REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
(LIMPOPO DIVISION, POLOKWANE)

(1) REPORTABLE: ~~YES~~/NO
(2) OF INTEREST TO THE JUDGES: ~~YES~~/NO
(3) REVISED.

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DATE 12/5/2020 SIGNATURE: .....
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**CASE NO: 1440/2014**

In the matter between:

**MAITE HARRY MOLOKOMME** **PLAINTIFF**

And

**MEC FOR HEALTH LIMPOPO** **DEFENDANT**

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**JUDGMENT**

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**MADAVHA: AJ**

[1] This is an action in which the plaintiff in his personal capacity and on behalf of the two minor children claims for loss of support from the Defendant arising from the death of his wife.

[2] At the commencement of the trial the issue of liability was separated for determination before all other issues. This Judgment deals with that issue only.

**BACKGROUND FACTS**

[3] It is common cause that:

(a) Plaintiff was married to the deceased (Kwena Jeanette Molokomme), they were blessed with three children. The two were both employed as teachers.

(b) On 12 August 2013 the deceased reported to the husband that she had tonsils and was not feeling well.

(c) On 19 August 2013 she consulted Dr Manthata who then referred her to Dr Masipa.

(d) On 21 August 2013 she consulted at Polokwane Provincial Hospital, Dr Masipa who is a specialist maxillofacial surgeon, diagnosed her to be having Ludwig Angina, in that he noticed the following symptoms: - She was walking with difficulty, talking with difficulty, she had a swelling below the lower jaw in the upper neck. Externally the nostrils were flurrying a sign indicative of searching for air, on the mouth area she had an open mouth, the tongue was elevated and the mouth was supplementing the nostrils for breathing.

Ludwig Angina is said to be rare but serious and rapidly progressing bacteria infection that affects the floor of the mouth and the neck.

(e) Upon the diagnosis, Dr Masipa noted that the deceased had an airway problem meaning she had difficulty in breathing. It was then of paramount importance to provide her with an airway. An insertion and drainage of the puss was done on the deceased, a large amount of pus was extracted and the deceased was immediately relieved.

(f) The deceased was given antibiotics and admitted for further drainage and medication to stop the pus.

(g) It is further common cause that on 22 August 2013, the deceased signed a consent form for the operation and an operation was done.

(h) The cause of death as noted on the post-mortem report was aspiration Pneumonitis associated with infiltrative neck abscesses. The neck structure had several abscesses.

**THE LEGAL TEST**

[4] The test in medical negligence cases is succinctly summarized inter alia by **Corbett JA in Blyth v Van der Heerer**,[1]. The two questions mentioned in Blyth arising in this matter are:

(i) What factually was the cause of death of the deceased?

[1] 1980 (1) SA 191 (A) at 196E

(ii) Did the negligence on the part of Defendant, if any, cause or materially contribute to the death in the sense that the Defendant by the exercise of reasonable professional care and skill could have prevented death from occurring.

[5] In proving its case the Plaintiff led evidence of an expert Dr Gregory Promnitz a specialist Physician. Dr Promnitz compiled a report on 25 September 2015, in which he opined as follows:

> "*That the deceased had developed a dental abscess with subsequent submandibular cellulitis resulting in her developing the so called Ludwig`s Angina. He opines that at that stage the patient should have been admitted to hospital and given intravenous antibiotics such as Augmentin and Flagyl. Ludwig angina is a clinical diagnosis, airway management is the foundation of treatment of Ludwig angina and the method of securing this patient airway would have resulted on clinical judgment. Approximately 65% of patients with this condition will require surgical drainage and Physical examination alone is in sufficient in determining which patient requires a surgical procedure. It is therefore recommended that x-ray imaging is indicated in patient with Ludwig angina once antibiotics have been commenced and decisions in regard to airways management have been made. It is recommended that a CT Scan with contrast be performed to detect patients have developed supportive complications.*"

Dr Promnitz testified that a surgical intervention was required and that a CT Scan should have been done, in order to check on how to manage her further. The CT Scan plans surgical approach, it gives an idea on what to expect and how best to secure the airway. He is of the opinion a tracheotomy should have been performed in that way the pus could not have gone into the lungs.

[6] The clinical examination of the diceased prior to her being sent to theatre was critical and it appears that the anesthetists did not see the patient in the ward prior to the surgery. He opined that had the patient been properly examined before the surgery and an inspection of her mouth been made it would have become obvious that the deceased would require a safe airway before attempting any drainage procedure. Under these circumstances it would have been appropriate to involve an ENT surgeon and the deceased should have had a tracheotomy performed. From the post mortem report it is obvious that an endotracheal intubation of this patient would have been extremely difficult and the decision to perform the tracheotomy on the deceased would have rested with the anesthetist and the treating doctors at the time.

Once it became obvious that this patient had such extensive changes in her pharynx, an emergency tracheotomy should have been performed to secure an adequate airway.

Dr Promnitz opinion is that the deceased death was completely preventable had she been properly assessed preoperatively and investigated preoperatively. She should have had a CT Scan prior to surgical intervention to assess the degree and extent of infection.

[7] Under cross examination, it transpired that when compiling his report Dr Promnitz did not have preoperative evaluation form, prescription chart and the preadmission

report made by Dr Masipa and Dr Baloyi. He however stands by his opinion and submitted that although he did not have all the information when opining it would not change his opinion.

**The Defendants evidence.**

[8] The defendant led evidence of Dr Masipa James who is a specialist Mascilofacial Surgeon. On 21 August 2013 he was on duty and he examined the deceased. She was diagnosed with Ludwig angina in that she had a swollen and tender to touch neck, she was unable to eat, she could not walk properly, she was breathing with difficulty and her tongue was elevated.

Since she had a compromised airway, an incision and drainage under local anesthesia on a dental chair was performed. The procedure in a way enabled the deceased to breath way better. The deceased was admitted for a further incision and drainage that had to be done in theatre the next day. Antibiotics, Augmentin and flaggy was given to the deceased. An x-ray (panoramic view) of the denture was done.

The deceased was on the following day prepared for theatre wherein a team was set to assist Dr Masipa, in doing the incision and drainage. A special arrangement to take her to theatre urgently was done in that she needed immediate attention.

Dr Masipa testified that although they wanted to operate on the deceased urgently so, all the theatres were occupied, and had to defer the operation for the following day. A team made up of Dr Ryabchiq who is the anesthetic, Dr Baloyi and Dr Shogole, together with Dr Masipa discussed the patient.

[9] When she arrived at theatre she was able to breath, and the symptoms were better than she was the previous day. Dr Boris assessed her and noticed that there was pus in the neck. The team having noted that there is pus on the neck agreed that they would opt for endotracheal intubation, which is putting a tube in the mouth rather than tracheotomy, which is cutting below the adam`s apple in order to insert the tube. The clinical presentation of the patient at that time warranted that they avoid tracheotomy in that there was a possibility that the patient might aspirate.

[10] Endotracheal intubation is a process wherein a pipe is inserted into the trachea with the intention of opening up the airway. This process is non-surgical in that there is no cutting.

Tracheotomy on the other hand, you use a knife, cut skin and deeper tissues aiming towards trachea to locate it, aiming at the windpipe, then insert the tube.

Dr Masipa considered the disadvantages of tracheotomy, in that it is surgical. The patient`s neck was short, swollen and it was going to be difficult to do a tracheotomy in that once they cut a great possibility of pus going into the trachea was foreseen.

In the process of trying to intubate the patient, pus came out, suction equipment was made available, a process of suctioning the pus was done, together with giving the patient air. Dr Boris was busy with suctioning, and he noted a lot of pus in the mouth. An ENT was then called and a successful tracheotomy was performed as soon as they cut the neck, pus was coming out. The patient then went to cardiac arrest and had heart failure. Dr Boris tried to resuscitate the patient unfortunately she died.

**Dr Boris Ryabchiq.**

[11] A specialist anesthetists, was informed that there was an emergency, Ludwig angina patient around 15h30 he saw the patient outside the operation room. Within the team the of the operation, they discussed tracheotomy, and found it to be dangerous cause there was a high risk of aspiration, in that if the incision was to go through the affected area, the pus would go out. On his first attempt to intubate, he realized the situation was actually worse. He saw huge tongue cells, he couldn't push the tongue because he did not want to temper with the visible abscess.

[12] He tried to insert the tube for about 10 minutes but it was difficult, he had to suck pus, blood and saliva. The mouth was stained with blood and pus, and it was difficult to intubate. The team decided to do a tracheotomy and in the process massive discharge of pus come out, when busy with tracheotomy, he was giving her oxygen and busy sucking the pus that came out profusely.

Dr Boris submitted that his first attempt to intubate was at 16h10, second one and 16h30 and the tracheotomy was done between 16h55 and 17h00.

[13] Dr Tsakani Mohlari, a Chief Specialist in health, specialist in aneostiology was called in as an expert witness by the Defendant. The diagnosis made on the patient was correct. The expert witness called by the plaintiff is a general practitioner and does not specialize in Ludwig angina, it is the maxillofacial who knows the condition better.

The discretion of which method to use, lies with the anesthetist. Airway management of patients with Ludwig angina depends on the condition of the patient and the facilities available in the institution.

[14] In this case the choice of using endotracial intubation was based on the fact that the pus was drained the previous day. The rupturing of pus locules is possible and it's a known complication of Ludwig angina. There was a need to protect the airway from aspiration hence they choose endotracial intubation. The reason why it failed twice was because pus was oozing all over. The doctor protected the brain by giving 100% oxygen.

**Pleadings**

[15] In the summons the Plaintiffs claim is based on various acts of alleged negligence by the Defendant. Both experts concede that the diagnosis made by Dr Masipa was

correct and that the patient case was an emergency. Dr Masipa in realizing that the patient has difficulty in breathing performed an incision and drainage in order relieve the patient. It was not in dispute that abscesses were on the neck and that pus was also noted on the neck. In deciding to perform an endotracheal intubation, the team had taken into account that the neck was swollen possibly due to the presence of pus. A tracheotomy procedure would mean they had to cut the neck in order to intubate and in cutting if they cut through the abscesses, pus would erupt.

[16] Dr Boris when noticing the massive pus suctioned the pus and blood at the same time providing oxygen to the patient. The post mortem report states the cause of death as being aspiration pneumonitis associated with infiltrative neck abscesses.

In conducting the endotracheal intubation, the defendant wanted to provide the patient with airway, so that they can be able to treat the abscesses on the neck.

Can it be said that Dr Masipa was negligent in not having used a computed tomography (CT scan) prior the intubation? The patient had abscesses on the neck and that was a clinical diagnosis made by Dr Masipa. The Plaintiff expert opined that had a CT Scan been used, the defendant would have seen where these abscesses were and would have opted for tracheotomy.

It was submitted that the abscesses move within the body its not stationery meaning the CT Scan could have shown an abscess at that particular time, which later could have moved.

The patient condition is said to have been an emergency and the Doctors had to do whatever that was possible at that time to assist her.

On noticing that the massive pus is oozing Dr Boris suctioned the pus and gave oxygen. On tracheotomy upon cutting of the neck lots of pus come out, this confirms the clinical exam by Dr Masipa that the neck was infested with abscesses.

**DISCUSSION**

It is trite that he who asserts a damage causing event must prove it. The legal duty owed by the medical staff at the health facilities to the deceased entailed that they adhere to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which they belonged.[2] They had no duty to provide the highest possible degree of professional skill. Only reasonable care and skill is required.[3] The Plaintiff had to prove, through credible and persuasive evidence that the doctors failed to adhere to the required standards.

The opinion of the medical experts was central to the determination of the required level of care and whether there was a breach of it.

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[2] Van Wyk Lewis 1924 AD 438 at 444
[3] Mitchell v Dixon 1914 AD 519 at 252

The requirement in evaluating such evidence is that expert witnesses support their opinions with valid reasons. Where proper reasons are advanced in support of an opinion, the probative value thereof is strengthened.[4]

It is not the mere opinion of the witnesses that is decisive but his ability to satisfy the Court that, because of his special skill, training and experience, the reasons for the opinion which he expresses are acceptable.[5]

In Michael v Linksfield Park Clinic (Pty) Ltd[6] it was held that:

> *"The court is not bound to absolve a defendant from liability for alleged 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 benefit and has reached a "defensible conclusion".*

The first difficulty with Dr Promnitz evidence is that he concedes that when compiling his report he did not have all the medical records in his possession, in his opinion he states that the patient should have been given antibiotics and when made aware of the fact that such was indeed done, he states that it does not in anyway change his opinion. The basis of negligence is based on the non use of a CT scan, the importance of the scan is to show the position of the abscesses, which diagnosis was done by Dr Masipa.

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[4] Schwikkard & Van de Merwe, Principles of Evidence 4 ed at 103
[5] Menday v Protea Assurance Co Ltd 1976 (1) SA 565 (E) at 569B
[6] Michael v Linksfield Park Clinic (Pty) Ltd (2001) 1 All SA 384 (SCA) para 37

Dr Promnitz opined that the method used to incubate the patient was incorrect and had a CT Scan been done the correct procedure could have been followed.

It was not disputed that the patient's neck had abscesses full of pus and upon the first attempt to incubate the pus oozed out.

Dr Boris tried to suction the pus but with difficulty, at the same time giving oxygen to the patient, is that not what a reasonable medical officer is expected to do under those circumstances.

In **Goliath v Member of the Executive Council for Health, Eastern Cape**[7] it was held: 'to hold a doctor negligent simply because something had gone wrong, would be to impermissibly reason backwards from effect to cause'.

Consequently, the following order is made:

1. The action is dismissed with costs.

PP

**M.B MADAVHA**

**ACTING JUDGE OF THE HIGH COURT**

**LIMPOPO DIVISION: POLOKWANE**

[7] (085/2014) ZASCA 182, 2015 (2) SA 97 (SCA) at para 9

**Appearances**

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| For the Plaintiff: | Adv: I Van Ende |
| Instructed by: | Smit & Maree Attorneys |
| For the Defendant: | Adv: Phaswane |
| Instructed by: | State Attorney Polokwane |
| Heard on | 10 December 2019 |
| Judgment delivered on: | 12 May 2020 |