

SOUTH AFRICA / JUDGMENT

C.C.M v MEC For Health, Gauteng (10242/2017) [2023] ZAGPJHC 381 (25 April 2023) [2023] ZAGPJHC 381

COURT

South Gauteng High Court, Johannesburg

BEFORE

Mia

CASE / FILE NUMBER

10242/2017

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OF SOUTH AFRICA

IN THE HIGH COURT OF

SOUTH AFRICA

GAUTENG LOCAL

DIVISION, JOHANNESBURG

Case Number:

10242/2017

NOT REPORTABLE

NOT OF INTEREST TO

OTHER JUDGES

In

the matter between:

M,
C C
Plaintiff
and
THE
MEC FOR HEALTH, GAUTENG
Defendant
Neutral
Citation: M
C C v The Mec For Health, Gauteng (Case
No: 2017/10242) [2023] ZAGPJHC 381 (25 April 2023)

JUDGMENT

Mia, J

Introduction

- [1] The plaintiff claims damages from the defendant based on the negligence of the staff at Chris Hani Baragwanath Hospital, situated in Johannesburg, Gauteng. An order was granted on 29 June 2020 when it was ordered by Ismail J that liability be separated from the quantum of the claim. The matter proceeds before me on the issue of liability only.
- [2] The plaintiff, Ms C C M was employed as a female store manager. She resides in Dobsonville, Johannesburg. The defendant is the Member of the Executive Council for Health for the Province of Gauteng with offices situated at 37 Sauer Street, Marshall Town, Johannesburg. The defendant has locus standi by virtue of being a nominal representative of the Minister of Health and cited in its official as a political head of the Department of Health's Chris Hani Baragwanath Hospital situated at 26 Chris Hani Road, Johannesburg, Gauteng.

Background

- [3] On 28 March 2013, the plaintiff was admitted to Chris Hani Baragwanath Hospital where she gave birth by vaginal delivery where an episiotomy cut was sutured with vicryl. After the birth, the plaintiff experienced pain and discomfort in the area of the episiotomy which did not abate. The pain was reported to the nursing staff at the Itireleng Clinic at her six-week check-up and again two weeks later when she still experienced continued pain and was compelled to consult a doctor at the clinic. The doctor prescribed antibiotics and advised she would need to return to the hospital if the condition did not improve. She was referred back to the hospital as the pain did not cease. Upon examination on 26 November 2013, it was found that the episiotomy was infected and required surgery in the form of a revision episiotomy. The revision episiotomy was scheduled for 22 February 2014. The plaintiff experienced discomfort throughout December 2013, and January 2014, and this resulted in her surgery being moved forward. The plaintiff was admitted on 5 February 2014 and the surgery, a fistulectomy, was conducted on 7 February 2014. The plaintiff was discharged on

11 February 2014 and advised that she could resume her ordinary duties on 13 February 2014.

- [4] On 11 February 2014, the plaintiff was concerned about whether she would be able to return to work so soon after surgery and visited the Department of Health in Johannesburg. The doctor was informed telephonically to extend the plaintiff's sick leave beyond 13 February 2014 and did so. The plaintiff attended follow-up visits from 18 February 2014 until she was discharged as an outpatient a month later on 18 March 2014 after the doctor conducted a visual examination. On 1 April 2014, the plaintiff experienced the first episode of fecal incontinence whilst walking her child to school in the company of her husband. The incidences of incontinence increased in frequency.
- [5] She requested from the Department of Health, to be assisted at a hospital other than Chris Hani Baragwanath medical facility. In January 2016, she was referred to Dr. Oettle at Helen Joseph Hospital to assess her physical incontinence. The assessment determined that her anal sphincter muscle had been cut possibly during the surgery at Chris Hani Baragwanath. The plaintiff requested assistance to address the incontinence. Dr. Kaula was requested to obtain a second opinion from Professor Lindeque in respect of Dr. Oettle's findings. Dr. Oettle's findings were confirmed by Professor Lindeque. The plaintiff has not received assistance from the Department of Health.

Issues in dispute

- [6] The parties agreed that the following issues required determination flowing from the issues in dispute:
- a. Negligence- whether there is evidence that the hospital staff acted negligently;
 - b. Causation- whether there is a causal link between the negligence of the medical staff at Chris Hani Baragwanath Hospital and the injury suffered by the plaintiff as described above.
- [7] It is apposite to commence with an introduction of the experts who testified. Dr Mark Stevens, the plaintiff's expert, is a specialist obstetrician and gynaecologist, with a degree in medicine and surgery from the Royal College of Obstetricians and Gynaecologists. Professor Nolte, is a nurse and midwife. She obtained a Masters degree from the University of the Free State and a Ph.D. in midwifery from Unisa. Dr Rawlins, a general surgeon, has an MBChB.; M Med from the University of the Orange Free State. He is also a member of the American Gastroenterology Association. He specialises anatomically in the small bowel, the colon and rectal area.
- [8] The defendant called five witnesses. Dr Shackis, a gynaecologist. Dr Kiss, a surgeon who obtained the equivalent of a MBChB in Hungary and the specialised in surgery. He commenced work at Chris Hani Baragwanath in 1991 as the head of the colorectal surgery unit where the plaintiff was treated. Dr Diana du Plessis, a Professor based at Fort Hare University in the public health leadership programme, holds a BSoc. Science Hon. Bloemfontein, Masters Degree UJ, and a Kriashonus doctorate equivalent to a PhD. Dr Leoni

Fourie has a Bachelors Degree in Medicine and a Bachelors degree in Surgery from the University of Pretoria. She has a Masters in Business administration from the University of the Witwatersrand and has specialised in colorectal surgery with the Department of Medicine. Dr Francis qualified as a doctor in the Eastern Cape, he worked with Dr Saths Cooper for a year

then transferred to the Wits Circuit where he worked as a Registrar.

[9] In *Blyth v Van der Heever* [1], the Court in determining the question of negligence considered the following issues:

‘(i) what factually was the cause of the ultimate condition of [M];

(ii) did negligence on the part of [the Defendant] cause or materially contribute to this condition in the sense that [the Defendant] by the exercise of reasonable professional care and skill could have prevented it from developing.’

[10] In determining whether there was negligence it is apposite to record the areas of agreement between the experts as well as the aspects which the experts conceded by the defendant’s witnesses. In the joint minute between Dr. Rawlins and Dr. Fourie, both specialist surgeons indicated there were “no clinical notes found on the clinical examination that was performed on Mrs. M on 26 November 2013 or during the operation on 7 February 2014”, they also agreed that “there was an unnecessary delay in the diagnosis and treatment of Mrs. M”. Both Dr. Rawlins and Dr. Fourie perused the plaintiff’s hospital records and concluded the episiotomy sutures were too deep and thus penetrated the anal sphincter muscles. Dr. Stevens testified that hospital records did not reflect the plaintiff had a perineal tear during her delivery. The hospital records were also silent on whether an examination had been conducted to assess whether the stitches were too tight so as to rule out the presence of stitches where they should not be.

[11] Dr. Francis and Dr. Du Plessis called by the defendant conceded that the records were silent on whether the perineal tear was present and whether it was a first, second or third-degree tear. In the event it was a third-degree tear, the episiotomy sutures ought to have been performed by a doctor. The absence of this record does not clarify the position. Dr. Schakis, the defendant’s witness, examined the plaintiff on 28 January 2014 and did not record that the plaintiff was incontinent when he examined her. Thus the incontinence did not occur after the episiotomy. Both Dr Kiss and Dr Du Plessis, agreed that it was necessary and important to note what was observed in the patient when she presented with symptoms and to record them in the medical records. Dr. Francis agreed that keeping records was necessary and agreed that the medical records did not reflect what the factual position was, in that it did not reflect a perianal laceration or a third degree tear which he said were present and communicated to him by Dr. Kiss.

- [12] Dr Francis expressed that the possibility of an anal sphincter complication was accepted and often encountered by surgeons in lithotomy and fistulectomy procedures. His view was that they operated on the fistula and not the anal sphincter. The tissue was distinguishable in colour, the anal sphincter being red as compared to white fibrous tissue in the area they operated on. If there had been a laceration the patient is called back in four weeks to repair and the hospital record would reflect and entry noted as “iatrogenic injury to the external sphincter for repair in 4 to 6 weeks once sepsis has cleared.” He expressed that a research area has been dedicated to missed third-degree incisions indicating how often they did occur. There was no record of a third-degree tear which would have required a doctor to attend to the plaintiff.
- [13] Mrs. M was a high-risk patient on antiretroviral medication, with a history of preeclampsia and a previous caesarean delivery. This placed her at high risk according to Dr Du Plessis and there was no indication as to why the episiotomy was performed in the medical records. A midwife is authorised to suture first and second-degree tears only. The record does indicate what tear if any occurred during Mrs M’s delivery. In addition, the medical record also omits to record a digital anorectal examination, suggesting that it was not done to assess for a possible anal sphincter injury. Mrs. M’s six-week follow-up visit to the clinic indicates that the nursing sisters attending to her observed her sutures were different. Mrs. M was unable to sit up at that stage which was unusual according to all the medical experts.
- [14] Dr. Stevens was not able to comment on the incision, drainage, and fistulectomy as he did not conduct such operations and was not a colorectal surgeon. He agreed that anal sphincter injuries were a well-known complication and injury which occurred during vaginal deliveries. He also agreed that the anal sphincter injury could have been sustained during the vaginal delivery, as the anal tone was recorded as normal thus no injury was observed and the episiotomy was sutured.
- [15] Dr. Kiss, the head of the colorectal unit at Chris Hani Baragwanath Unit, did not make notes on the hospital record and his evidence was limited to his recollection and limited notes in the record which bore his signature.
- [16] Having regard to the various expert’s opinions and the medical records as well as Mrs. M’s recollection of her treatment, there are two material times when an injury could have been caused to the anal sphincter. The first occasion would have occurred at the time of the delivery. The possibility of disruption to the anal canal is not likely as the visit to the clinic indicated there was no report of incontinence. When Dr. Shackis attended to Mrs. M in January 2014, she did not report fecal incontinence when she arrived for the treatment of pain in the episiotomy area. He indicated that the plaintiff would have noticed soiled undergarments and reported this. He also indicated that injury to the anal muscles could occur during vaginal delivery. This could result in incontinence.

[17] Dr. Fourie also refuted Dr. Francis's suggestion that the incontinence could occur two to eight weeks after a vaginal delivery. Dr Fourie indicated it could occur at any time and she often saw her clients long after their deliveries. In Mrs. M's case, Dr Francis said that sepsis had distorted the anatomical structures making it difficult to identify structures in the site of sepsis. He explained the fistula was away from the anal region but the region was the size of a matchbox. The medical records indicated an operation in the perianal fistula yet Dr. Francis was resolute that they did not operate near the anus. His view was that they preferred stool to remain solid and did not administer a laxative. The medical record reflected lactulose was administered to soften stool.

[18] Dr Rawlins indicated that the injury causing the fecal incontinence could not have occurred during childbirth as the plaintiff would have suffered incontinence much sooner, probably two months after delivery. The fecal incontinence occurred after the procedure to rectify the episiotomy suture.

[19] In considering the expert evidence, the decision in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*, [2] the Court said:

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

And

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

[20] In *PriceWaterhouseCoopers v National Potato Co-operative Ltd*, [3] the following passage from a Canadian judgment was cited with approval:

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

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

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

- [21] The experts were agreed that there were no entries of observations made in the hospital records. The records were silent in relation to the degree of the tear, the reason for the episiotomy and whether there was a digital examination to check for sutures in the anal sphincter. Therefore, the first opportunity was missed to identify and correct an error that may have occurred and to give the patient the correct advice regarding care.
- [22] The second opportunity occurred when according to Dr. Francis, he was informed by Dr. Kiss that they were attending to a missed third-degree tear, namely the fistula. This confirmed that in the absence of a digital examination, there was a third-degree tear which the colorectal unit was requested to attend to. However, Dr. Francis indicated that it was difficult to distinguish the anatomical structures that were distorted in the midst of the sepsis. They were also working in a small area the size of a matchbox. The possibility remains that it is possible that they did not see the red striated muscle of the internal anal sphincter if it was torn, because Dr Francis, who conducted the procedure, explained that it was difficult to distinguish between the anatomical structures where they were distorted by sepsis as had occurred in Mrs. M's instance. It was possible then that the anal sphincter muscle was cut at that stage. The time frame suggests so too. After the fistula was drained, Mrs. M, who had hard stool previously, now had unannounced incontinence.

[23] In *Caswell v Powell Duffryn Associated Collieries Limited*:^[4], it was said

"Inferences must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish ... But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture"

[24] In *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another*, ^[5] the Court said:

"... [I]t should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the

particular circumstances the conduct complained of falls short of the standard of the reasonable person. 40.2. [I]t has been recognized

that while the precise or exact manner in which the harm occurs need not be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable."

[25] Having regard to the issue of factual causation, but for the wrongful conduct of the hospital staff, would the plaintiff's

loss have ensued or not? It was submitted on behalf of the plaintiff that if the wrongful negligent conduct of the hospital staff was eliminated - and on the assumption that all precautionary requirements were satisfied and carried out - the damage to the anal sphincter would not have occurred. Factual causation has thus been satisfied. Our Courts have indicated that a plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss.[6]

[26] Causation has been established at the time of delivery as well as during the procedure to revise the episiotomy and drain the fistula. The first leg of the inquiry is answered positively. The second enquiry is also answered positively as the incision of the perianal fissure did contribute materially to the condition and resulted in fecal incontinence. This also materially contributed to Ms M's condition in that the defendant by the exercise of reasonable professional care and skill could have prevented it from developing.

[27] The outcome of the dispute whether the defendant, through its staff's medical treatment and or medical care which led to the respondent's injury, could be described as negligent, ultimately turns on a choice between the opposing views of two sets of expert witnesses, where there are vast portions of agreements. It is true, of course, that the determination of negligence ultimately rests with the court and not with expert witnesses. Yet, that determination is informed by the opinions of experts in the field which are often in conflict, as has happened in this case. To the extent that I rely on an analysis underlying reasoning which led the experts to their conflicting opinions, there has been agreement on a number of issues by both sides. The management of the patient requiring her medical records to be more complete, the examinations to be completed and observations to be noted. The negligence occurred earlier and the surgeons were tasked to attend to the correction and this suggests negligence on the part of the defendant's staff. This is confirmed by Dr. Francis who conceded a third degree incision may have occurred and that he was informed by Dr Kiss. Dr. Francis also indicated they could not distinguish between anal muscle and other tissue when attending to the revised surgery and fistulectomy. Dr. Marishane's evidence contradicted the experts and did not clarify the position or assist other than to deny any statements put to him.

[28] In the result I make the following order:

Order

1. The defendant shall pay to the plaintiff all the damages as proven or agreed as a result of the negligence of the defendant's staff at Chris Hani Baragwanath Hospital resulting in the plaintiff's fecal incontinence.
2. The defendant shall pay the plaintiff's costs of suit which shall include the costs of obtaining the medical reports, addendums and joint minutes of:

2.1. Dr Rawlins

2.2. Dr Stevens

2.3. Prof Nolte

2.4. The qualifying, attendance, preparation, travelling fees where applicable of the aforesaid witnesses.

2.5. The costs consequent upon the employment of two counsel, where employed.

2.6. The costs associated with the drafting of heads of argument.

SC MIA

JUDGE OF THE HIGH COURT

JOHANNESBURG

APPEARANCES

For the Plaintiff: Adv Craig Cremen Instructed by: Houghton Haper Inc For the Defendant: Adv T Masevhe Instructed by: State Attorney

Heard: 08/9/10/11/12 November 2021 & 13/25 January 2022

Delivered: 25 April 2023

[1] Blyth v Van der Heever 1980

(1) SA 191 (A) at 196E

[2] Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH 1976

(3) SA 352 (A) p at [33]

[3] PriceWaterhouseCoopers Inc and Others v National Potato Co-operative Ltd and Another [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) para 99.

[4] Imperial Marine Co v Deiulemar Compagnia 2012 1 SA 58 (SCA) at 70 at par 24.

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

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

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

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