HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, JOHANNESBURG)

(1) REPORTABLE: Electronic reporting only
(2) OF INTEREST TO OTHER JUDGES: No.
(3) REVISED.

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DATE SIGNATURE

Case no: 00790/15

In the matter between:

ADV S M N.O. Plaintiff
(as curator ad litem obo NS)

and

MEC FOR HEALTH, PROVINCE OF GAUTENG Defendant

Case Summary: **Medical Negligence – whether failure to diagnose osteomyelitis of the left tibia earlier constitute negligence *in casu*.**

JUDGMENT

MEYER J

[1] This is a delictual claim for damages instituted by the plaintiff in his representative capacity on behalf of his minor son (to whom I shall refer as NS or the plaintiff's son), who sustained a minor injury to his left ankle during January 2012 when

he was skateboarding. He subsequently developed chronic osteomyelitis of his left tibia which eventually resulted in a pathological fracture developing. He has been left with a deformity of his left tibia with shortening. The claim arose from the failure of the casualty officers employed at the Rahima Moosa Mother and Child Hospital to diagnose the osteomyelitis at an earlier stage. Osteomyelitis is an infection of the bone, which can happen if a bacterial or fungal infection enters the bone tissue from the bloodstream. The matter presently only concerns the issues pertaining to the defendant's liability; the quantum of damages allegedly suffered by the plaintiff's son was ordered to stand over for later determination at the commencement of the trial.

[2] The defendant is the member of the executive committee for the department of health, Gauteng. It is common cause that the defendant would be vicariously liable for any negligent treatment or diagnosis of NS by the medical doctors and staff of the Rahima Moosa Hospital. The case centres on medical expert evidence and the conflicting views of two orthopedic surgeons, dr GA Versfeld, who gave expert evidence on behalf of the plaintiff, and dr M Eltringham, who gave expert evidence on behalf of the defendant. The plaintiff also testified, and the defendant called drs P Nair and A Radionova, who were the casualty officers on duty in casualty at the Rahima Moosa Hospital during the nights on 2 February 2012 and 14 February 2012 respectively.

[3] The matter is vexed by the fact that, according to the hospital records, NS suffered from recurring tonsillitis. In fact, he had a long history of tonsillitis. He was treated for tonsillitis after his ankle injury and a diagnosis of osteomyelitis was entertained only later. The general symptoms of tonsillitis and osteomyelitis are similar. The critical question is whether the failure to diagnose osteomyelitis earlier amounted to negligence which was the cause for NS's ultimate condition.

[4] The legal principles relating to professional negligence are trite. They were concisely stated in *Topham v Member of Executive Committee for the Department of Health, Mpumalanga* [2013] ZASCA 65, thus:

'Professional negligence is determined by reference to the standard of conduct of the reasonably skilled and careful practitioner in the particular field and in similar circumstances. A medical practitioner diagnosing and treating a patient is expected to adhere to the general level

of skill, care and diligence possessed and exercised at that time by the members of the branch of the profession to which he or she belongs. It follows that a wrong diagnosis does not per say amount to negligence on the part of the medical practitioner concerned. It will only be negligence if the practitioner's conduct does not comply with the general standard of care to which I have referred.'

(Footnote omitted.)

[5] The plaintiff testified that on Sunday, 22 January 2012, his son fell off his skateboard and bumped his left ankle. The plaintiff believed that it was a minor injury and did not take him for medical treatment. However, because his son's foot became swollen and he was complaining of pain, he took him to the Rahima Moosa Hospital on Wednesday, 25 January 2012. There he was just given a Panado and sent home. The swelling remained the same and he kept on complaining of pain during the next few days. The plaintiff therefore took him back to the Rahima Moosa Hospital around seven or eight in the evening on 28 January 2012. He was not seen by a medical doctor, but only by a nursing sister who gave him no treatment, no medication and merely sent him home. Because the pain persisted, the plaintiff took his son back to the Rahima Moosa Hospital during the afternoon on 31 January 2012, where he was seen by a doctor, x-rays were taken, and the doctor advised him that there was no fracture. His ankle and foot were placed in a backslab, he was given crutches, and sent home. I interpolate to mention that a backslab is used as a treatment to immobilize a limb. It is a type of cast that is non-circumferential, only covering the posterior aspect of the limb. It is held in place by wrapping a bandage around it. The plaintiff testified that no medication was given, and he was told to bring his son back to the hospital in two weeks' time if the pain persists. The pain persisted, his son's foot became more swollen and it appears that the blood was not circulating. He therefore took his son back to the Rahima Moosa Hospital on 2 February 2012. He was not seen by a doctor, but only by a sister. He asked her to remove the backslab and to see what was going on with his son's foot, because it seems to him that the blood was not circulating, the foot was getting more swollen and it seems the backslab was too tight. The sister refused and sent him home. His son received no treatment and no medication.

[6] The plaintiff, his wife and their son, NS, reside in a cottage on a property in Fairland. On Tuesday, 14 February 2012, the plaintiff's wife asked the daughter of the owner of that property, Ms Jeanine Schoeman, an occupational therapist, to remove the backslab and to have a look at what was going on underneath the bandage and the backslab, because NS was crying of pain. Ms Schoeman, who also testified, observed that the bandage was wet and smelling. Once she had removed the backslab, she observed that his leg was swollen with blisters. She advised the plaintiff's wife that NS needed to see a doctor. That evening the plaintiff took him back to the Rahima Moosa Hospital. The first person he met at the hospital was the nursing sister who 'chased' them away on 2 February 2012. He was told that they cannot help him and that he must take his son to a different hospital. He was given a referral letter to the Charlotte Maxeke Johannesburg Academic Hospital. The plaintiff took his son to that hospital where he was seen by a doctor and an x-ray of his ankle was taken. He was then referred to the Helen Joseph Hospital and the plaintiff was given a referral note. They arrived at the Helen Joseph Hospital early in the morning on 15 February 2012 where NS was seen by doctors in the emergency department. They spoke amongst themselves and then told the plaintiff that the damage was done and that they must go back to the Rahima Moosa Hospital. They went back to the Rahima Moosa Hospital on 15 February 2012 where NS was admitted and received surgery. The next day he underwent another surgical procedure.

[7] A materially different picture emerges from the Rahima Moosa Hospital records, the attending casualty officers' clinical notes and the evidence of two of the attending casualty officers, drs Nair and Radionova. There are no clinical notes or hospital record to support the plaintiff's version that NS attended or was seen at the Rahima Moosa Hospital on 25 January 2012. I accept, as was also conceded by dr Nair when she was cross-examined, that documents get lost and are misfiled in public hospitals and that it is possible that the casualty clinical note relating to NS's alleged attendance on 25 January 2012 could have been lost or misfiled. But dr Radionova testified that the particulars of every patient who attends at casualty are entered in the casualty registration book where his or her complaint or complaints are also entered as well as the result of the attendance. Dr Eltringham testified that he went thoroughly through all

the hospital records pertaining to NS and looked very carefully for evidence of an admission form being filled out for NS as an outpatient of casualty on 25 January 2012, for any nursing notes that were possibly made or any prescription note that were possibly made and he could find none prior to the 28th January 2012.

[8] From the casualty records it appears that NS's first presentation at the Rahima Moosa Hospital regarding the event in question was at approximately 20h50 on Saturday evening, 28 January 2012. He was brought in by his father with a history of a temperature for one day having injured his leg falling off his skateboard two days before. He complained of a painful swollen left ankle as well as constitutional symptoms. The attending casualty officer on the Saturday night performed a clinical examination and noted that he had tonsillitis, was walking on the limb with minimal swelling, the range of movement in the ankle was reduced and that the medial malleolus was tender; ' ++tender medial malleolus'. The attending casualty officer diagnosed a soft tissue injury and an upper respiratory infection with acute tonsillitis and prescribed Ibugesic 10 ml (Brufen) and Augmentin 250 mg that was changed to Amoxil 500 mg. NS was requested to come back to the hospital, possibly for an x-ray, if the pain or swelling in his leg persists.

[9] NS indeed returned to casualty on Tuesday, 31 January 2012. The attending casualty officer recorded in his clinical note that there was no improvement of the ankle and it was still swollen and painful. He referred NS for x-rays of his left ankle and tibia, which showed no fracture. He was diagnosed with having a sprain and treated by immobilizing his left lower leg in a backslab and providing him with crutches to allow partial weight bearing. He was advised to go to the Orthopaedic Outpatient Department in two weeks' time for review.

[10] The plaintiff took his son to casualty on 2 February 2012 when he was seen by dr Nair at 09h45. The nursing staff noted on the casualty note that he had a temperature of 39 degrees, a pulse of 132 and blood pressure of 105/74. According to her casualty clinical note, dr Nair recorded that he was complaining of fever, vomiting and diarrhea for one day. The diarrhea occurred once and was yellow. The vomiting was non-projectile and without blood. She recorded that he had been on Amoxicillin for the past

four days for tonsillitis, which has not improved. Under the heading medical history she recorded that he presented with tonsillitis two to three times a year, that no abnormalities were detected with his growth milestones, that he had a previous fracture of the right arm with surgery, that he was on Ritalin possibly for being hyper-active. Under the heading clinical findings she recorded that he was a 'sick looking child', his left lower limb was in plaster of paris, he had normal heart sounds and no murmurs, he had fever, his chest was clear, his abdomen was soft and non-tender and her ear nose and throat clinical examination revealed that he had bilateral tonsillitis with gastro-enteritis. She modified the antibiotics prescribed for his tonsillitis four days ago to a seven day course of Ciprofloxacin 250 mg instead of the Amoxil, and she also prescribed Panado, Brufen, and Disprin to gargle with. This appears from the written prescription that she completed and signed.

[11] Dr Nair obtained the MBChB degree in 2009, then did two years internship at Steve Biko Academic Hospital and she started at the Rahima Moosa Hospital during January 2012, initially as a casualty officer and at present she is a qualified obstetrician and gynaecologist. On 2 February 2012 her shift in casualty commenced at 8.00 pm and ended the next morning at 8.00 am. Dr Nair, understandably (many thousands of patients are seen annually in casualty at the Rahima Moosa Hospital), does not have an independent recollection of her examination of NS but relies on her casualty note. In response to the plaintiff's version that was put to her when she was cross-examined that NS was not seen by a doctor on 2 February 2012, but only by a sister who refused his request to remove the backslab to see whether there was a problem when she had been asked to do so and instead sent him home, she said that she always introduces herself to patients, and she continued to say:

'. . . I am the casualty doctor, I would not make up notes. This is a note that I cannot even remember that I had written on the 2nd of February. Why would I make up notes on a patient? I have definitely seen this patient, I have examined the patient, sat with the patient, taken a full history of the patient and examined the patient from head to toe and made a diagnosis, and prescribed medication'.

She confirmed that she had completed the clinical note relating to NS's presentation at casualty on 2 February 2012 as well as the written prescription, and that she signed both.

[12] Dr Nair testified that the first person a patient would make contact within casualty is an attending nurse. The nurse takes the vital signs – temperature, pulse and heartbeat - and 'do what nurses are supposed to do'. Once that has been done, the casualty officer sees the patient in one of the cubicles that are in casualty for that purpose, obtains his or her medical history and examines the patient 'from head to toe'. The complaint, as recorded in her casualty note, with which NS presented was fever, vomiting, and diarrhea for one day. She is adamant that had there been any complaint relating to his ankle injury or had there been a request for her to remove the backslab because his leg was swollen or he felt numbness or had he presented with excruciating pain in his leg, she would have recorded that in her clinical note as part of the history and paid more attention to the leg. The ankle had already been attended to and was, according to her, not a presenting complaint. But, as recorded by her in the casualty note, NS presented with a specific complaint, which was that he had been to casualty four days before and prescribed Amoxicillin for tonsillitis, which was not getting better, and that he, at the time when he was seen by her, had fever, vomitting and diarrhea for a day. Furthermore, she was told, as recorded by her, that he has a history of recurring tonsillitis two to three times a year.

[13] Dr Nair testified that when a patient presents with complaints of fever, vomiting and diarrhea, the attending casualty officer seeks the source of the infection. It is a general complaint by many children who attend at casualty and casualty officers try to figure out the source of the infection from a variety of possible sources. She, as recorded in her clinical note, examined NS to find the source of the infection that caused him to have fever, vomiting and diarrhea at the time. On examination of his ears, nose and throat, she found bilateral inflamed tonsils, which is tonsillitis. She found that the tonsils were still inflamed despite the use of Amoxicillin for the past four days. The antibiotic prescribed four days before, in her view, was not working for NS. She accordingly escalated the Amoxicillin to a broader spectrum antibiotic, Ciprofloxacin,

and also prescribed Panado, Brufen and Disprin to gargle with. In her view, she did a full examination of NS, including an ear nose and throat examination, pinpointed what she thought the cause of the infection was, and addressed it.

[14] NS presented back to casualty at approximately 8.00 pm on 14 February 2012. This time he was seen by dr Radionova. The history provided to dr Radionova as recorded in the referral note referring NS to the Charlotte Maxeke Johannesburg Academic Hospital, was *inter alia* that NS bumped himself on a skateboard and that he was complaining of ankle swelling and pain. She recorded the medication that was prescribed to him (Ciprofloxacin, etc.) and the reason why she was transferring him was for him to have a surgical consultation, because the 'wound is pretty septic'.

[15] Dr Radionova qualified as a medical doctor in the Ukraine in 1990. She has been working as a casualty officer in the casualty department of the Rahima Moosa Hospital since 2005. She too does not have an independent recollection of the attendance of the plaintiff and his son at casualty during the evening on 14 February 2012 when she was the attending casualty officer on duty and needed to rely on the hospital records. She testified that her provisional diagnosis was one of a soft tissue injury; a septic wound on the left ankle. She did not suspect any bone injury. She dressed the wound and prescribed an intra-vascular injection of Rocephin that was to be administered by the nursing staff. The prescription is documented and signed by her. Rocephin, according to dr Radionova, is a strong broad-spectrum antibiotic. It is the strongest one that was available in casualty at the Rahima Moosa Hospital. The reasonableness of the medical treatment to administer a single dose of intra-muscular Rocephin to initiate antibiotic therapy does not seem to be in issue. Dr Radionova testified that because the wound was becoming septic she wanted a proper diagnosis, which only a specialist could give, as soon as possible and not merely her own provisional diagnosis. She therefore referred NS for a surgical consultation at the Charlotte Maxeke Johannesburg Academic Hospital. Later that evening NS was indeed seen by a pediatric surgeon at the Charlotte Maxeke Johannesburg Academic Hospital who diagnosed him with a bone injury, osteomyelitis, and he was transferred to the Helen Joseph Hospital for surgery. Dr Radionova testified that had she suspected a

bone injury, she would have referred NS to the Helen Joseph Hospital, because it is best equipped to deal with orthopedic medical problems.

[16] The hospital records show that NS arrived at the Charlotte Maxeke Johannesburg Academic Hospital at about 11.00 pm on 14 February 2012 where he was seen by a surgeon and referred to the Helen Joseph Hospital. It is undisputed that the Charlotte Maxeke Johannesburg Academic Hospital has a strict admission policy. He arrived at the Helen Joseph Hospital at about 3.00 am on 15 February 2012 and was later referred back to the Rahima Moosa Hospital. He arrived at the Rahima Moosa Hospital at about 7.00 am, was admitted at 11.00 am and a surgical procedure in the form of an incision and drainage was performed on him from about 12.00 pm for the osteomyelitis of the tibia. A large abscess from his tibia and ankle joint was drained. The following day he was taken back to theatre for a relook and debridement of the surgical wound. Drs Eltringham and Versfeld are *ad idem* that the treatment that was given to NS on 15 and 16 February 2012, was appropriate medical treatment.

[17] Dr Eltringham is of the view that the original presentation of NS at casualty on 28 January was handled in a very acceptable manner. The attending casualty officer assessed him as having had a minor soft tissue injury to his left ankle and, because of the history of a temperature, the casualty officer looked carefully and after a thorough examination felt that he had tonsillitis, which he has had a recurrent history, and that the tonsillitis was the cause of his pyrexia. Appropriate medication and therapy, in the view of dr Eltringham, were prescribed. Dr Versfeld disagrees that NS was appropriately treated on 28 January, because there is no indication that he was complaining of tonsillitis. NS was complaining of a painful ankle and dr Versfeld believes that his symptoms were coming from the osteomyelitis affecting his tibia. The attending casualty officer, in the view of dr Versfeld, failed to take notice of the bony tenderness of the medial malleolus. An ‘astute doctor’, in his view, would have realised that there were already features present which suggested that the treatment given was not appropriate.

[18] The repeat consultation on 31 January was, in the opinion of dr Eltringham, again performed in an acceptable manner; the leg was noted to be still painful and swollen

and an x-ray was taken to confirm that there was no bone injury. For the soft tissue injury to NS's leg he was appropriately provided with a pair of crutches and his leg immobilized in a plasters splint. An unsupported and unprotected ankle ligament injury or a substitute injury may lead to the increase in symptoms, because the injured area is repeatedly re-injured. Also, the swelling and pain will increase and therefore the correct treatment would be to immobilize on the assumption that it is an uncomplicated soft tissue injury. Dr Versfeld, on the hand, is of the opinion that all went drastically wrong on the 31st; the x-ray that revealed nothing should have alerted the attending doctor that 'something is not right here' and the doctor should have escalated the matter to an orthopaedic surgeon. Strains get better not worse with time. In his opinion a diagnosis of an ankle injury that is getting worse nine days later (from 22 January) as a soft tissue injury and the treatment with a pair of crutches and immobilization of the limb, are inappropriate and illogical. He is of the view that in the presence of no intervening injury (a fracture), a sprained ankle that appears to have been getting steadily worse should have indicated to the attending doctor that something was wrong and possibly a diagnosis of osteomyelitis or septic arthritis should have been entertained. Failing to do this, in his view, constitutes negligence.

[19] The presentation on 2 February at casualty was, in the view of dr Eltringham, probably confusing for the casualty officer in that NS presented with fever, vomiting and diarrhea. It was noted that he had been on antibiotics for tonsillitis for four days. The tonsillitis was still felt to be a significant problem. The casualty officer undoubtedly thought that the leg injury was being adequately treated with immobilization and crutches. A course of antibiotics was prescribed. In his opinion NS was appropriately treated for his presenting symptoms, particularly given his history of tonsillitis and the attending casualty officer's clinical diagnosis of bilateral tonsillitis. Accepting that this time NS was only seen by a nurse, who refused to remove the backslab and to look what was going on underneath it when she was requested to do that, but instead told the plaintiff and his son to come back in two weeks-time, dr Versfeld expressed the view that that was unacceptable and constitutes negligence. Again, in his view, a diagnosis of osteomyelitis should have been entertained. Furthermore, and having regard to the

casualty note of 2 February, dr Versfeld considers the examination and diagnosis as 'totally unreasonable',

'[b]ecause the man comes in, complaining of a leg problem and they have not examined the leg . . . the backslab was not removed. That was his complaint. That is what he came to the hospital for. He did not come to the hospital for tonsillitis.'

[20] Dr Versfeld's views that NS did not receive reasonable and appropriate medical treatment by the attending medical staff at the Rahima Moosa Hospital is on the one hand based on the account which he received from the plaintiff and his son, and on the other based on the medical records and particularly the clinical notes of the attending casualty officers. Dr Versfeld assumes that NS's ankle injury occurred on 22 February, that he attended at the Rahima Moosa Hospital on 25 January and thereafter again on 28 and 31 January and on 2 February. During that period, in his view, the leg symptoms seemed to have been deteriorating. Nine days after the injury an x-ray was taken and NS was advised that there was no fracture. It should, in the view of dr Versfeld, have been apparent to the doctor that something was wrong and that a diagnosis of osteomyelitis or septic arthritis should have been entertained. Insofar as dr Versfeld's views are based on the account of the plaintiff and his son he made certain material factual assumptions that have not been established. Dr Versfeld *inter alia* relies on the plaintiff's evidence that his son hurt his ankle on 22 January, that he took him to the Rahima Moosa Hospital for the first time on 25 January, that his son was never given any medication at the Rahima Moosa Hospital except for a Panado on 25 January, that his son was only seen by a nursing sister on 2 February who chased them away and refused to open the backslab on their request to see what was going on underneath it, and that his presenting complaint on each occasion when her attended at casualty was his painful and swollen left ankle.

[21] I do not consider the plaintiff a credible witness and his evidence on the controversial issues to be reliable. His evidence must be treated with caution. If he were to be believed, the clinical records and written prescriptions of the attending casualty officers on 28 January and 2 February were falsifications, and the evidence of Dr Nair a lie from beginning to end, even though she made a good impression in the witness stand and conceded that she gave no attention to NS's ankle other than to note

that it was immobilized. The plaintiff blames the medical staff at the Rahima Moosa Hospital for his son's present condition and is on a conspectus of the evidence clearly biased.

[22] Dr Versfeld's point of departure seems to be that NS's diagnosis of and treatment for tonsillitis was a red herring. Somebody with tonsillitis, in his opinion, would normally present with a sore throat and that there is no history of a sore throat recorded in respect of NS's presentations at casualty on the occasions in question. The plaintiff or his son did not complain of a sore throat or of tonsillitis, but of a sore ankle. In his view the attending doctors were negligent in not assessing and treating the problem that was presented to them, a painful swollen ankle. Dr Versfeld assumes, therefore, that NS did not present with tonsillitis. In this regard he states:

'Well, I believe that what temperature he had was related to the osteomyelitis and that the diagnosis of tonsillitis was really made on really flimsy grounds. I mean if you have got a patient who is not complaining of a sore throat, one wonders where the diagnosis came from.'

Dr Versfeld further assumes that the plaintiff and his son asked a nursing sister on 2 February to take the backslab off and that she refused to do that. Dr Versfeld says:

'Because the man comes in, complaining of a leg problem and they have not examined the leg. I mean no, they have not examined the leg, because the cast was not, the backslab was not removed. That was his complaint. That is what he came to hospital for. He did not come to hospital for tonsillitis.

[23] However, the plaintiff's evidence that his son only attended at the Rahima Moosa Hospital with complaints relating to his ankle during the relevant period, is refuted by the evidence of dr Nair and is improbable. She recorded his complaint in her clinical note on 2 February as one of fever, vomiting and diarrhea for one day and she testified that had he complained of his left leg or requested her to remove the backslab she would have recorded that in the clinical note. Furthermore, although the pertinent clinical notes indeed show that the plaintiff or his son did not complain of a sore throat or of tonsillitis when he attended at casualty on 28 and 31 January and on 2 and 14 February, it is apparent from the clinical notes of 28 January and of 2 February that the diagnosis of tonsillitis was made on the attending casualty officers' clinical examinations of NS. According to dr Eltringham - who has a special interest in pediatrics and whose

practice as an orthopedic surgeon is now about 80 to 90% pediatrics and who many years ago worked as a consultant in the pediatric unit at the Johannesburg General Hospital - children frequently do not complain directly of certain things. But moreover, he expressed the opinion that a person does not have to have a sore throat to have tonsillitis. Dr Nair explains that tonsillitis is the swelling of tonsils accompanied by fever. A sore throat is indicative of pharyngitis and not tonsillitis. Dr Versfeld concedes that he is not an expert on tonsillitis.

[24] The plaintiff's evidence that his son hurt his ankle on 22 January is not reliable. The history recorded by the attending casualty officer on 28 January was an 11 year old boy brought by dad with fever since a day ago; he bumped himself on a skateboard two days ago. I realise that the attending casualty officer who completed this clinical note was not called to testify, but this is the selfsame clinical note on which the attending casualty officer recorded his clinical diagnosis of tenderness on the medial malleolus, which, in the view of dr Versfeld, was the first sign of osteomyelitis, and on which the plaintiff strongly relies to establish negligence on the part of the attending casualty officers at the Rahima Moosa Hospital.

[25] The plaintiff's evidence that he and his son attended at the Rahima Moosa Hospital on 25 January is not supported by any of the documented evidence of that hospital. What is somewhat surprising to me is that it is not only the clinical note of the attending casualty officer on 25 January that is lost or mislaid but all the medical records pertaining to such alleged attendance.

[26] Relying on the plaintiff's evidence that he took his son back to the Rahima Moosa Hospital on 2 February and that he was only seen by a nursing sister who refused to take his backslab off despite the complaint that his leg was very painful and his foot very swollen and instead sent him home, dr Versfeld expressed the opinion that this 'was unacceptable that the nursing staff turned this child away, and this is negligence'. That evidence is false. It is refuted by the evidence of dr Nair and the objective evidence in the form of her clinical note and written prescription.

[27] The plaintiff's evidence that his son received no medication when he attended casualty at the Rahima Moosa Hospital is improbable. The medication prescribed to

him on 28 January, on 2 February and on 14 February is documented and both drs Nair and Radionova, who were the attending casualty officers on 2 February and on 14 February respectively, confirmed that they indeed prescribed the medication that they have documented. Dr Nair noted in her clinical note of 2 February that the patient was seen four days ago and on Amoxicillin for tonsillitis which has not improved. Every item prescribed by her in terms of the written prescription is ticked off twice. Dr Nair testified that in terms of the practice followed at the Rahima Moosa Hospital the ticking off of items of medication on a prescription indicate that the medicine was dispensed or issued. Dr Eltringham, who in his career worked at the Charlotte Maxeke Johannesburg Academic Hospital and at the Rahima Moosa Hospital, also testified that ticking off the medication is a convention that the majority of pharmacists use in the majority of hospitals as a method of confirming that the medicine has been dispensed or collected. Furthermore, according to Dr Eltringham, there were two occasions when hospital prescriptions were written out for NS and it would be unusual if the medicine would not have been provided to him. Dr Versfeld conceded that ticking off the items of medication on a prescription 'may indicate' that the medication was given to the patient and in response to dr Eltringham's view that the method of ticking off is confirmation that the medication was prescribed and dispensed, he said: 'Fair enough'.

[28] Moreover, the fact that NS did not get progressively worse rapidly, in the view of dr Eltringham, indicates that he may have taken the medication, despite the fact that his father states that no medication was ever given to his son. In the view of dr Eltringham, the treatment that was offered was probably administered and it suppressed the infection sufficiently to alleviate the symptoms. Once the antibiotic course was completed, after seven days, the symptoms would have rapidly increased again and that is why he presented at the Rahima Moosa Hospital on 14 February. Had he not had the antibiotics his symptoms would have rapidly increased prior to that date.

[29] Dr Versfeld is of the opinion that the outcome of the treatment of acute osteomyelitis in children depends on how rapidly the condition is treated. In its early stages, it is, according to dr Versfeld, a completely treatable condition and often all it requires is appropriate antibiotic treatment. The available literature gives a success rate

of ‘something like’ 90% if the condition is treated rapidly and correctly. Dr Eltringham agrees that osteomyelitis, if neglected, is more likely to be problematic. In his view, there is no guarantee that an earlier diagnosis of NS’s osteomyelitis would have changed the cause and outcome significantly in any way whatsoever. Not all acutely managed, acutely presenting osteomyelitis are resolved initially and in many instances especially in children, acute bone infection can progress onto chronic osteomyelitis as NS developed. However, he agrees that chronic osteomyelitis is less common when it is treated rapidly and correctly. But in his view, it would not be an unexpected outcome for acute bone infection in children to progress onto chronic osteomyelitis. Osteomyelitis does not always behave the same in every individual.

[30] The correlation between a sprained ankle, a sore ankle, and an infection (osteomyelitis) is, in the opinion of dr Eltringham, an unusual one. In other words, osteomyelitis associated with ankle sprain is very uncommon. Most osteomyelitis in his view does not have a preceding history of trauma. Osteomyelitis following NS’s ankle injury is thus an uncommon occurrence. Dr Eltringham testifies that in his career as an orthopaedic surgeon he has only seen three or four, or maybe four or five, children who have presented with trauma and developed subsequent osteomyelitis in the area of the preceding trauma. It is, in his view, not a common presentation. On the other hand, soft tissue injuries around the ankle are commonly seen in casualty departments. Many children sprain their ankles and they are often getting injured. But very few of them are complicated by developing an infection. Tonsillitis too is a relatively common presenting problem especially in hospitals such as Rahima Moosa, which hospital serves the community at large and is not a specialist referral centre.

[31] Orthopedic surgeons, according to dr Eltringham, are often teased for not examining the rest of the patient, but rather concentrating on limbs or bones. Some casualty officers are career casualty officers and have tremendous experience and others are relatively junior and inexperienced. The expertise of casualty officers (who frequently deal with sprained and twist ankles and few are complicated by developing infection, as well as tonsillitis) and orthopedic surgeons are different. They would have examined a patient such as NS with a very different perspective to a generalist. Dr

Versfeld is also of the view that an orthopedic surgeon or a pediatrician would have been in a better position to make the diagnosis of osteomyelitis.

[32] Dr Eltringham is of the view that it is very likely that NS had tonsillitis at the time he sustained the injury to his leg. Osteomyelitis, in the view of dr Eltringham, can be difficult to diagnose especially when there are other reasons for a temperature such as NS had. Hypothetically, if one has a sprained ankle one would have a swollen sore ankle that may be red, warm to the touch and sore to walk on. The only difference between that and an infection in the same area would be the presence of a temperature or other signs of infection. But swelling and inflammation with warmth and sometimes redness is overlapping symptoms. Dr Eltringham is of the view that the history of NS having recurring tonsillitis and the fact that he had a concurrent tonsillitis at the time of his ankle injury would be confusing to a casualty officer. The attending casualty officers on 28 January and 2 February had, in the view of dr Eltringham, found a reason for NS's temperature, for the infection. The initial approach to manage NS's temperature has been caused by the tonsillitis. Dr Eltringham is of the view that was appropriate. Dr Versfeld agrees that the general features of tonsillitis and osteomyelitis are similar with the exception that a patient gets more toxic and the symptoms would tend to be more severe with osteomyelitis. He concedes that there are times when osteomyelitis can be difficult to diagnose, especially in this case where NS also had tonsillitis at the time. He also agrees that NS had '[m]any episodes of tonsillitis according to the history'.

[33] Dr Eltringham is of the opinion that the bacteraemia that was present at the time of NS's ankle injury could have been the cause for the infection settling around his ankle. Within a day or two the injured area is colonized by bacteria that are floating around in the bloodstream, whether from a tooth infection, soft tissue infection in the skin such as a boil or scar which children often get or from tonsillitis. The infection in the bloodstream can then seed or localize to an injured area. The infection can often spread or occur several days after the original injury, usually quicker in children than in adults, but it can be a few days up to a week or two. It is, according to dr Eltringham, speculation as to when the infection took hold in NS's left tibia. Dr Versfeld agrees that

the bacteraemia is spread by the blood and the bone infection could have arisen from the tonsillitis.

[34] Dr Eltringham has no doubt that the antibiotics prescribed for NS's tonsillitis inhibited the bacteria that were causing his osteomyelitis, suppressing the tibial infection enough to make a diagnosis of a tibial osteomyelitis difficult and thus delaying the diagnosis. The antibiotics would delay the seeding process by a few days. NS presented at casualty on 28 January, 31 January and 2 February in relatively quick succession and then there was a relatively long interval until 14 February when he attended at casualty again. On 31 January he was prescribed antibiotics for his tonsillitis and on 2 February he was prescribed a seven-day treatment of Ciprofloxacin. The relatively long interval that it took him to attend at casualty again is for dr Eltringham in keeping with a lull in his symptoms, an improvement as a result of the treatment of an infection with antibiotics. The antibiotics stopped seven days after 2 February, and he got worse, which in the view of dr Eltringham is expected. The symptoms seemed to dr Eltringham as having increased a day or two after NS stopped the Ciprofloxacin that was prescribed to him on 2 February and finished on or about the 9th of February. This to Dr Eltringham is in keeping with the request to Ms Schoeman to remove the backslab on 14 February and his attendance at casualty later that evening. If NS did not have tonsillitis at the time of his presentation to casualty on 28 January, 31 January and 2 February, dr Eltringham is 'certain that the diagnosis of osteomyelitis would have been made sooner. Dr Versfeld concedes that the antibiotics prescribed for NS's tonsillitis inhibited the bacteria that was causing his osteomyelitis.

[35] Dr Versfeld says that he does not know when the osteomyelitis started, but there were features of osteomyelitis present on 28 January. Central to dr Versfeld's opinion that NS's symptoms were not appropriately dealt with by the attending casualty officers and that a diagnosis of osteomyelitis or septic arthritis should have been entertained earlier on and the matter escalated to an orthopaedic surgeon, is the clinical diagnosis of ++ tenderness of the medial malleolus, which to dr Versfeld means a considerable amount of tenderness of the medial malleolus, that was made by the attending casualty officer on 28 January. The medial malleolus is the protruding bone from the inside of

the ankle. The tenderness covers a very narrow area and is very localized and specific. If it was merely an ankle injury one would have expected the tenderness to be where the ligament is and not on the bony structure. Tenderness of a sprain would be over the ligament and here the attending casualty officer diagnosed tenderness over the bone. The ++ tenderness of the medial malleolus was, in the view of dr Versfeld, the first sign osteomyelitis.

[36] Dr Eltringham, on the other hand, is of the view that dr Versfeld's view amounts to mere speculation as to when the osteomyelitis took hold of NS's left tibia and is 'highly unlikely'. First, the ++ in his view is a bit of a random comment and a slightly vague description. A + would be very slightly tender, ++ fairly tender and doctors might go to +++ or ++++. But he agrees that the tenderness 'was not just like minor it was more a minor but not the most severe or very severe tenderness'. Second, the description of a tender medial malleolus is in the opinion of dr Eltringham 'more of a generic description for the region of the symptoms' and not localised 'to an area the size of a thumb nail'. This view of dr Eltringham, of course, is supported by the attending casualty officer's clinical diagnosis of a soft tissue injury. Third, children have ligaments that are stronger than their bones whereas adults have bones that are stronger than their ligaments. On average adults tear the ligaments around the ankle and children fracture bones rather than tear ligaments. The most common scenario with children is to avulse the ligament off the bone pulling with it the periosteum (thin sleeve of soft tissue which is not visible on x-rays) over the medial malleolus. Usually the injury of a ligament in children occurs at the point of origin of the tendon on the medial malleolus and the medial malleolus would thus be the point of tenderness. Fourth, what dispels dr Versfeld's theory in the opinion of dr Eltringham, is that there was never osteomyelitis of the medial malleolus, but of the distant third of the tibia. The point of tenderness over the medial malleolus does not correlate to the subsequent diagnosis of the location of the osteomyelitis. The medial malleolus is part of the epiphysis, which is the area below the growth plate of the tibia. The metaphysis is the area above the growth plate. The osteomyelitis was of the metaphysis of the tibia and not the epiphysis. The growth plate is, generally speaking, a barrier. Tenderness that correlates to the subsequent diagnosis of osteomyelitis would therefore, in the opinion of dr Eltringham, have been

above the medial malleolus, not on the medial malleolus. The clinical diagnosis of tenderness on the medial malleolus, in the view of dr Eltringham, is consistent with a ligament injury or a sprain or a soft tissue injury. And that was the attending casualty officer's diagnosis on 28 January, as noted in the clinical note.

[37] Dr Eltringham is of the view that the treatment provided by the casualty doctors on the days up and until the 14th of February, was under the circumstances of them not being orthopedic surgeons, acceptable and reasonable. On 28 January NS presented with a one day history of temperature and two days history of his ankle. The casualty officer looked for a reason for the infection and found active tonsillitis and NS was shown to have suffered from recurring tonsillitis. Dr Eltringham is of the view that the casualty officer was 'probably quite pleased they had found a reason for the temperature, managed the temperature by treating the tonsillitis with appropriate antibiotics'. The casualty officer noted a soft tissue injury. NS was walking on his leg, it did not seem to severe to the casualty officer and felt it did not need specific treatment but should it not settle requested that he comes back for re-assessment and x-rays. Under cross-examination dr Versfeld testified thar he 'is not saying that the doctor was negligent' on this occasion if it was not NS's second visit to the hospital, but that the treatment given was not 'necessarily ideal treatment at that moment in time'. He further states that he does not believe that it was a serious omission of the attending casualty officer not to refer NS to an orthopaedic surgeon at this time.

[38] The pain and swelling persisted and NS did go back to the Rahima Moosa Hospital on 31 January as prescribed by the casualty officer on 28 January. The casualty officer, dr Eltringham assumes, undoubtedly went through the casualty notes and noted the soft tissue injury was deemed to be relatively minor, but that an x-ray had not been taken and he was obviously swayed by the comment that if NS comes back and his ankle is still sore an x-ray should be taken to exclude a fracture. And that is precisely what the casualty officer did. The x-rays showed no fracture. The appropriate treatment in the event of an uncomplicated soft tissue injury to the ankle is to immobilize the ankle, because if it is unsupported and unprotected the symptoms may increase since the injured area is then repeatedly re-injured and the swelling and pain will

increase. That is what the casualty officer did. Dr Versfeld agrees that immobilizing a soft tissue injury is appropriate treatment and he concedes that over-use of a limb may cause pain and swelling of an ankle sprain not to decrease. He further concedes that if it is accepted that the ankle injury occurred on 26 January, the diagnosis and treatment received on this occasion were reasonable.

[39] As regards NS's presentation at casualty on 2 February, dr Eltringham says that the previous two presentations had been for different symptoms. Now there was a patient who was presenting in the middle of the night to a casualty facility with vomiting, diarrhea, and a fever. And not, according to the clinical note, of his ankle or of increasing ankle pain. If that was the case dr Eltringham would have expected that the history would have documented painful ankle rather than the history of fever, vomiting and diarrhea. It appears not to have been the overriding presenting symptom on that particular day. NS presented with a history of an injury to his ankle and normally an injury to an ankle would not cause a temperature. He has a history of recurring tonsillitis infections and so the casualty officer evaluated the patient and examined him. General practitioners normally assess the ears, the throat, the nose, and listen to the chest. If they still can't find the cause of infection in children then they look at urine, because those are the common sources of infection. In evaluating NS it appears from the clinical note that the casualty officer visualized what she felt was tonsillitis and she felt that the clinical impression of the tonsillitis was the cause for the temperature and made the diagnosis of tonsillitis, which was the cause of the infection. Temperature is normally the result caused by an infection, either viral or bacterial. With a clinical appearance of infected tonsils plus the temperature, a diagnosis of tonsillitis rather than an assumption that he had acute osteomyelitis in those circumstances, in the view of dr Eltringham, is reasonable. Unless NS had complained of progressively increasing ankle pain, there was no particular reason for the casualty officer to concentrate on the ankle on this occasion. Under cross-examination dr Versfeld conceded that if the diagnosis on this occasion was based on the presenting symptoms as recorded in the attending casualty officer's clinical note - fever, vomiting and diarrhea – and not the ankle complaint, then the diagnosis would be a correct one on the recorded presenting symptoms and the treatment given (the medication prescribed) reasonable.

[40] Dr Versfeld's opinion that NS's symptoms were not appropriately dealt with by the attending casualty officers and that a diagnosis of osteomyelitis or septic arthritis should have been entertained at an earlier stage and the matter escalated to an orthopaedic surgeon, is outcome based. He expressed the view:

'I mean if you look at the outcome you cannot say that they were appropriately dealt with.'

But this is a wrong approach. One cannot look at the outcome and then conclude that there must have been negligence. As was said by Ponnan JA in *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 97 (SCA) para 9:

'For to hold a doctor negligent simply because something had gone wrong would be to impermissibly reason backwards from effect to cause.'

[41] All facts on which the expert witness relies must ordinarily be established during the trial, except those facts which the expert draws as a conclusion by reason of his or her expertise from other facts which have been admitted by the other party or established by admissible evidence. (See: *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämp-fung MBH,* 1976 (3) SA 352 (A) at 371G; *Reckitt & Colman SA (Pty) Ltd v S C Johnson & Son SA (Pty) Ltd* 1993 (2) SA 307 (A) at 315E); *Lornadawn Investments (Pty) Ltd v Minister van Landbou* 1977 (3) SA 618 (T) at 623; *Holtzhauzen v Roodt* 1997 (4) SA 766 (W) at 772). Material facts upon which dr Versfeld relies have not been established during the trial. Furthermore, the conflicting views of drs Eltringham and Versfeld are not both capable of logical support. The opinions advanced by Dr Eltringham have a logical basis and accord with the proven facts and probabilities. (See *Michael and another v Linksfield park Clinic (Pty) Limited and another* 2001 (3) SA 1188 (SCA) paras 34-40.) Dr Versfeld's views are for the reasons given not capable of withstanding logical analysis and are therefore not reasonable. The views of dr Eltringham are thus preferred.

[42] Finally, the matter of costs. No good grounds exist for a departure from the general rule that costs follow the event, in other words that the successful party should be awarded its costs. What has to be considered though, is the defendant's request that the costs order should include the fees consequent upon the employment of two counsel. I am of the view that neither the factual nor the legal difficulties were such as to warrant the engagement of two counsel for the defendant.

[43] In the result the following order is made:

The plaintiff's claim is dismissed with costs.

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P.A. MEYER
JUDGE OF THE HIGH COURT

Hearing:	26-30 November 2018 15 April 2019 24 June 2019
Judgment:	31 January 2020
Plaintiff's counsel:	Adv JF Grobler
Instructed by:	Friedman Attorneys, Killarney, Johannesburg
Defendant's counsel:	Adv P Pauw (assisted by Adv Mansingh)
Instructed by:	State Attorney Johannesburg