REPUBLIC OF SOUTH AFRICA

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

CASE NUMBER: 2016/03425

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED.

6 May 2020

DATE SIGNATURE

ELECTRONICALLY DELIVERED DUE TO COVID 19 RESTRICTIONS

In the matter between:-

M, F Plaintiff

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH GAUTENG PROVINCIAL GOVERNMENT Defendant

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JUDGMENT

FMM SNYMAN (AJ)

Introduction

[1] The plaintiff, a 53 year old male, was admitted to Far East Rand Hospital on 21 May 2013 for a scheduled surgery to remove a suspicious malignant tumour on the left side of his face. The tumour was situated under the plaintiff's left ear.

[2] An excision of the left submandibular gland was performed on 21 May 2013 and the plaintiff was discharged 6 days post-surgery on 27 May 2013. The laboratory results indicated the tumour to be benign.

[3] After the surgery the plaintiff experienced facial palsy as the left side of his face was numb or "droopy". Since then, the plaintiff has no control over the left side of his mouth, he experiences difficulty with chewing and eating and he is unable to completely close his left eye.

[4] It deems to be mentioned at this stage already that two different facial glands are referred to and distinguished between frequently in this judgment, which two glands were also prominent subject matters during the trial. The first gland to identify is the parotid gland which is - roughly described - situated in front of a person's ear. The second gland is the submandibular gland, situated under the jaw (mandible).

[5] The plaintiff issued summons against the defendant for being vicariously liable for the conduct of the medical personnel in negligently injuring the plaintiff's left facial nerve during the surgery, resulting in the facial nerve palsy.

[6] The facial nerve is the seventh cranial nerve, or simply CN VII. It emerges from the pons of the brainstem, controls the muscles of facial expression, and functions in the conveyance of taste sensations from the anterior two-thirds of the tongue. There are two facial nerve stems, one on the left and one on the right side of the human face. This matter concerns only the left seventh cranial nerve ("facial nerve").

[7] Regarding the anatomy of the facial nerve, the trunk of the facial nerve stems from the brain and is exposed (in that it is not covered by the scull) for a very short distance right under the ear. Thereafter it enters into the parotid gland from below, surfaces to the mid parotid gland and whilst still in the parotid gland, divides in five different branches to serve the various facial nerves.

[8] The trunk of the facial nerve (or interchangeably referred to as the "facial nerve stem") leaves the brain through a tunnel of bone structure situated approximately 1 – 2 cm or 2 – 3 cm deep from the skin, situated under the earlobe.

[9] The matter was set down for determination on the merits only.

[10] The issue of *quantum* is postponed *sine dies* by agreement between the parties.

The disputes

[11] The defendant disputes whether there is an injury to the left facial nerve (a factual enquiry); and

[12] If the nerve is injured, the defendant disputes whether the surgery performed on 21 May 2013 caused the facial nerve injury. Causation of the injury (a legal enquiry) is thus disputed.

[13] The plaintiff has the onus to prove both the above issues on a preponderance of probabilities.

[14] Should both these questions be answered in the positive, the defendant would be liable for the damages suffered by the plaintiff as a result of the surgery and merits would be found in favour of the plaintiff.

[15] The defendant does, however, admit that the facial nerve of the plaintiff is paralysed. This paralysis, so the argument goes, were not caused by any actions during the surgery, but is due to another unknown

cause, such as a stroke resultant from high blood pressure, or Bell's Palsy resultant from a virus.

[16] In the context of this matter (and not necessarily in accordance with medical terminology) the difference between an "injury" and "paralysis" is that injury to the facial nerve would result in permanent damage, whereas paralysis would be of temporary nature and may improve over time.

The surgery

[17] The facts of this case are largely common cause. As with any matter relating to medical issues, it has to be kept in mind that the human anatomy is not a fixed subject with hard and fast rules.

[18] The plaintiff visited his local clinic after an unsightly and visible gland under his left ear developed. The gland extended to under the plaintiff's jaw. He underwent a sonar examination during November 2012 after being examined, and so recommended, by doctor Seape on 7 November 2012.

[19] The radiology report is dated November 2012 and refers to a mass situated medial-infra-parotid gland, which indicates the lower region of the parotid gland. The radiology report repeatedly refers to the parotid gland and reads as follows:

> *"A large 27.4 x 32.8 x 22.8 mm) heterogeneous, hypervascular hypoechocic mass lesion noted medial-infra-**parotid** gland (LT) ? **Parotid** mass ? Lymph node.*
> ***Parotid** gland LT = 35.2 x 34.1 x 27.4mm = appears symmetrical as compared to RT. Reactive, small (subcm) nodes noted at bilat. Neck. It would be helpful to do a biopsy; CT scan to further assess."*
> (own emphasis)

[20] Doctor Seape testified that he did not deem it necessary to have a biopsy or a CT scan done. His evidence was that the plaintiff wanted to have the mass removed, and as such the next step would be the surgery. According to him it would be nonsensical to embark on two separate surgeries (that of a biopsy and an excision) where an excision would remove the gland and a post-surgical biopsy can be done.

[21] The "Consent to Operation Form" reflects that the surgery was conducted by doctor Seape as assisted by doctor Pratt. In line with doctor Seape's evidence, it also reflected that the nature of the surgery was *"excision of submandibular gland."*

[22] During the surgery a tumour was indeed found in the plaintiff's submandibular gland and was *in toto* encapsulated within the submandibular gland. Under a microscope or an x-ray both the submandibular and parotid gland look similar. Both these glands are salivary glands.

[23] Since the submandibular gland is located under the jaw, a surgery to remove such gland would not venture near the facial nerve trunk. The joint expert report with the plaintiff's expert witness professor D Pantanowitz (Specialist Surgeon / Vascular Surgeon) and defendant's expert witness doctor E T Mabaso (Maxillo Facial and Oral Surgeon) reflects that there is *"No disagreement"* between the experts and both agree that *"It is unacceptable to transect the trunk of the 7th cranial nerve (facial nerve) during an operation to excise the submandibular salivary gland"*.

[24] However, with the parotid gland located in front of the ear and the nerve stem below the earlobe, the surgeon would have to take extra care with any parotid gland surgery to identify and isolate the facial nerve since the facial nerve is located under and within the parotid gland. According to standard practice, surgery to the parotid gland will commence with an incision in front of the ear and extend vertically alongside the ear and down the neck.

The surgical notes

[25] The theatre notes of the plaintiff's surgery on 21 May 2013 reflect the commencement of the surgery at 10:25 and 10:40 respectively and conclusion of the surgery at 12:45 and 12:55 respectively. It is unsure which times refer to actual theatre time or time of anaesthetics. Doctor Seape testified that the surgery for a submandibular gland would, in the

absence of any complications have a duration of approximately 45 minutes. At the very least, the duration of the plaintiff's surgery was approximately 2 hours.

[26] The content of the theatre notes read as follows:

> *"Operation: Excision of submandibular gland*
> *Surgeon: Dr Seape*
> *Assistant: Dr Pratt*
> *Anaesthetist: Dr Neohoff*
> *Procedure: Pt positioned supine. Beard shaved, patient cleaned + draped. Horizontal incision made below L inferior margin of mandible ± 10 cm. Platysma M incised, blunt dissection done + submandibular gland visualised. Blunt dissection done to mobilise gland. Stensons duct identified + ligated c. 3.0 chromic. Branches of facial artery ligated + haemostasis easily achieved. Pencil drain inserted. Plaserva M + subcutaneous tissue approximated + closed c vicryl. Skin closed c vicryl. Skin closed c subcutaneous stiches. Dressings applied, gauze + opsite.*
> *Specimen sent off for histology*
> *P T/F pt to ward. Analgesics (signed Dr Pratt)"*

[27] The surgical notes indicted that an incision of ± 10 cm was made. The surgical notes also referred to the "stensons" duct, which is situated in the parotid gland, whereas the "whartons" duct is situated in the submandibular gland.

[28] When the plaintiff woke up after the surgery, his face was swollen at the left side, which is normal after a submandibular gland removal.

[29] The hospital records reflect:

[29.1] On 21 May 2013 the day of the surgery it is noted that the blood pressure of the plaintiff was 166/107 prior to the surgery. This is a relative high blood pressure, the norm being 120 / 80.

[29.2] An unknown doctor noted on 23 May 2013 post excision of submandibular gland, that the plaintiff had a swollen jaw and inability to close his left eye. It was also noted that his blood pressure remained high.

[29.3] On 24 May 2013 mention is made of a *"Dr Thomas"* and it is also recorded that the plaintiff is *"still unable to close"* his left eye properly.

[29.4] On 25 May 2013 it is noted that the plaintiff complained of a headache. The plaintiff's blood pressure is recorded as 171/106.

[29.5] On 26 May 2013 an unknown doctor noted *"VII palsy (? Neuropraxia)"*. In July 2013 an unknown doctor noted *"signs and symptoms suggestive of facial nerve injury"*.

[29.6] On 1 July 2013 the hospital records reflect *"53y Pt underwent a Lt submandibular gland excision and is …..(illegible)… and symptoms suggestive of Lt forced nerve injury."*

[29.7] In the hospital records dated 22 July 2013 it is noted by doctor Seape that: *"Submandibular salivary gland excised. Please get histology. (signature) Note the VII nerve palsy – following the surgery."* Here doctor Seape's notes indicate that the nerve palsy follows the surgery.

[29.8] On 21 August 2013 Doctor Seape again notes *"7th nerve palsy*", and it is also noted by an unknown doctor on 18 November 2013 on the left side of plaintiff's face *"7th nerve palsy"*.

[29.9] The hospital records by doctor Nyembe dated 26 February 2014 refer to drooping of the plaintiff's face on the left side and that the plaintiff cannot close his left eye lid. It is also noted the 5th and 7th palsy secondary to a questioned "*? Iatrogenic surgical injury*". Doctor Nyembe wrote under treatment: *"advice Tape for L eye at night. Counsel patient on condition."* An iatrogenic injury is an injury caused by a medical professional.

[30] Professor Pantanowitz testified that under regular circumstances with no complications the scar for a submandibular gland removal would be

approximately 4 – 5 cm. The theatre notes indicated a horisontal incision of ± 10 cm was made to remove the gland. Doctor Seape's evidence was that the length of the incision is discretionary to the surgeon's decision.

[31] To test the functioning of the facial nerves after a surgery, the surgeon would conduct the following "stress" tests: to ask the patient to smile, to clench his/her teeth, to close both his/her eyes tightly, to look up with both eyes while keeping his/her head still, and/or to stretch the eyes as large as the patient can. This would immediately indicate unresponsiveness of a nerve.

[32] When a nerve is damaged or severed during a surgical procedure, the nerve is unresponsive immediately after surgery and will not recover unless a nerve reconstruction is done. No reconstruction of the nerve was done in this matter.

[33] When a nerve is paralysed, it can be due to a virus or injury, and the responsiveness of the nerve may recover over time.

The disputes

[34] The plaintiff questions the extent and nature of the surgery that actually took place, namely whether it was surgery to the submandibular gland

only, or a hybrid form of surgery that extended to both the submandibular and parotid glands which injured the facial nerve trunk.

[35] The plaintiff's case is that the surgery of the submandibular gland probably extended to the parotid gland and as such caused the nerve damage. The plaintiff's case is further that the parotid gland was probably dissected during the surgery and the facial nerve trunk was injured when the surgery ventured near the parotid gland.

[36] The defendant's case is that the surgery was a left submandibular gland excision only and did not extend to the parotid gland. The surgeon who performed the surgery, doctor Seape, testified to that effect. The defendant held other unknown causes to be the origin of the facial palsy, such as Bells' Palsy or a stroke. The defendant denies that the paralysis or injury of the facial nerve is a result of the surgery.

[37] The defendant's expert was not called to testify, but his report was entered into evidence by agreement between the parties. He diagnosed the plaintiff with Lagophthalmos, which is the inability to close his left eyelid completely. He also explains that the interesting phenomenon of excessive sweating that occurs when the plaintiff eats, is called Frey's syndrome which is mainly caused by injury to the auriculotemporal nerve which is a branch of the trigeminal nerve. He states that this nerve is usually injured by surgeries in the parotid and submandibular region.

[38] The two questions remain: whether the facial nerve has been injured (thus damaged or severed), and if so, whether the surgery is the cause of the facial nerve palsy.

The evidence

[39] The first witness to testify on behalf of the plaintiff was the expert witness instructed by the plaintiff, professor Pantanowitz. He is a specialist- and vascular surgeon.

[40] The experience and expertise of professor Pantanowitz is in question. He testified that he examined the plaintiff and noted a surgical scar on the left side of the plaintiff's face, under the jaw, which curved up to the left ear of the plaintiff, ending right under the earlobe of the plaintiffs' left ear.

[41] Professor Pantanowitz also testified that the scar, in his opinion, was not a scar typical with that of a submandibular surgery. His evidence was that it appears that an incision was made with the intention of performing a submandibular surgery, under the jawline, and went up to the left ear ending below the left earlobe. According to professor Pantanowitz's evidence the incision should have ended under the jaw, far from the ear. His evidence was that the scar was too long for a

submandibular gland removal, as the length of a normal scar for such removal would be a maximum of 4 - 5 centimetres.

[42] Professor Pantanowitz postulated that the surgeon might have removed the submandibular gland, thought he did not get the tumour, and extended the surgery to the lower region of the parotid gland. He further postulated that the surgeon might have pulled the parotid gland down, in order to examine whether the tumour might be in the parotid gland or attached to the lower part of the parotid gland. With this examination of the parotid gland, so the hypothesis goes, the nerve trunk or several of the facial nerves would become exposed and at risk to be injured and/or cut.

[43] Professor Pantanowitz referred to the radiologist report and the theatre notes in support of his hypothesis. I will refer to these notes when analysing the evidence rendered in this matter.

[44] In his report professor Pantanowitz reached the following conclusion which was echoed in his evidence :

> *"Facial nerve injury (permanent) from operative damage resulting in disfigurement of the peri-oral aspect of the face. This nerve trunk is never damaged during submandibular surgery: this is the first time I have seen this complication. Only the mandibular branch is at risk with submandibular surgery. Thus the surgeon must have performed parotid gland surgery*

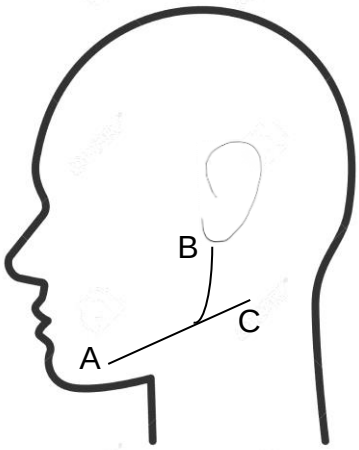
thinking that the tumour was in the submandibular gland, while it was actually in the parotid gland."

[45] The location and extent of the scar is in dispute. The defendant alleges that the scar does not go up to the earlobe of the plaintiff, but ends far away from the earlobe in the plaintiff's neck. The line that professor Pantanowitz alleges is a scar, is according to the defendant a skin-fold. The photograph of the plaintiff's scar and other pictures handed in as evidence was helpful in determining the difference between the two versions, but a factual finding on whether the extension to the ear is a scar or skinfold could not be made from the documents.

[46] I found that a physical inspection would be necessary to examine the plaintiff's skin and the scar under sufficient lightning and up close in order to come to a conclusion on whether the line is a surgical scar or a skinfold.

[47] After professor Pantanowitz testified, the court adjourned to conduct an inspection *in propria persona* on the scar of the plaintiff in the judges' chambers with a torch used for additional lighting. Both parties' representatives, professor Pantanowitz, doctor Seape as well as the interpreter and plaintiff were present.

[48] I have recorded the findings in the inspection of the scar as follows in a sketch:



[49] It is not clear on the above sketch, but the incision starts under the plaintiff's jaw. Both parties agree that point A is where the incision started. Point C is where the defendant alleges the incision ends, and point B is where the plaintiff alleges the incision ends. The distance between point A and point B is ± 10 cm, and the distance between point A and point C is ± 10 cm.

[50] The plaintiff testified next. He woke up after the surgery with pain in his jaw and a head-ache. The plaintiff noticed that he could not close his left eye when he wanted to sleep. He used his finger to press the left eyelid down, but had to ask the nurses for assistance when the eyelid

did not stay down. The nurses closed his eyelid with the application of a band-aid on the eyelid.

[51] The plaintiff further testified that he found that his mouth was weirdly twisted. He also noticed that he sweats profusely when he eats anything. This sweating started immediately after the surgery and remains consistent years after the surgery.

[52] The plaintiff testified that a doctor named “Thomas” came to see him after the surgery, and asked him to smile. When he smiled, he could feel his mouth was twisted. The doctor informed the plaintiff that he is “not right” and should stay in the hospital for a week after the surgery.

[53] The plaintiff testified that he is suffering from the same symptoms despite the fact that several years have passed. He conceded under cross-examination that the symptoms became better, but he maintained that he could still not completely close his left eye, use the left side of his mouth and that the left side of his face remained droopy and numb. Having heard the evidence of the plaintiff, I find that the plaintiff’s symptoms have improved marginally.

[54] The plaintiff closed his case after the evidence of professor Pantanowitz and the plaintiff.

[55] The defendant called one witness, namely doctor Seape who was the Head of the Department: Surgery during the period of 2013 at the Far East Rand Hospital. He testified that he performed the surgery together with doctor Pratt, who was an intern assisting in the surgery. The theatre notes reflects the sequence of the events during the surgery. Doctor Seape would give running commentary, or instruct doctor Prat during the surgery to perform some surgical tasks. Doctor Seape testified that he would be teaching during the surgery.

[56] Doctor Seape conceded that the theatre notes of the surgery mentioned the incorrect gland by referring to the incorrect duct. He testified that *"as surgeons, we get carried away sometimes. We might give a wrong name to the duct"* in response to why the stetsons duct (in the parotid gland) was referred to as opposed to the whartons duct (in the submandibular gland). He could not recall whether he noticed the mistake on the notes, or whether he named the incorrect duct during surgery. He was however consistent in his evidence that he performed an excision of the submandibular gland and not the parotid gland.

[57] Doctor Seape confirmed that a doctor Thomas worked in the hospital, and testified that any complications of the surgery would have been recorded in the hospital records.

[58] Doctor Seape confirmed that he made the inscription in the hospital records on 23 July 2013 "*VII nerve palsy – following the surgery"* and

on 21 August 2013 "*7th nerve palsy Submandibular salivary gland excision. Please get histology VII nerve palsy following surgery."* He signed the hospital records on 21 August 2013.

[59] Under cross-examination, doctor Seape conceded that he cannot recall the specific surgery and he had no independent recollection of the surgery itself. Doctor Seape also conceded under cross-examination that the surgical incision, having regard to the photograph of the plaintiff in relation to the cadaver picture used as evidence during the trial, would have exposed the parotid gland. Put differently, he conceded that the incision with the endpoint marked as "B", would have exposed the parotid gland.

[60] After finalisation of doctor Seape's evidence, the defendant closed its case.

Documentary evidence

[61] The radiologist report dated November 2012 refers to the parotid gland. Professor Pantanowitz testified that the ultrasound of the plaintiff's face on 10 October 2012 (which is 7 months prior to the surgery) described "*L side of the face ? parotid mass"*. This ultrasound thus referred to the parotid gland which is in line with the evidence of professor Pantanowitz regarding the probability that the surgery extended to the parotid gland.

[62] Doctor Seape denied any controversy over the wording of the ultrasound, laboratory report and the theatre notes in as far as it might be indicative thereof that the surgery of the submandibular gland extended to the parotid gland. According to doctor Seape the references to the parotid gland and the parotid duct (stensons duct) were done mistakenly and/or co-incidentally and the reports should have reflected submandibular gland and submandibular duct (whatsons duct). Doctor Seape held the view that there is nothing to it that the incorrect gland has been referred to, and it is inconsequential in the matter.

Is there an injury or a paralysis to the plaintiff's left facial nerve?

[63] The defendant's case is that the facial palsy of the plaintiff is not related to an injury to the facial nerve sustained during surgery, but that the facial nerve is paralysed due to an unrelated issue and might recover fully.

[64] I need not look further than the defendant's own expert report where doctor ET Mabaso (maxillo facial and oral surgeon) finds that the plaintiff exhibits muscle weakness on his left forehead, has a lagophthalmos on his left eye and weakness of his left cheek muscles and is unable to move his left lower lip or show his left lower incisor teeth. Doctor Mabaso finds that the plaintiff is unable to close his eye

because of a weak orbicularis oculi muscle, which is innervated by the zygomatic and temporal branches of the facial nerve.

[65] During the plaintiff's evidence under cross-examination, he was challenged by counsel acting for the defendant stating that the plaintiff was blinking (or was able to wink) his left eye during his evidence. The plaintiff became upset and denied that he can blink his left eye. Doctor Mabaso, the expert for the defendant, has examined the defendant and found that the plaintiff is not able to close his left eye. Counsel for the defendant, by making such a statement to the plaintiff, appears to distance herself from the defendant's own expert's finding. However, counsel for the defendant pursued the point that she saw the plaintiff blinking during his evidence, and argued that the plaintiff's condition is improving which is in line with the defendant's case that the facial nerve is paralysed and the paralyses improves with time.

[66] After the statement was put to the plaintiff under cross examination that he has function in blinking his left eye, I deemed it necessary to verify whether the plaintiff is indeed able to close his left eye. The evidence for the plaintiff continued to the next subject of cross-examination when I requested the translator, who was standing to the left of the plaintiff, to move and stand on the right hand side of the plaintiff. With this change in positioning, I had a complete and undisturbed view of the plaintiff's facial movements and more specifically his eye movements. My observation was that the plaintiff is able to move his left eye (the eye-

ball itself) when looking up or down. However, it was clear to me that the plaintiff's left eyelid did not blink, which is consistent with the findings of both parties' experts that the plaintiff cannot close his left eye. The movement of the plaintiff's eye-ball, and the subsequent movement of the eyelid in line with the movement of the eye-ball itself might have created the impression that the plaintiff had voluntary control over his left eyelid. As mentioned, my finding after observation confirms the reports of both parties' experts in relation to the existence of facial palsy in the left eye of the plaintiff.

[67] Doctor Mabaso continued in his report to find that the plaintiff is unable to blow and depress his left cheek due to a weakness to his buccinators muscle which is innervated by the buccal branch of the facial nerve. Doctor Mabaso also finds that the plaintiff is unable to control his left lower lip because of a loss of function of the left depressor labii inferioris, depressor anguli oris and mentalis muscles due to loss of function or innervations of the left marginal mandibular branch of the facial nerve. In both experts' reports it have been emphasised that all the branches of the left facial nerve have been affected and that the plaintiff has facial palsy due to the failure of the left facial nerve to function properly.

[68] In his evidence, professor Pantanowitz stated that there is no prospect of the facial nerve regaining function, some 7 years after the surgery. According to professor Pantanowitz the current state of the plaintiff's

facial palsy is also indicative there-of that the trunk of the facial nerve was injured, or severed, during the surgery. Professor Pantanowitz persisted in cross-examination that any other cause of the palsy would be highly unlikely as the facial palsy occurred directly after the surgery.

[69] When conducting a factual enquiry in establishing whether the onus of proof has been met, all other available and independent evidence must be regarded objectively. This principle was confirmed by the Supreme Court of Appeal in the matter of **Anglo Platinum Management Services (Pty) Ltd v Commissioner, South African Revenue Service** 2016 (3) SA 406 (SCA) on page 411:

> *"[10] It is a question of fact in each case whether a salary sacrifice agreement was achieved. In this regard a court is not concerned with the subjective belief of the parties to the agreement — no matter how genuine this belief may be — but with whether the facts, objectively viewed, establish that this result was attained. It must thus consider the oral and documentary evidence to assess the probabilities. The taxpayer bears the burden of proving that the Commissioner's decision to disallow its objection to the assessments was wrong. And where, as in this case, the taxpayer's is the only oral evidence, it must be considered carefully in the light of the available documentary evidence, before a court is able to conclude whether or not the taxpayer has discharged the onus."*
>
> (own emphasis)

See: **Erf 3183/1 Ladysmith (Pty) Ltd and Another v Commissioner for Inland Revenue** 1996 (3) SA 942 (A) at 950I – 951C.

[70] I have had regard to the hospital records, the medical expert reports as well as the evidence of the plaintiff, the surgeon doctor Seape and professor Pantanowitz.

[71] The hospital records and both expert reports support the case of the plaintiff that the facial nerve has indeed been injured or severed.

[72] Counsel on behalf of the defendant argued that the facial nerve has not been damaged or severed due to the fact that professor Pantanowitz conceded that he is not a neurologist and he did not do a nerve conducting study or examined the actual facial nerve. I cannot find this to be a valid argument. The damage of the nerve can be established by clinical examination of the plaintiff, which professor Pantanowitz confirmed he has done.

[73] Counsel on behalf of the defendant further argues that, due to the absence of a nerve conducting study or examination of the physical nerve, the conclusions of professor Pantanowitz are based on speculations and should accordingly be found inadmissible. This argument similarly holds no water. Two clinical assessments,

conducted by both parties' medical experts, confirmed damage to the nerve.

[74] Having observed the plaintiff during the rendering of his evidence as well as his communication with me when obtaining permission to inspect the surgical scar in the judges' chambers, there is no doubt in my mind that the facial nerve has been damaged or severed.

[75] The plaintiff has mentioned some improvement to the facial palsy from after the surgery to the trail, but it is so marginal over some 7 odd years that I cannot find that there is any room for further improvement or full recovery. This was also confirmed by professor Pantanowitz. The deformity of the plaintiff's face, due to the lack of facial muscle use, furthermore confirms that the facial nerve would in all probabilities not recover.

[76] I subsequently find that the plaintiff's left facial nerve has indeed been injured or severed and is not paralised.

Causality between the nerve palsy and the surgery

[77] Having found that the facial nerve of the plaintiff has been severed or injured and not paralysed, the next enquiry is whether the actions or inactions of the surgeon during the surgery caused the facial nerve palsy.

[78] The success of a delictual claim is subject to proof of a causal link between a defendant's actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand. The test utilised in establishing such a link, has been dubbed the 'but-for' test. Legal causation has to be established by the plaintiff on a balance of probabilities.

[79] The plaintiff testified that this facial palsy started directly after the surgery, when he woke up in the hospital room. The hospital records dated 23 May 2013, some 2 days after the surgery, reflect that the plaintiff is unable to close his left eye. The hospital records of 24 May 2013 also reflect that the plaintiff is unable to properly close his left eye. Counsel on behalf of the defendant argued that the absence of any record reflecting facial palsy on the day of the surgery or the day there-after, is indicative there-of that the facial nerve was not injured during the surgery.

[80] Both doctor Seape and professor Pantanowitz agree that it might have been difficult to diagnose facial palsy right after surgery, as the plaintiff's jaw was swollen and covered with bandages.

[81] On 22 July 2013 it is written in the hospital records by doctor Seape that "*VII nerve palsy following the surgery"*. This inscription is indicative thereof that doctor Seape links the nerve palsy to the surgery. In

addition thereto, the fact that it has been recorded that the plaintiff is unable to properly close his left eye 2 and 3 days after the surgery, is further indicative thereof that the facial palsy is most probably resultant from the surgery.

[82] Doctor Mabaso (the expert for the defendant) finds that he is unable to correlate the weakness of the zygomatic and buccal branch of the left facial nerve with the surgical procedure that was performed to remove the left submandibular gland without adequate hospital records, especially surgical notes preoperatively and postoperatively.

[83] Doctor Mabaso thus cannot find any causation of the damage in the facial nerves in relation to the surgery without preoperative surgical notes. The postoperative notes in the form of hospital records do exist, and it is unknown whether Doctor Mabaso has had sight of the notes in the light of his comment that he required surgical notes postoperatively. Doctor Mabaso was not called to testify.

[84] The Supreme Court of Appeal confirmed in **Jacobs and Another v Transnet Ltd t/a Metrorail and Another** 2015 (1) SA 139 (SCA) in paragraph 14 that, where the high court was faced with conflicting expert opinions, it is for the court to decide which, if any, to accept. This principle was also referred to in **Buthelezi v Ndaba** 2013 (5) SA 437 (SCA) para 14.

[85] The value of expert reports during trials have recently been discussed by Davis J in **Modise obo a Minor v Road Accident Fund** 2020 (1) SA 221 (GP) as follows:

> *"Expert reports are, unless an agreement has been reached between the parties, simply what they purport to be — an opinion expressed by a person who, by virtue of his qualifications and expertise, is regarded as an expert in a specific field, which renders his opinion admissible and which opinion and conclusion might assist a court in adjudicating a case.*
> *See* ***Holtzhausen v Roodt*** *1997 (4) SA 766 (W) and* ***Visagie v Gerryts en 'n Ander*** *2000 (3) SA 670 (C)."*

[86] In the joint minutes both medical experts agree that it is unacceptable to transect the trunk of the facial nerve during a surgery to excise the submandibular gland. Professor Pantanowitz on behalf of the plaintiff, qualified this agreement in his evidence that the facial nerve cannot be damaged, or reached, during a submandibular gland excision. This is so since the submandibular incision (under the jaw) is a distance away from the facial nerve trunk (under the earlobe). Having found that the facial nerve has been injured, and both experts agree that injury cannot result from a submandibular surgery, it follows that the plaintiff in all probabilities did have a submandibular excision that extended to the parotid gland.

[87] It is trite that the court must regard the evidence rendered during the trail as a complete unit and not be distracted or focussed on isolated evidence rendered by experts. This principle was again confirmed recently in the matter of **Life Healthcare Group (Pty) Ltd v Suliman** 2019 (2) SA 185 (SCA) as follows:

> *"[15] Judges must be careful not to accept too readily isolated statements by experts, especially when dealing with a field where medical certainty is virtually impossible. Their evidence must be weighed as a whole and it is the exclusive duty of the court to make the final decision on the evaluation of expert opinion."*

[88] In the matter of **Minister of Justice and Constitutional Development v X** 2015 (1) SA 25 (SCA) the test for determining negligence were confirmed as follows:

> *"[20] The test for determining negligence was formulated as follows by Holmes JA in **Kruger v Coetzee** 1966 (2) SA 428 (A) at 430E – F:*
>
> *'For the purposes of liability culpa arises if*
>
> *(a) a diligens paterfamilias in the position of the defendant —*
>
> *(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss;*
>
> *(ii) would take reasonable steps to guard against such occurrence; and*
>
> *(b) the defendant failed to take such steps.'*

[21] As emphasised by Harms JA in Carmichele (SCA) para 45, it 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. See also ***Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another*** *2000 (1) SA 827 (SCA) ([2000] 1 All SA 128) para 21."*

[89] The Constitutional Court has confirmed that the requirements for causality is to be established on a balance of probabilities in **Oppelt v Department v Department of Health, Western Cape** 2016 (1) SA 325 (CC) as follows:

"[35] A successful delictual claim entails the proof of a causal link between a defendant's actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand. This is in accordance with the 'but-for' test. Legal causation must be established on a balance of probabilities. The vital question is whether, as a matter of probability, the applicant's paralysis would not have occurred or been rendered permanent had the reduction procedure been performed promptly and within a time that was reasonably likely to prevent permanent quadriplegia. The answer lies in the Supreme Court of Appeal's evaluation of the expert medical testimony.

[36] The correct approach to the evaluation of medical evidence is the one laid down by the Supreme Court of Appeal in ***Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*** *2001 (3) SA 1188 (SCA) where it held that —*

'it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised.

. . .

Although it has often been said in South African cases that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field, that criterion is not always itself a helpful guide to finding the answer.

. . .

That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of ***Bolitho v City and Hackney Health Authority*** *[1997] UKHL 46; [1998] AC 232 (HL(E)). With the relevant dicta in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.*

The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion (at 241G – 242B).”

[90] Further, also in **Oppelt v Department of Health, Western Cape** 2016 (1) SA 325 (CC) it is specified in paragraph 48 that the 'but for' test requires flexibility and a common-sense approach when the issue of causation has to be decided on the ground of an alleged negligent omission, as opposed to a negligent commission:

> *"[48] While it may be more difficult to prove a causal link in the context of a negligent omission than of a commission, Lee explains that the "but-for" test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the but-for test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible.*
> *Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."*

[91] The scar on the plaintiff's neck provides valuable evidence and an indication of the incision made for the surgery and the extent of the surgery.

[92] Regarding the physical examination of the plaintiff in chambers, as well as the evidence of both professor Pantanowitz and doctor Seape, I find that the scar remaining from the incision starts at point "A" and splits in a "Y" under the left jaw and ear. The one leg of the "Y" ends in position

"B" with an upward curve to the plaintiff's ear, and the second leg of the "Y" ends in position "C". I find the line on the plaintiffs jaw which goes up to the plaintiff's ear, to be a scar and not a skinfold as testified by the defendant's witness, doctor Seape.

[93] Any incision that was made under the left ear of the plaintiff, would risk injury to the facial nerve. As I have found the line from point "A" to "C" to be a surgical scar and not a skinfold, and a surgical scar is proof that an incision was made, it follows that the surgery in all probabilities extended to the parotid gland.

[94] In **Minister of Safety and Security v Van Duivenboden** 2002 (6) SA 431 (SCA) para 25 the court held 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, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.'*

[95] Factual causation can be difficult to prove. It was held in the Supreme Court of Appeal in **Life Healthcare Group (Pty) Ltd v Suliman** 2019 (2) SA 185 (SCA) that factual causation must be demonstrated in that *"but for"* the doctor's action or inaction harm would not have occurred. The question to be asked is whether the plaintiff would have suffered with left facial palsy, had the surgery been conducted by a reasonable

precautious surgeon whom has had proper regard to the facial nerve stem.

[96] In the event that the origin of the facial palsy is a stroke, or Bell's palsy, the facial palsy would have occurred irrespective of the surgery. There is no evidence before court to find that the facial palsy had any other origin than the surgery. The statements made during cross-examination of the plaintiff's expert witness, does not constitute evidence in itself. The plaintiff's version remained constant.

[97] Doctor Seape is not an independent witness as he was the surgeon conducting the surgery. He reasonably conceded that he has no independent recollection of the surgery itself which was more than 7 years ago.

[98] The evidence of professor Pantanowitz is more probable, namely that the surgeon has made the incision, removed the submandular gland and may have been unsure whether the complete tumour was removed. This is particularly so due to the fact that the tumour was completely encapsulated in the submandibular gland and the surgeon would not have been able to physically see the tumour which was inside the submandibular gland.

[99] The documentary evidence supports the evidence of professor Pantanowitz and not that of doctor Seape. The hospital records, the

surgical scar of the plaintiff and the oral evidence of the plaintiff and professor Pantanowitz are sufficient to discharge the onus that rests on the plaintiff.

[100] In short, the plaintiff has proven that the surgery to the submandibular gland caused the facial palsy. The next investigation is for this court to determine whether the damage to the facial nerve was caused negligently.

[101] The plaintiff put up a case for the defendant, which the defendant is called on to answer.

[102] In **Stargrow (Pty) Ltd v Ockhuis and Others** 2018 (1) SA 298 (LCC) p 309 – 310 the question of *prima facie* proof provided by the applicant, were found as follows:

> *"[53] The necessary consequence of this is that if an applicant, in an application for eviction under ESTA, contends in the first instance that the respondents are not ESTA occupiers, it needs to allege and put up evidence (at least of a prima facie nature) of this. Such prima facie evidence would generally call for an answer on the part of the respondents which would place an evidentiary burden upon them. If not effectively answered, the prima facie evidence put up by the applicants would become sufficient proof that the respondents are not ESTA occupiers."*

[103] The defendant's case that the palsy had some other origin, not relating to the surgery, is not supported by any hospital records, other evidence

or expert opinion. It was also not pleaded by the defendant that the facial palsy was caused independent of the surgery. The plea of the defendant is a bare denial and the plaintiff is put to the proof of his claim.

[104] Counsel for the defendant argued that a stroke or Bell's palsy could have caused the facial palsy. It is so that the plaintiff did have high blood pressure, as indicated in the hospital records. Despite recording the high blood pressure, there is no indication that the plaintiff suffered from a stroke. None of the medical personnel who examined the plaintiff after the surgery made any mention that the high blood pressure puts the plaintiff at risk of a stroke.

[105] There is no basis for any finding that a stroke was the cause of the facial palsy. In contradiction thereto, several doctors, including doctor Seape himself, linked the surgery to the facial palsy.

[106] In relation to the argument by defendant's counsel that the facial palsy can be as a result of Bell's palsy, it was testified by professor Pantanowitz that the symptoms of the palsy would improve over time. Professor Pantanowitz testified that the initial diagnosis of facial palsy would exhibit similar symptoms than facial nerve palsy after the surgery. He did however qualify that statement in saying that Bells' palsy would improve over a period of time, and had the plaintiff suffered

from Bell's palsy, he would have completely or very close to completely, recovered.

[107] The defendant further pleaded that damage to the facial nerve branches is a known complication of surgery involving the parotid gland region. It was, however, not the defendant's case that there was surgery to the parotid gland. On trial, the evidence of the defendant was that a submandibular gland excision was performed. As such, it is not the defendant's case that nerve palsy was a known complication of the surgery, as the defendant insisted that surgery was performed on the submandibular gland. The evidence of doctor Seape, in as far as he testified that he recalled the surgery, was that the surgery was definitely limited to the submandibular gland.

[108] Had the surgery been to the parotid gland, the risk of complications would be much higher and the surgeon performing such surgery should have identified the facial nerve intraoperatively and should have taken definitive steps to isolate and preserve the facial nerves and facial nerve trunk. This was not the evidence of doctor Seape, as the same precautions and risks do not exist with a surgery of the submandibular gland.

[109] In **Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another** 2001 (3) SA 1188 (SCA) the Supreme Court re-emphasised that the question of reasonableness and negligence is one for the court

itself to determine on the basis of the expert opinions presented. The court has to examine the opinions of the experts and analyse their essential reasoning, and on that basis reach its own conclusion.

[110] Doctor Seape conceded that he could not recall whether he was the surgeon performing the surgery, or whether it was doctor Pratt who performed the surgery under his guidance. Doctor Seape also struggled to explain why the theatre notes incorrectly refer to the stensons duct which is part of the parotid gland. I cannot find that a senior surgeon with 18 years of experience in the surgical field, will easily confuse the stensons duct with the whartons duct. I can furthermore not accept the evidence of doctor Seape that the surgical scar up to “B” is a skinfold.

[111] The probabilities that the surgery started off as an excision of the submandibular gland and then ventured to the parotid gland is overwhelming. In application of the principle set out above in **Minister of Safety and Security v Van Duivenboden** 2002 (6) SA 431 (SCA), I find that the plaintiff has established a causal link that the wrongful conduct was probably the cause of the plaintiff’s loss of his left facial nerve. I have made a sensible retrospective analysis of what could probably have occurred, based on the evidence presented and what can be expected to occur in the ordinary course of a surgery to remove a tumour in one (or more) of the salivary gland(s).

[112] As confirmed in **Daniels v Minister of Defence** 2016 (6) SA 561 (WCC) the standard of care the courts expect from a surgeon is not the highest standard but rather a reasonable standard. The degree of care and skill expected of a diligent medical practitioner in the position that the defendant's employees found themselves, namely as doctors treating a patient with a tumour referring to under his left ear is not that of a reasonably skilled practitioner. A reasonably skilled surgeon would have taken the necessary precautions should the surgery have to extend to the parotid gland.

[113] Professor Pantanowitz testified that the incision for a surgery to the parotid gland would be done in front of the ear to minimise any possible damage to the facial nerve. This was not done, as the incision was done from below, extending in one leg of the “Y” right under the plaintiff’s left earlobe, which is where the trunk of the facial nerve is situated. This incision from below did not carry with it the normal safety measures when operating on the parotid gland: the incision should be done in front of the ear with identification of the nerve stem before removing or cutting from the parotid gland. When cutting from below, it would be difficult to identify the facial nerves situated in the parotid gland.

[114] I find that the medical personnel at the Far East Rand Hospital had conducted themselves negligently in that the injury to the plaintiff’s

facial nerve could have been avoided, had reasonable care been taken when the surgery ventured near the parotid gland.

I make the following order:

1. The defendant is liable to the plaintiff for 100% of his proven or agreed damages caused as a result of the surgery on 21 May 2013.

2. The issue of *quantum* is postponed *sine dies* by agreement between the parties.

3. The defendant is ordered to pay the costs of the plaintiff on a scale as between party and party, including but not limited to:

a. The reasonable costs of the report of professor Pantanowitz;
b. The preparation costs of professor Pantanowitz including the cost of the joint meeting with doctor Mabaso;
c. The reasonable costs of expert reports and consultations; and
d. The cost of the interpreter during the evidence of the plaintiff.

_____

FMM SNYMAN, AJ
ACTING JUDGE OF THE HIGH COURT

DATE OF HEARING: 17 TO 21 FEBRUARY 2020
DATE OF JUDGMENT: 6 MAY 2020

JUDGMENT HANDED DOWN ELECTRONICALLY DUE TO COVID 19 RESTRICTIONS

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