reliability; and (c) the probabilities. As to (a) the Court's finding on the credibility of a particular witness will depend on its impression about the veracity of the witness. That in turn will depend on a variety of subsidiary factors, not necessarily in order of importance, such as (i) the witness' candour and demeanour in the witness box, (ii) his bias, latent and blatant, (iii) internal contradictions in his evidence, (iv) external contradictions with what was pleaded or put on his behalf, or with established fact or with his own extracurial statements or actions,

(v) the probability or improbability of particular aspects of his version, (vi) the calibre and cogency of his performance compared to that of other witnesses testifying about the same incident or events. As to (b), a witness' reliability will depend, apart from the factors mentioned under (a)(ii), (iv) and (v) above, on (i) the opportunities he had to experience or observe the event in question and (ii) the quality, integrity and independence of his

recall thereof. As to (c), this necessitates an analysis and evaluation of the probability or improbability of each party's

version on each of the disputed issues. In the light of its assessment of (a), (b) and (c) the Court will then, as a final step, determine whether the party burdened with the onus of proof has succeeded in discharging it. The hard case, which will

doubtless be the rare one, occurs when a Court's credibility findings compel it in one direction and its evaluation of the general probabilities in another. The more convincing the former, the less convincing will be the latter. But when all factors are equipoised probabilities prevail".

[30] Mr Pillay has described the plaintiff as someone who was unsophisticated. I am not certain as to what was intended by this submission but the plaintiff did not come across as being simplistic or unaware of what he was doing when he consulted the defendant. I formed a similar impression of him when he testified. Mr Pillay also submitted that the plaintiff did not give any indication of dishonesty or exaggeration. While that submission is undoubtedly correct the plaintiff's obvious interest in, and his natural bias towards, the outcome of this matter cannot be ignored completely.

[31] Mr Pillay has also criticised the defendant, describing him as a poor witness and as being unconvincing. He also described him as unimpressive and unconvincing, particularly when his submissions dealt, rather dismissively, with the defendant's terse notetaking and with

the apparent differences between his notes and his letter to the plaintiff's medical aid society (see para 20 above). He was critical of the defendant's recollections of his usual practice (his way of doing things) as opposed to his inability to recall some of the specifics. In my view none of those criticisms are valid, or even relevant. I gained the impression that the defendant was attempting to give an honest account of himself and, while all the lawyers in the case would have preferred more detailed and more accurate notetaking – this aspect did not seem to trouble the experts.

- [32] So too, in my view, the differences (such as they are) between the evidence of Dr Miller, on the one hand, and that of Dr du Plessis, on the other, are largely matters of opinion on which experts may, or do, differ. Mr Acker suggests that in most if not all of the important instances, the experts are ad idem and their evidence, in the main, is supportive of the defendant's case and destructive of that of the plaintiff.
- [33] Mr Pillay submitted that Dr Miller was "improbably articulate" and "fairly honest" while on the other hand he described Dr du Plessis as a "rather poor witness" and "most unimpressive". In my view, but for the observation I shall make presently concerning Dr Miller, the comments made concerning either of the expert witnesses were not justified. I regarded both as attempting to present, as accurately as each could, a fair account of their views and opinions on the subject at hand. Although the remark was later withdrawn, Mr Pillay's observation that Dr du Plessis was "...a man who testifies all over the place in many cases ... no doubt always for the insurance company..." was perhaps a telling window into the plaintiff's approach to the case. I am also compelled to observe that I found Mr Pillay's characterisation of Dr du Plessis as a witness somewhat surprising as during that portion of the trial (ie the defendant's case when Dr du Plessis testified) Mr Pillay was not involved, the plaintiff instead then being represented by Mr Moola SC.
- [34] It emerged during Dr Miller's evidence in chief that he had become involved as an expert witness for the plaintiff, and had even commenced his evidence, without him looking at and examining the MRI scan. To the extent that it may be relevant, however, criticism may legitimately be levelled at Dr Miller for being prepared to express views on critical issues both in his report and in his evidence without having examined the MRI scans. Certain of these opinions had later to be retracted when Dr Miller had had the opportunity of examining the scans properly. As a result Mr Acker submits that, at least to some extent, Dr Miller's objectivity must be questioned as a consequence thereof.
- [35] The attempt to downplay Dr Miller's oversight by contending that Dr du Plessis did not also consider the MRI scan before giving evidence must be rejected. It was abundantly clear that although the MRI scans were not supplied to Dr du Plessis initially, he requested them and considered them before meeting with Dr Miller for the purposes of compiling the joint minute they both agreed upon.

CONSERVATIVE TREATMENT

[36] There is at least some confusion on the evidence as to the purpose of conservative treatment and much controversy over the duration of such treatment. Dr du Plessis dealt with these as follows:

“... the relevance of this is that all forms of conservative treatment for lumbar disc herniation are attempts to buy time to see whether the disc herniation will not shrink by itself. And this is where the time period of six to eight weeks comes from. Conservative treatment is an attempt to make life easier for the patient during the waiting period to see if the disc herniation will not resolve spontaneously. So it does not matter what kind of conservative treatment you attempt, it is just to bide time in order to see whether this is not going to resolve spontaneously or not.”

[37] As to whether (without further conservative treatment) surgical intervention was reasonable in this instance, both experts were agreed that it was, provided that the option of conservative treatment had been discussed with the patient.

[38] In attempting to define “appropriate treatment” for this case, Dr Miller said the following:

“... the appropriate treatment here would be for me to discuss it with the patient and to say ‘Look, there are two ways you can treat this ; obviously there’s surgical way and everybody knows that, but there is another option or another alternative which may work on you. Its not a high chance of it working or a particularly high chance of working’, I could give him a figure of let’s say 15% and you could say to him ‘There is this option if you are really against an op, or you want to avoid an op, or you want to think about things, there is another option which is available here and it might work’, because this may get better with conservative treatment. So the answer is not a question of relevant treatment, it’s a question of discussing it with the patient and see what he says. And some patients will perhaps insist on surgery and my experience has been that many – well, not many maybe, but a certain percentage will certainly say, ‘Doc, lets try the non-operative way’. ”

[39] In fact, when asked whether he would be “...critical of [the defendant’s] decision to operate...”, Dr Miller said that he would be “...critical of that decision if [the defendant] hasn’t done a basic step of discussing the question of optional treatment with the plaintiff ... I’d be critical of that aspect only”.

[40] At this point the following extract from the plaintiff’s evidence becomes crucial to the evaluation:

MR ACKER Mr Batohi, you will recall that when we finished yesterday, we were discussing the question of conservative treatment versus surgery, do you recall? Yes.

And it was put to you as a question that if you had been offered a choice between conservative treatment, that's in the form of

painkillers and the like and surgery, which would you choose, do you remember being asked that question? Yes,

I do.

And what was your answer? That I would have had the operation, I would have went for conservative treatment.

And you went on, did you not, to say that effectively had you known at the time what the outcome would be, you would clearly not have chosen surgery Yes.

That's for the benefit of hindsight is it not? Meaning?

That's because you now know what the outcome is. --- Yes.

So obviously you would be crazy if you elected surgery knowing what the outcome would be what it is. --- That's right.

But I want you to take yourself back to the position you were in at that time, that's on 9 March 2011, let's look at the circumstances that you were in. You were in extreme pain, is that correct? Don't nod your head. Yes? Don't nod your head.

Yes.

Say yes if it is yes. --- Yes.

And you had suffered for some time between Christmas and New Year, is that correct? Yes.

You had tried a whole lot of different conservative treatments without any relief, is that correct? No.

Had you not tried conservative therapy? Are you speaking from January?

Yes, from just before New Year was the time you identified. No.

You say you didn't have conservative treatment? No.

I can't hear you. --- No.

You didn't have conservative treatment? No.

But you've explained that you did, you took painkillers. That was when I went to see Dr Ganesh.

So after you saw Dr Ganesh at the end of February, then you didn't take any medication, is that correct? No.

I only took conservative, when we talking about conservative, I'm talking about the injection.

And/or painkillers, medication, tablets, All I did take was an injection and that was after I saw Dr Ganesh. When I went to see Dr Ganesh, that was the only time from the time I had the pain, which was at the end of January, up until I went and saw Dr Ganesh, that was the only time I took an injection.

Is that what you've told Dr Miller? Yes, I think that's exactly what I told Dr Miller.

In other words I just want to be clear on this, Mr Batohi, are you saying that between the period from just before New Year in 2010 up until 3 March the following year when you saw Dr Ganesh, you didn't take a single painkiller or any anti-inflammatory or anything else that might have given you some relief, are you saying that ... --- I hadn't seen a doctor at all, no.

That's not the question, the question was, do you say that you took no pain relief or anti- or anything of that nature from New Year right up until 3 March, yes or no? No, not with regards to my pain, no.

You didn't take it? No.

Why not? Okay, the way I look at it is this, okay, in 2004 when I had this, in 2003, from 2003 to 2004 when I did have this pain for six months, all the medication, all the tablets that was prescribed by any doctor, by the hospital, never did really work for me. So I knew for a fact that even if I did take any tablets it was never really going to work for me. I am now disabled, I am in pain 24 hours, I am on medication which is doing absolutely nothing for me but keeping me in a drugged state. So my answer to you will be is this here, that I knew that the medication that if I was going to take anything, was not going to help me in any way.

So would it be correct to say that at that time and even today you have no faith in this medication? No.

Is that correct? Yes.

Let's go back to listing the various facts that were relevant to the decision as to what to take on surgery or to subject yourself to further conservative treatment, let's go through those. You had had surgery previously and you nod, yes and it had been entirely successful. --- Yes.

Is that correct? It was a miracle, as I put it to you.

Now against that background, can you possibly suggest that if Dr Roux had offered you surgery or conservative treatment, that you would have taken conservative treatment? My discussion with Dr Roux goes again like this here, "Mr Batohi, it is a minor operation, do not worry, we will sort you out."

VAHED J That's not counsel's question and perhaps we could recast the question slightly differently. --- Okay.

Bearing in mind what you've said a few seconds ago, that you had no faith in any form of oral medication because whatever any doctor was going to prescribe, you knew it's not going to work. Yes.

If Dr Roux and this is counsel's question, had said, "These are the two options, there's pill A, capsule B, tablet C,

- go on all of that and let's see what happens; or surgery,” what were you going to choose? If Dr Roux had told me to either choose medication or surgery, I would, if he had told me medication there is a possibility, I would have went with the medication because it is coming from Dr Roux because I have faith in Dr Roux. I would have went with his knowledge of, “Okay, why don't we first try, Mr Batohi, there is a possibility that there's new medication or something that's out,” which can help me. So I would have went with conservative treatment, yes, most definitely.

MR ACKER If you were told by Dr Roux when he was offering you these alternatives, surgery or conservative treatment ... If at the time that you were discussing this question of surgery on the one hand or conservative treatment or oral medication, as he thought you could, on the other, you had been told that the risk of neural damage, if you had surgery, was less than 1 percent and your chances of recovering with conservative treatment were about 20 to 25 percent, would that have changed your opinion, your selection?

VAHED J Do you follow the question? Not really because I don't know how to answer that question like that, I don't.

Dr Roux, we all supposing that this might have happened and we want to know what your responses would have been back then. As much as possible try and block out the fact that you here today, as you put it, disabled by this operation. Back then on 9 March you sitting in Dr Roux's rooms and you [are] in the pain that you have described. Dr Roux says and I use your words, “There's this new drug on the market, let's try it, Mr Batohi, but the chances of this new drug working, not working, about 25 percent,” ... Not working 75 to 80 percent. The chances of it working are about 20 to 25. As opposed to that, there's the option of surgery and [build] in everything that you recall about what he said about surgery, that there's scar tissue and what have you and that the risk of nerve damage from the operation is 1 percent. --- 1 percent, the success ... [intervention]

The nerve damage ...[speaking simultaneously] --- ...or 1 percent success rate?

99 percent probability of no nerve damage. --- Okay.

That's covered. Have I captured it?

MR ACKER You have it, thank you, M'Lord.

VAHED J What would you have said? Against the 75 percent on the medication?

75 percent chance not working. --- And 99 percent chance of working, am I right?

MR ACKERMAN Yes. --- I would have went with the 99 percent chance of it working. So I would have went ...

So you would have gone with surgery. --- ...so I would have went with surgery.

May I suggest to you that that was effectively what you were told, in other words that there was a very low risk of something going wrong with surgery? Told to me?

That's what I said to you. --- By Dr Roux?

Of course. --- No.

He didn't tell you? No.

He said nothing to you about the risks being very small? No.

...

MR ACKER I'm indebted to Your Lordship, I think ...[indistinct], I have no further questions.

VAHED J Thank you. Re-examination?

RE-EXAMINATION BY MR PILLAY Thank you, M'Lord. Mr Batohi, I notice you are sitting down this morning. --- Yes.

When you gave evidence in the courtroom yesterday, you stood for some periods. --- Yes.

Yes.

MR PILLAY Yes. You also sat, that's right? Yes.

And you also crouched and seemed to stretch. --- Yes.

Why was that? That's the different pains that I go through at different times.

Yes. Now, you've been asked about these two broad options, operation, surgery versus conservative treatment. --- Yes.

Now you obviously have no medical training yourself. No, not really.

What do you understand by conservative treatment, what are the options? I think conservative treatment is just medication.

We know that the GP had prescribed medication which you didn't take. --- Yes.

VAHED J What did he prescribe, remind me? I've got no idea, sir.

It's Tramacet and something else, wasn't it?

MR PILLAY Yes and a sleeping tablet. --- And a sleeping tablet, yes.

VAHED J Tramacet is a painkiller, some anti-inflammatory. Yes.

And what painkillers are you on at the moment? Tramacet, Lyrica ...[intervention]

Painkillers? Yes, painkillers.

MR PILLAY Now you didn't take the drugs that Dr Ganesh prescribed? No, besides the sleeping pills.

You said yesterday that if Dr Roux had prescribed medication, I think you repeated that this morning. --- Yes.

You would have been willing to try. --- Yes.

But why that difference? As I said yesterday, Dr Roux is a specialist, okay and I've been to see him previously, okay and if he had said, "Mr Batohi, there might not be a chance of surgery, let's just try medication because there's new medication," or something of that sort, I would have most probably – not most probably, I would have went with that. I would have went with his suggestion because from my point of view I trusted him wholeheartedly the first time and it was a perfect success.

You know there's a suggestion that physiotherapy is an alternative conservative treatment? That was never ever mentioned to me.

And of course cortisone injection, did you hear about that? No.

That's directly into the affected parts. No.

And a lumber brace? No.

A sort of brace around the back? No.

Has bed rest ever been mentioned to you? No.

So those options were not considered? No.

The difference in your mind was between tablets versus operation, as you sat there on 9 March? Yes.

In your mind it was either medicine or operation? At that time?

Yes. --- At that time there was no medication. At that time all we spoke about was I need an operation.

Now different percentages were put to you, you were told that the chances of conservative treatments succeeding was 20 to 25 percent. That's correct.

That means between one in four, one in five people it will work. It will work, that's correct.

Ja, you understand that? Yes.

So of course it means that for the other three out of the four it may not work. --- Yes.

Yes. Then it was suggested to you that there is some small chance of an operation going wrong. --- Yes.

A figure of one percent was given to you. --- Yes.

Have you heard that figure before? No.

No. --- No, never.

Was ever percentage at all mentioned? No.

In fact we need to place on record that our witness is going to say it's between 5 and 6 percent, our expert sitting in court. So let's contrast now, you understand what between 5 and 6 percent means? Hmm, if you break it down to me, sir.

VAHED J Five out of a hundred may go wrong, on the operating table.

MR PILLAY Well, if I simplify further, for one in 20 people it may go wrong. Okay.

VAHED J You can play with numbers to change perceptions, Mr Pillay.

MR PILLAY Well, M'Lord, I'm not sure everyone understands percentages in quite the same way, I just want to explore.

VAHED J No, what I meant was, as my example of five in a hundred to yours of one in 20.

MR PILLAY Yes.

VAHED J Okay.

MR PILLAY So let's contrast two different scenarios now, His Lordship asked you an important question and you gave a definitive answer and I just want to be sure that is your real answer. --- Yes.

So we've got two different scenarios, conservative treatment of whatever form, not just tablets but all the other options, with the chance that up to one in four cases it may succeed, it will succeed in one in four cases, up to, versus an operation which may go ...[indistinct] wrong in one in 20 cases, do you understand that? Yes.

Now all these are hypothetical, there's going to be evidence about these numbers, but assume that was told to you by a neurosurgeon, he said to you, "If it goes wrong, the pain can be a lot worse," what would your reaction be? Now I know it's difficult to put yourself back in that situation. So we going back to the 1 percent chance of ...[intervention]

No, the evidence is going to be from a neurosurgeon, who is our next witness. --- Okay.

That it's actually a chance of between 5 and 6 percent, that's one in 20 people that could go wrong and if it goes wrong, the condition is worse than before, you understand that? Okay, yes.

So one in 20 chances of an operation going wrong versus a chance of up to one in four people of conservative treatment succeeding, do you understand the difference? Yes.

If you got any questions you must ask because ...[intervention] So you meaning that the chances of an operation versus the chances of the tablets?

The chances of an operation going wrong versus the chance of tablets and other conservative treatments working. --- Conservative, yes.

You understand that? So you want to know which will be a higher success rate?

No, I'm not asking you – I'm asking you, what would you choose? You were told, let's pick something specific. --- Right.

Let's forget tablets. --- Okay.

Let's say a cortisone injection, this is a simplification. --- Okay.

Will work in one in four patients. Cortisone injections ...[speaking simultaneously] strict bed rest. --- Okay, I would have went, okay, in that instance I would have ...[intervention]

No, hold on, I haven't asked the question. Cortisone plus strict bed rest which the neurosurgeon will tell you, you've got to comply with to the letter, will work in one in four patients.

VAHED J What does, "Strict bed rest," mean, how many injections, over what period of time and how long do you get confined to bed?

MR PILLAY I have no idea, M'Lord, we will hear that when our expert testifies.

VAHED J Isn't that a factor that you need to take into account?

MR PILLAY I'm not sure.

VAHED J If I'm told that I have to take a cortisone injection once a day, once every two days, does the frequency of the injections irrelevant but I have to be confined ...[intervention]

MR PILLAY I can simplify the matter by saying it's two and a half weeks of conservative treatment with usually one, possibly two cortisone injections.

VAHED J So two and a half weeks of being confined strictly to bed with those injections because your expert nods his head.

VAHED J The question is this, you see the neurosurgeon on 9 March and he tells you, "We can try a course of cortisone injections, it will be two or three injections," ...[intervention]

MR PILLAY One or two, M'Lord, ...[indistinct]

VAHED J "One or two injections into the site," I think, "of the source of the pain and you have to stay in bed for two and a half weeks. Three out of four people, it's not going to work and you going to be back here for us to look at alternatives. As opposed to that, we can go into surgery. If the surgery goes wrong, there is a high possibility that your pain is going to be worse, if it goes wrong, but 19 out of 20 people it goes right." Yes, I understand.

You understand? Yes.

What would your answer be? Then I would have went for surgery.”

[41] I quote that extract in extensive detail because to my mind the plaintiff was, after clarification, in no doubt as to the import of the questions. There was no confusion and he understood clearly the significance of the percentages being put to him. Perhaps it was in this context that Mr Pillay attempted to clothe the plaintiff with a measure of unsophistication.

[42] In addition, in his evidence-in-chief, Dr Miller recognised that surgery may “definitely” be indicated without conservative treatment where the patient specifically desires this and after a discussion of the other option.

[43] Describing what would happen in the “practical private world”, Dr Miller said that their approach would be as follows :

“We can get rid of your pain and we can do surgery, but I need to inform you that there is another way and you really should think about this and if you hear what I have got to say and you still want surgery, well, it’s our pleasure to do it, but you need to hear what we have got to say first”.

[44] The fundamental essence of Dr Miller’s view was that provided there was adequate discussion between doctor and patient, the decision to operate is not negligent.

[45] Under cross-examination, Dr Miller readily agreed that there are cases “...where a simple look at the MRI in conjunction with a positive leg-raising test and severe pain will lead one to the conclusion almost inevitably that surgery is going to be required.” When it was put to him that the defendant would say that this was “...very much one of those cases where it looked to him as though surgery would be inevitable...”, he described this as a “matter of opinion”; but acknowledged that “...the odds are probably that he will need surgery...”. He also acknowledged that there were those categories of cases “...where there is going to be no conservative treatment and the patient heads straight for surgery...”.

[46] Dr du Plessis’ views as to the indicators for surgery as a treatment of first resort were as follows:

“The third group of patients would be a patient who is in severe pain which is resistant to treatment with painkillers. And the MRI scan showed severe nerve root impingement due to a large disc herniation. ... the patient will be counselled first and he will be informed that based on his clinical picture, a spinal surgeon’s experience and the findings on the MRI scan that the chance of spontaneous recovery on conservative treatment is small. And for that reason surgery is proposed not taking into consideration the duration of the persons’ symptoms. ... Obviously a reasonable spine surgeon will never recommend an operation where he knows from experience it’s not indicated even if the patient wants the operation, but in many of these cases there are grey areas and the surgeon is then led by what the plaintiff wants. And what also plays a role, ... , and I can also quote it from the literature that I have included are the financial implications for the patient inasfar as being off work for an extended period of time without have a guarantee that he is going to come right without surgery.”

- [47] Flowing from that Mr Acker submits that the plaintiff's case, on the evidence, was plainly one of those referred to by the experts or, put differently, the plaintiff has not succeeded in discharging the onus of proving that it was not. He contended that Dr du Plessis was clear in his evidence that the defendant was justified in concluding that surgical treatment was required and that the decision to operate was reasonable.
- [48] That the alternative to surgery (such as it was) was canvassed with the plaintiff admits of little doubt. Certainly, the probabilities overwhelmingly favour the defendant on this score. It is very clear that his experience of the pain (recalling the earlier 2004 experience) coupled with Dr Ganesh's suggestion that he consult a neurosurgeon led the plaintiff to an expectation of surgery when he arrived at the defendant's consulting rooms. His evidence that he would undoubtedly have tried whatever medication the defendant would have prescribed rang hollow.
- [49] At the end of the day, it is apparent from their evidence that both Dr du Plessis and Dr Miller shared the view that, in the circumstances of this case, it was not unreasonable for the defendant to have recommended surgery without further conservative treatment.

INFORMED CONSENT

- [50] At a basic level, the fact that the plaintiff has abandoned his allegations of negligence on the defendant's part in the performance of the surgery disposes of the issue of informed consent.
- [51] In *Sibisi NO v Maitin* 2014 (6) SA 533 (SCA) the issues were very similar. There the Court said:
- "[45] Mrs Sibisi argued before this court that we ought to extend the common law so as to recognise that the test for whether a patient has given informed consent to a procedure should be whether the reasonably prudent patient, given the information about the risks of vaginal delivery, would have agreed to it or elected to have her baby delivered by C-section. It was common cause that Dr Maitin had at no time advised her about the possibility of shoulder dystocia occurring and of a resultant brachial plexus injury, leading to Erb's palsy.*
- [46] Our courts have in the past held that in order to determine whether a doctor is under a duty to disclose the risks of a procedure we must determine whether a reasonable doctor, in the position of the defendant, would have disclosed risks however remote. In *Richter and Another v Estate Hamman* 1976
- (3) SA 226 (C) Watermeyer J said (at 232G – H)

'A doctor whose advice is sought about an operation to which certain dangers are attached — and there are dangers attached to most operations — is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it.

It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'

[47] The argument for Mrs Sibisi is that this approach leaves the determination of a legal duty to the judgment of doctors appointed in their own cause. In keeping with the rights to autonomy and bodily protection, now entrenched in the Constitution, the test should rather be whether the reasonable patient, in her position, if warned of the risk, would attach significance to it.

[48] In *Castell v De Greef* 1994

(4) SA 408 (C) a full court accepted that this should be the test and Mrs Sibisi relied on that as well as the authorities in foreign jurisdictions cited in that case. Ackermann J (Friedman JP and Farlam J concurring) said that South African courts should follow

the approach of an Australian decision: *Rogers v Whitaker* [1992] HCA 58; (1993) 67 ALJR 47 (a decision of the High Court of Australia). That court also took into account English and Canadian decisions that have adopted the same approach.

[49] Ackermann J said (at 426D – H) that South African courts ought to adopt the approach in *Rogers* 'suitably adapted to the needs of South African jurisprudence'. He continued:

'It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common-law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. . . .

I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

- (a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
- (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.' [My emphasis.]

- [50] This passage makes it clear, however, that the question of informed consent goes to the wrongfulness element of the Aquilian action. Negligent conduct on the part of the doctor will be wrongful if the patient has not given informed consent. Negligence is still a requirement, and in Castell it was established. Where there is no negligence proved, however, the test for wrongfulness does not even arise.
- [51] In this matter Mrs Sibisi did not prove that Dr Maitin was negligent. In the circumstances there is no need for this court to determine which test should be adopted in relation to informed consent.
- [52] In any event no evidence was led to show what the reasonable patient in Mrs Sibisi's position would have done had she been warned of the risk of shoulder dystocia (a risk that was lower than 1 %), and advised about the choice between a vaginal delivery or a C-section. Would she have taken the far greater risks attendant on a C-section or the very minor risk of shoulder dystocia occurring? We do not know. And Mrs Sibisi herself said, when asked if she knew about delivery by C-section, and about the risks attendant on it, that she did know of such risks, though not anything about shoulder dystocia, brachial plexus injury or Erb's palsy. It was suggested to her that both Dr Maitin and she had to weigh up the respective risks. She responded:

'I don't believe that. I placed all my trust in him in the sense that it was he who was going to make a decision as to the correct procedure to adopt.'

On the facts, therefore, it cannot be found that the conduct of Dr Maitin was wrongful. And since he was not negligent, liability cannot be established."

- [52] In any event, it is clear on the defendant's evidence (which accords with the probabilities and which I accept) that the risks of surgery were explained clearly to him and that the plaintiff was more than willing to undertake these.
- [53] In this regard:
- (a) the plaintiff had suffered severe pain since about Christmas in the year before surgery which caused him to have to undergo bedrest and prevented him from working;
 - (b) the conservative treatment which he had been given had had no beneficial effect at all;
 - (c) the previous surgery which he had undergone in 2004 had been a "miraculous" success.
- [54] In any event, as was the case in Sibisi no evidence was led to show what the reasonable patient in the plaintiff's position would have done had he been warned of the risks of surgery and advised about the choice between surgery and conservative treatment. Indeed the plaintiff made it clear that, had he been presented with the full facts, he would nonetheless have elected to undergo surgery.

CAUSATION

[55] Dealing with causation Mr Pillay relies on Cameron J's judgment in *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC), describing it as "...a recent development regarding legal causation in the law of delict...". The plaintiff (Lee) was an awaiting trial prisoner and had contracted tuberculosis whilst in prison and sued the Minister for damages. In *Lee*, Cameron J, writing for the minority observed (footnotes omitted):

"[93] To bring the matter starkly back to the case before us, because a claimant in the position of Mr Lee may never be able to trace the source of his or her infection, the prison authorities would on the but-for test for causation have no legal incentive, at least in principle, to reduce the risk of contagion. This is because they need show only a small chance that a claimant like Mr Lee may have contracted TB anyhow, even if reasonable systemic measures had been applied. Because the risk was not altogether eliminated, the claim will fail. And this will almost always be the case. Hence, claimants in Mr Lee's position will, on the existing test, almost never be able to succeed."

[94] These problems all arise from the rigidity of the common-law test for causation, which requires claimants to prove more probably than not that the defendant's negligence caused their injury. They are not unique to our legal system. They have caused other jurisdictions to grapple with new approaches to the test for causation in cases where the claimant is unable to pinpoint the source of his injury, or to indicate that his injury was probably caused by a defendant who contributed to it, or where the defendant exposed the claimant to a risk of the injury in fact suffered.

[100] What seems clear is that in some classes of claim the traditional common-law but-for test is just not enough to deliver adequately just outcomes. This is particularly so in the case of Mr Lee. As the main judgment rightly points out, prisoners are particularly vulnerable and there are special reasons for imposing liability to ensure accountability and responsiveness. The Supreme Court of Appeal in its judgment gave feelingful expression to the same point. It noted that Mr Lee was delivered into the absolute power of the state, lost his autonomy and was entitled to measures ensuring his physical welfare. It said there was 'every reason why the law should recognise a claim for damages' to vindicate prisoners' rights.

[101] All this indicates that the common-law but-for test for causation is an over-blunt and inadequate tool for securing constitutionally

tailored justice in cases where prisoners have proved exposure to disease because of negligence on the part of the prison authorities,

but cannot pinpoint the source of their injury. The change in the United Kingdom jurisprudence has been justified frankly, on grounds

of simple justice, since it would be wrong for employers to avoid liability for wrongdoing because of causal indeterminacy. The English courts did this without constitutional imperative. With us, that imperative is there. In Mr Lee's case, his vulnerability as a prisoner, which meant he was unable to put himself out of harm's way, together with the lack of proper care on the part of the prison authorities, makes a similarly powerful case for developing our common law.

[102] This is not to say that normative considerations bearing on what wrongs should be compensable in our constitutional system play into determining factual cause and effect — but, rather, these considerations make the case for relaxing the over-rigid strictures of but-for factual inferences. Should the common law be developed, the causation inquiry remains a question of fact, though now the question is a wider one, that is easier to answer in cases like Mr Lee's: would reasonable measures have reduced the overall risk of infection? And, then, should the extent of risk to which the defendant's negligent conduct exposed the claimant lead to recovery for the injury that was suffered?"

[56] Mr Pillay overlooks the fact that Cameron J was in the minority and that, in addition, he did not decide the case along the lines discussed by him. Instead, after examining the issue of causation both locally and in foreign jurisdictions, he concluded that he would have remitted the matter to the High Court for that Court to assess whether there was room to develop the common law in accordance with those observations.

[57] On the other hand, Nkabinde J, writing for the majority said this (footnotes omitted):

"[72] I am indebted to Cameron J for the exposition of developments in the Anglo-American common law, which illustrates the solutions that other jurisdictions have arrived at in relation to similar problems of causation. I draw comfort from the fact that the injustice of an inflexible legal approach to factual causation is also recognised in foreign jurisprudence. The common law may well have to develop from time to time in this area, as in others. But in the circumstances of this case — particularly the nature of the omission — I do not consider that our law needs to be developed in accordance with the casuistic approach endorsed by the cases referred to.

[73] The underlying cause for the development of exceptions in relation to causation in these foreign cases appears to be the inflexibility of the application of the but-for test. Our law has always recognised that the but-for test should not be applied inflexibly. A court ultimately has to make a finding as to whether causation was established on a balance of probabilities on the facts of each

specific case. Causation will not always follow whenever a wrongful and negligent omission is shown.

[74] The concern that a flexible approach to factual causation and the relaxation of the but-for test in appropriate cases may lead to limitless liability, especially in relation to omission cases, has been addressed by the development of the test of reasonableness in the wrongfulness enquiry. That enquiry now concerns the reasonableness of imposing liability on a defendant, and is not restricted to the reasonableness of the defendant's conduct, which

is an element of the separate negligence enquiry in our law. The wrongfulness requirement in our law thus provides a normative mechanism, in addition to the negligence enquiry, to decide whether delictual liability should be extended or restricted. On my understanding of the duty of care in other common-law systems, it does not allow for that kind of extended judicial policy control of imposing liability in tort, hence the perceived need to do so through exceptional relaxation of the but-for test of causation.”

[58] Mr Pillay invited me to also have regard to the decisions in tort in *Chester v Afshar* [2004] UKHL 41 and in *Crossman v St George’s Healthcare NHS Trust* [2016] EHC 2878 (QB).

[59] In *Chester* a surgeon failed to warn Miss Chester of a 1% – 2% risk developing cauda equina (a particularly devastating complication in

spinal surgery) as a result of the spinal surgery that he had advised should be undertaken. Whilst the surgery was performed to a reasonable standard, Miss Chester suffered the rare complication. The failure to warn of the rare risk was a breach of duty. But for the breach of duty, Miss Chester’s surgery would have been delayed whilst she considered her options. There was no evidence to suggest that the risk injury would have been greater or lesser with the delay. The question for the House of Lords was whether Miss Chester could succeed in proving her case on causation. The House of Lords were split 3-2 in favour of Miss Chester. The majority agreed that a modification of causation principles was justified in *Chester* on policy grounds, justified by the close connection between the duty to provide informed consent, and the injury sustained. All three discussed that there was only a ‘modest extension’ of the existing test; not creating an entirely new one.

[60] In *Crossman* the plaintiff began to suffer symptoms of numbness and pain in his arm and neck. An MRI scan revealed degenerative changes in Mr Crossman’s cervical spine. A consultant discussed various treatment options with Mr Crossman who advised that spinal decompression surgery be performed if a 3 month course of physiotherapy was not successful. A series of errors resulted in Mr Crossman being listed for surgery before physiotherapy was commenced. Mr Crossman queried whether there had been a mistake when he was notified of the date for a pre-operative assessment and admission for surgery, but was told that he would be put to the back of the waiting list if he did not keep his appointment. Mr Crossman underwent surgery and suffered a nerve root injury. This was a recognised risk of non-negligently performed surgery assessed to be in the region of 0.5%, which Mr Crossman was warned of. It was originally agreed by the experts that the risk of the injury eventuating would have been the same following a 3 month delay. It was found that, had surgery been performed at a later date, the risk of the injury occurring ‘may have been somewhat higher’ than at the earlier surgery date, but not to the extent that it was more likely than not that the Mr Crossman would have suffered the injury had surgery been performed at a later date. It was accepted that it was negligent to have failed to have followed the plan for physiotherapy prior to undertaking surgery. However, the Trust alleged that Mr Crossman bore some responsibility for the failure to follow the plan for physiotherapy, and that causation could not be established.

[61] Both Chester and Crossman provide interesting perspectives. The decisions are, however, not uncontroversial. I pause to mention that Crossman was the decision of a single judge and that the decision relied heavily on Chester. By way of example as to the controversy I refer to the opening paragraphs in Hogg, M 2005, 'Duties of Care, Causation, and the Implications of Chester v Afshar'; *Edinburgh Law Review*, vol 9, pp. 156-67. DOI: 10.3366/elr.2005.9.1.156 (footnotes omitted):

"In its decision in Chester v Afshar, a 3:2 majority of the House of Lords held that the scope of a doctor's duty to warn his patient of a non-negligible risk

inherent in surgery extends to liability for personal injuries sustained by the patient as a result of the actuation of such risk.

Where the warning required by the duty is not given, the patient may claim in damages for the injuries sustained, even although, on normal causal principles, she cannot show that she would not have undertaken the surgery at some later date had the warning been given. The course adopted by their Lordships is one which had already been charted by the High Court of Australia in *Chappel v Hart*, a decision to which the majority of the Judicial Committee made extensive reference.

This result may cause consternation in some circles, particularly medical ones, although it is one for which there has been advocacy from leading legal academics. Opposition is likely to centre upon concerns about the alleged lack of a causal connection between the doctor's breach of duty and the injuries suffered by the patient, concerns which were given primacy by the minority. If Miss Chester was unable to prove on the balance of probabilities that she would not have had the surgery on being warned of the risks of the injury (in this case, a condition known as cauda equine syndrome, "CES" for short), then she could not prove that but for the doctor's failure to warn she would not have been in the same position.

I wish to argue that the decision reached in *Chester v Afshar* is not explicable primarily by reference to causation at all. Rather, a proper explanation of the decision lies in the formulation given by the majority of the scope of the duty of care undertaken by the doctor towards his patient. Because the majority defined the scope of the duty as extending to injuries which were encompassed within the very risk of which the doctor was required to warn, difficulties with the causal connection between breach of the duty and the harm ensuing were thereby overcome at the duty level. The result was that the majority felt it unnecessary to explain the precise causal connection in anything other than the vaguest terms, and certainly without the need to have recourse to any of the traditional tests of causation-in-fact. The explanation of the decision thus lies in a normative conclusion of their Lordships (the doctor ought to be liable for this injury) rather than in a causative one (the doctor caused this injury)."

[62] It will be recalled that in Sibisi reference was made to the Australian Case of *Rogers v Whitaker* [1992] HCA 58; (1993) 67 ALJR 47 (also at [1992] HCA 58; (1992) 175 CLR 479). The principles established in *Rogers* were affirmed by the Judicial Committee of the High Court of Australia in *Chappel v Hart* [1998] HCA 55; (1985) 195 CLR 232. *Chappel* is referred to in the extract from Hogg (para 60 above). The controversy I alluded to above crosses the hemispheres and the professions. Thomas B Hugh Msc, FRCS, FRACS,

writing in the ANZ Journal of Surgery (a publication of the Royal Australasian College of Surgeons), said in *Surgical Sense and Legal Non-Sense – Chappel v Hart revisited* ANZ J Surg (2009) 554-557 (footnotes omitted):

“The relationship between medicine and law has always been uneasy. Many doctors have a perception that the legal process is ill-equipped to unravel complex technical issues when experts disagree about medical care. Judges, on the other hand, by their own account often fail to understand expert evidence and find deficiencies in the way it is presented to them.

Expert evidence is sought by courts to assist in making decisions about disputed facts. The High Court noted in *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 that in medical malpractice litigation ‘Courts rely heavily, and in some cases, almost exclusively, on expert medical opinion’. Judicial evaluation of expert evidence utilises the forensic tools of examination-in-chief and cross-examination and there is an expectation that experts will be objective and not an advocate for either defendant or plaintiff.

The reality of medical malpractice litigation is far removed from this utopian ideal, notwithstanding Codes of Conduct and other recently introduced court rules. This occasionally results in serious defects in the presentation and judicial understanding of medical expert evidence and sometimes produces legal outcomes that seem nonsensical to practising clinicians. *Chappel v Hart*, an oft-cited Australian judgment, involving an allegation of a failure to warn about the risk of injury to the recurrent laryngeal nerve (RLN), demonstrates these weaknesses. Examination of the surgical evidence in that case discloses what may be perceived as a miscarriage of justice, with extremely severe personal and professional consequences for the defendant doctor.

Rogers v Whitaker reshaped the landscape of the legal obligation of doctors, particularly surgeons, to warn patients of the risks of medical treatment,

imposing an onerous duty to consider the significance of a particular risk to a particular patient, no matter how rare the probability of that risk eventuating. *Chappel v Hart* appears to have extended that obligation to an absurd extent without consideration of the probability of the risk, which, it turns out, only ever eventuated in the case of the plaintiff, Mrs Hart.”

[63] I have no particular desire to examine either controversy, whether in the northern or southern hemisphere; law versus surgery notwithstanding. In my view a careful consideration of both *Sibisi* and *Lee* provides a complete answer in our law and there is consequently no need to venture into the academic terrain of how the English or

Australian Courts dealt with similar cases.

[64] Even if it can be established that the defendant was negligent in not treating the plaintiff conservatively before resorting to surgery, the plaintiff has not succeeded in establishing that further conservative treatment would have resulted in a recovery. On the contrary, the opposite is more likely to have been the case. This is what Dr Miller had to say:

“MR ACKER Let’s just try and sum up and see where we are, Dr Miller. Do you agree that it is not possible for you to say that had further conservative treatment taken place, there would have been a recovery? Ja, you can’t say that, because these cases are very, these neuropathic pain cases are very difficult or nightmares to treat.

So there was a possibility – in fact, I could even put it there’s a high possibility that even with the conservative

treatment, things wouldn’t have changed, he would have still been in pain, because that has been our experience, but it’s

also been our experience that some cases do get better.”

[65] The evidence, in any event, clearly established that conservative treatment had been given to the plaintiff over many weeks before he consulted the defendant and, not only was this not successful, but the plaintiff had no faith in it and, in fact, did not take certain of the medication which had been prescribed. The plaintiff has thus not discharged the onus of proving causal negligence on the part of the defendant.

THE RESULT

[66] I grant judgment in the defendant’s favour, together with costs, costs to include the qualifying fees of Dr du Plessis and those incurred as a consequence of the employment of Senior Counsel.

Vahed J

Case Information:

Dates of Hearing:

5, 6, 7 November 2014; 15, 16 May 2017; 21 September 2017;

13 December 2017

Date of Judgment:

16 November 2018

For Plaintiff:

L Pillay SC on 5, 6 7 November 2014

F Moola SC on 15, 16 May 2017

L Pillay SC (with M Bahadur) 21 Sept 2017 & 13 Dec 2017

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