IN THE HIGH COURT OF SOUTH AFRICA **REPORTABLE**

(CAPE OF GOOD HOPE PROVINCIAL DIVISION)

CASE NO: **10253/01**

In the matter between

JAMES PETER OLDWAGE Plaintiff

And

DR HENK D LOUWRENS Defendant

JUDGMENT DELIVERED ON 19 FEBRUARY 2004

YEKISO, J

INTRODUCTION

[1] On the 8th June 2000 the Defendant, a vascular surgeon, performed a vascular surgery on Plaintiff at Panorama Medi-Clinic (hereinafter referred to as "Panorama") to relieve him of severe pain in his right leg. There is a dispute as regards the precise nature of the operation the Defendant performed. The initial averment in the pleadings was that the operation performed was the so-called *femoro-femoral* by-pass operation. At the commencement of trial the Defendant applied for an amendment of paragraph 8.2 of the Defendant's Plea, the amendment sought being the deletion of the words *"femoro-femoral* by-pass procedure*"* wherever such words appear in paragraph 8.2 and by the substitution thereof with "*ilio-femoral* by-pass

procedure". Paragraph 9 of the Defendant's Plea was to be amended by inserting an admission that the Defendant performed an *ilio-femoral* by-pass operation and finally, deletion of the words *"femoro-femoral"* in paragraph 13.1.2.1 of the Defendant's Plea and by the substitution thereof with the words *"ilio-femoral"*. Initially Plaintiff, through Counsel, indicated that the proposed amendment would be opposed. Plaintiff subsequently changed its position, advising that the amendment sought would no longer be opposed subject to it being recorded that the operation purportedly performed was not being admitted. Thus the precise nature of the operation purportedly performed is still in dispute.

[2] On 20 October 2003 Plaintiff filed a Notice of Amendment in terms of Rule 28 seeking to amend its Particulars of Claim by the insertion of paragraph 7A immediately following paragraph 7.4 of the Particulars of Claim. The effect of the proposed amendment would be the addition of "assault" as an alternative cause of action in Plaintiff's claim. In the same proposed amendment, Plaintiff sought to add "contumelia" as a further sequelae to the alleged breach or misrepresentation as paragraph 9.8 after the existing paragraph 9.7; Paragraph 10.1 was to be amended by adding "assault" as an alternative cause of action and, finally, paragraph 10.3 was to be amended to include "contumelia" as one of the several categories of general damages suffered. The Defendant did not oppose the amendment sought so that after the expiry of the *dies induciae,* Plaintiff's Particulars of Claim were deemed so amended.

[3] Turning to the facts of the matter, Plaintiff was admitted at Panorama on 7 June 2000, a day preceding the date of the operation. On that day the Defendant performed an angiogram on him. The operation was performed the following day. Plaintiff was discharged from Panorama on Sunday, 11 June 2000.

[4] On discharge from hospital, so it is contended on behalf of Plaintiff and so did Plaintiff testify in evidence, Plaintiff was not relieved of pain he experienced prior to the operation. On Wednesday, 14 June 2000 Plaintiff consulted a Dr Kieck, a neuro-surgeon, in his rooms at Vincent Pallotti Hospital, Pinelands. Dr Kieck examined Plaintiff and diagnosed a prolapsed

disc as the source of pain Plaintiff experienced at the time. On 21 June 2000 and at Vincent Pallotti Dr Kieck performed a laminectomy on Plaintiff. Plaintiff remained in Vincent Pallotti until Sunday, 24 June 2000, on which latter date he was discharged and relieved of pain.

[5] A few days after his discharge from Vincent Pallotti and in an attempt to do some physical exercise, as he was accustomed to do prior to undergoing the vascular operation, Plaintiff went for a walk with his wife when he discovered that, after walking a short distance of about 30m, he experienced cramps and pain in his left leg. This necessitated Plaintiff to rest, but the pain would recur as soon as he would resume walking.

[6] Plaintiff subsequently saw Dr Kieck for a follow-up operation on Monday, 3 July 2000. On this occasion Dr Kieck noted that Plaintiff claudicates. Dr Kieck further noted that Plaintiff ‘s left foot was cold to touch; that the pulses in the left leg were negative and that, according to Plaintiff, this symptom manifested after the vascular operation.

[7] In the course of trial it became apparent that when Plaintiff consulted the Defendant and subsequently operated on, Plaintiff presented an extensive vascular disease. When pain persisted after this operation he consulted Dr Kieck who diagnosed a prolapsed disc in the L4/5 lumbar region as a source of pain

necessitating a laminectomy which Dr Kieck performed on 21 June 2000. The Plaintiff thus not having been relieved of pain he experienced after the vascular operation, the primary issue I have to determine, amongst other ancillary issues, is what medical intervention, if any, was reasonably required to address the pain Plaintiff experienced prior to the performance of the two operations on him. In order to determine this issue and, of course, other related issues, it is necessary to examine Plaintiff's health history prior to the operations on 8 June 2000 and 21 June 2000 by the Defendant and Dr Kieck respectively.

HEALTH HISTORY PRIOR TO PERFORMANCE OF THE OPERATIONS

[8] Except for a laminectomy which was performed on him at Dundee, in the Province of Kwazulu Natal during 1972, Plaintiff was otherwise fit and healthy up until 27 April 2000 when Plaintiff sustained an injury to his back in Cedarberg, Clanwilliam, Cape. At that stage Plaintiff and his wife occupied a flat in Milnerton. The flat was situated on the fourth floor of a block of flats and could only be accessed by four flights of stairs. Plaintiff utilized a flat on the second floor of the same building as an office.

[9] During December 1999 Plaintiff purchased two mountain bicycles for himself and his wife. This, so Plaintiff testified in evidence, was at the suggestion of his wife in order that they could exercise regularly. At regular intervals, Plaintiff and his wife would visit the Clanwilliam Dam area where they would either stay with Plaintiff's brother, George, or would stay at a house referred to in evidence as "The Thatch Roof House". During such visits, Plaintiff would undertake regular exercise activities such as walks and

bicycle rides.

[10] On one such visit on the long weekend commencing 27 April 2000 Plaintiff and his wife went for a walk next to the Clanwilliam Dam when, during such a walk, Plaintiff slipped landing on his buttocks and hurting his lower back in the process. Plaintiff was laid up for the rest of that long weekend with significant backache. As a result of this incident, Plaintiff and his wife returned to Cape Town earlier than anticipated due to discomfort and inconvenience Plaintiff experienced subsequent to the slipping incident.

[11] On his return to Cape Town the back injury was treated conservatively by way of bed rest and after a few days Plaintiff resumed work as before. Towards the end of May 2000 Plaintiff experienced increasing and later intense pain in his right leg. On 5 June 2000 he visited Dr Simons, a general practitioner, for the first time. While waiting in the reception room prior to seeing Dr Simons, Plaintiff did not sit down, but leaned against the wall or a table. This was because of severe pain he experienced at the time.

[12] When Plaintiff subsequently consulted Dr Simons he complained of five days of pain in the lower aspect of the right leg which was preceded by numbness especially when getting out of bed; the pain was aggravated by movement and radiated up to the right buttock. Dr Simons performed a single leg raise test on Plaintiff. Dr Simons neither made notes regarding any complaint of claudication on the part of Plaintiff, any pain in the right foot, discolouration of the right foot, abnormal temperature in the right foot nor the precise nature of any neurological tests he may have performed.

[13] Dr Simons referred Plaintiff to the Defendant for an appointment at the latter's rooms at Panorama on Tuesday, 6 June 2000. Plaintiff duly visited the Defendant as arranged. He took a taxi because it would have been too uncomfortable to drive because of pain. Plaintiff handed to the Defendant a note sealed in an envelope given to him by Dr Simons. The contents of this note are not known as it was neither discovered nor produced in evidence.

[14] After taking an oral history the Defendant examined Plaintiff on his examination couch. Plaintiff did not remove his trousers as it was too painful to do so. Defendant examined Plaintiff in the groin by loosening Plaintiff's trousers. Defendant examined Plaintiff's right foot. In the consultation preceding the examination the Defendant did not ask Plaintiff whether he had experienced any symptoms of claudication nor did he take any record of Plaintiff's exercise regime or eating habits. The Defendant did not perform a Doppler test on Plaintiff. Plaintiff did not mention the fall in Cedarberg to the Defendant, nor did the Defendant direct any enquiry to Plaintiff which would have elicited that information.

[15] After examining Plaintiff, the Defendant held the view that Plaintiff was

suffering from a problem with his vascular circulation resulting in blockages in his arteries, that the problem could be addressed by the insertion of a balloon into Plaintiff's arteries or a graft to replace certain of the blocked veins in the body with a plastic prosthesis and that further tests were required before the Defendant could determine which surgical procedure would be appropriate. Plaintiff went home and returned the following day when an Electrocardiogram (ECG) was performed and after he was given a sedative later in the day, the Defendant performed an angiogram on him. The angiogram confirmed an occlusion of various arteries in Plaintiff's right iliac system, the internal iliac artery and the superficial femoral artery in the left leg. He was subsequently admitted to the ward. Plaintiff was informed that a by-pass operation was necessary to relieve him of his pain.

[16] An operation was performed on Plaintiff by the Defendant some time between 08h45 and 12h45 on the morning of Thursday, 8 June 2000. As has already been pointed out, Plaintiff was discharged on Sunday, 11 June 2002 still not relieved of pain he experienced prior to the performance of the operation.

THE PERIOD BETWEEN THE FIRST AND SECOND OPERATION

[17] The Defendant had in the meantime departed for a conference in America and had left Plaintiff in the care of Dr Michaelowsky. On discharge from Panorama, Plaintiff was seen by Dr Michaelowsky. Shortly before his discharge Plaintiff told Dr Michaelowsky that he continued to experience a similar pain in his right leg to that which he had experienced before the operation. According to Plaintiff Dr Michaelowsky's response was that Plaintiff should give it time. Plaintiff's wife, who had gone to the hospital to collect him, overheard this discussion. The discussion took place whilst Dr Michaelowski examined Plaintiff prior to his discharge. On his discharge, Plaintiff was unable to walk very far and had to make use of a wheelchair when leaving the hospital. Upon returning to his flat that Sunday morning, Plaintiff ascended the flight of stairs with great difficulty. He had to be

supported throughout by his wife. It was necessary for them to rest on a chair at each landing along the way.

[18] Plaintiff continued to complain about pain in his right leg until Monday, 12 June 2000. He directed various telephone calls to Dr Simons in an endeavour to discuss the ongoing discomfort with him. Dr Simons eventually spoke to Plaintiff late in the afternoon on Monday, 12 June 2000. The following day Dr Simons attended to Plaintiff who was then in his office on the second floor and examined him on a makeshift couch. Plaintiff's wife testified that Plaintiff complained to Dr Simons that the pain in the right leg was now worse than before and that, on this occasion, his left foot was cold. Dr Simons corroborates Plaintiff's wife's evidence in this regard. He prescribed certain analgesic drops and told Plaintiff to give the leg time to recover.

[19] In a state of frustration, Plaintiff then proceeded to telephone a number of medical specialists in an attempt to obtain advice regarding his pain. He eventually made contact with Dr Freddie Kieck's rooms whereafter an appointment was set up for the following day.

[20] Plaintiff saw Dr Kieck in his rooms at the Vincent Pallotti Hospital in Pinelands on Wednesday, 14 June 2000. After a Magnetic Resonance Imaging (MRI) scan Dr Kieck diagnosed a large rupture of the L4/5 disc with root compression. Dr Kieck advised that Plaintiff undergo surgery within the next week to alleviate the pain.

[21] Dr Kieck's handwritten notes taken in that consultation record a slight pain of approximately a week in Plaintiff's right lateral calf which got worse after three days; an *"on/of"* back problem which manifested for three to four weeks every few years; acute backache for two weeks in April 2000 when the back was out; Plaintiff's general practitioner thought he was suffering from peripheral vascular disease; Plaintiff had undergone iliac femoral by-pass the previous week; the original pain was still there; that it was terrible and presented in the buttock/thigh/calf and that Plaintiff was more comfortable at rest while bending was worse.

[22] Upon examination Dr Kieck noted that Plaintiff experienced pain; the leg-raise examination on the right leg was limited to 30 degrees and Plaintiff's pulses on the right were recorded as positive while those on the left were recorded as negative.

[23] On the same day Dr Kieck addressed a letter to Dr Simons in which he set out full details of his observations and proposed management of the problem. Although the letter is addressed to Dr Simons at his fax number at

his rooms, Dr Simons denies receiving the fax.

[24] Plaintiff continued to experience pain in his right leg for the following week. On Wednesday, 21 June 2000 Dr Kieck operated on Plaintiff's back and performed a right L4 laminotomy. Dr Simons assisted in that operation but did not see Plaintiff at any stage between 15 and 21 June 2000, nor did he inform Plaintiff that he was aware of the intended operation or of the fact that he had been invited by Dr Kieck to assist therein.

[25] Plaintiff was immediately pain free after the lumber operation and was discharged from Vincent Pallotti on Saturday, 24 June 2000. When returning home on that occasion Plaintiff was able to ascend the four flights of stairs to his flat with much greater ease than after the first operation.

[26] A few days after Plaintiff had been discharged from Vincent Pallotti he attempted to recommence exercising and went for a walk with his wife. Plaintiff would have proceeded very gingerly due to the operation wounds. During his first walk Plaintiff immediately showed signs of claudication in his left leg.

FOLLOW-UP CONSULTATION WITH DR KIECK

[27] Plaintiff saw Dr Kieck for a follow-up consultation on Monday, 3 July 2000. During that consultation Dr Kieck noted that Plaintiff claudicated in the left leg after walking a distance of 30 metres; that the left foot was cold to touch; the pulses in the left leg were negative and that the claudication had manifested after the vascular operation.

CONSULTATION WITH DEFENDANT ON 4 JULY 2000

[28] In the meantime the Defendant had returned from his trip abroad and was back at work on Monday, 19 June 2000. His appointment book for Tuesday, 20 June 2000 indicates that an appointment he had with Plaintiff at 14h30 on that day had been cancelled. Defendant was to have telephoned Dr Kieck on that day. Defendant's appointment book for Thursday, 22 June 2000, reflects that Defendant was to have telephoned Dr Kieck. Dr Kieck

would have performed the laminectomy a day before. Judging by the tick next to Dr Kieck's name and telephone number, it would appear that the call was indeed made.

[29] On Monday, 26 June 2000 Defendant wrote a letter to Dr Simons in which letter the Defendant sets out details of the consultation he had with Plaintiff on Tuesday, 6 June 2000; an analysis of the angiogram performed on Wednesday, 7 June 2000 and the particulars of the by-pass operation performed on Thursday, 8 June 2000.
The letter concludes that the Defendant was aware of the lumbar surgery performed on Plaintiff by Dr Kieck and concludes with the following sentence:

> "This may be a case of double pathology but I hope that he will now be able to return to work."

[30] On Tuesday, 4 July 2000 Plaintiff saw Defendant in the reception area of his rooms. Plaintiff states in his evidence that the Defendant did not examine him whilst the Defendant, on the other hand, is adamant he examined Plaintiff on this last occasion. This dispute will be dealt with later in this judgment. In any event, according to Plaintiff no examination was conducted but merely a discussion relating to Plaintiff's then current complaint of claudication. This is not surprising as Plaintiff, by all accounts, had lost confidence in the Defendant. According to Plaintiff the Defendant informed Plaintiff that the claudication problem could not have been foreseen during the vascular operation and that there was nothing that could be done to remedy the problem. Instead the Defendant advised Plaintiff to lead a healthier lifestyle. Plaintiff also informed the Defendant of the back operation he had undergone and of the subsequent pain relief in his right leg.

[31] On the same day that Plaintiff saw the Defendant, the latter wrote a further letter to Dr Simons in which letter he (the Defendant), for the first time, mentioned the complaint of claudication. The letter further records that on examination all pulses were present in the right leg; only a femoral pulse was apparent in the left leg and that a total occlusion of the superficial femoral artery was the likely cause of Plaintiff's symptoms of claudication.

THE ISSUES: BREACH, MISREPRESENTATION AND ASSAULT

[32 The issues which, in the final analysis, will call for determination are whether the Defendant acted in breach of his obligation arising from the agreement entered into between Plaintiff and the Defendant, whether the Defendant misrepresented to Plaintiff that the vascular procedure performed would relieve Plaintiff of the severe pain; whether Plaintiff consented to such procedure and if no consent was given or proved whether, in that event, the Defendant's conduct constitutes assault rendering him liable for whatever damages Plaintiff might prove. A finding on these latter issues has to be preceded by a finding as regards what medical intervention, if any, was reasonably required to address Plaintiff's complaint regarding pain during the period Monday, 5 June 2000 to Thursday, 8 June 2000. As a point of departure I propose to refer to the relevant portions of the pleadings.

[33] Paragraphs 6 and 7 of Plaintiff's Particulars of Claim in their amended form, which I propose to quote in full, read as follows:

"6 In breach of the agreement between the parties Defendant failed to

exercise the degree of care and skill required of a specialist vascular surgeon in that Defendant:

6.1 failed to take a full and proper medical history, inter alia, regarding the “pinched nerve” complaint;

6.2 Failed to examine Plaintiff adequately;

6.3 Failed to diagnose Plaintiff’s symptoms correctly;

6.4 Failed to appreciate that the Plaintiff’s symptoms were indicative of nerve compression in the lumbar region with referred pain down the leg;

6.5 Failed to appreciate that the co-existence of vascular and neuropathic pathology is perfectly possible and not uncommon and that his symptoms at that stage were not related to vascular insufficiency;

6.6 Failed to refer Plaintiff to an appropriate speciality for further treatment;

6.7 Failed to procure Plaintiff’s informed consent by *inter alia* failing to advise, warn and inform Plaintiff that:

6.7.1 The proposed femoro-femoral by-pass operation had a well known complication of possible claudication of the left leg;

6.7.2 The status of the left leg (vascular occlusion) presented a high probability

that the aforesaid complication would ensue;

6.7.3 The alternative procedure of an aorto bifemoral plus femero-popliteal by-pass was available and much more appropriate under the circumstances;

6.8 Failed to perform the correct procedure in respect of the presenting complaint;

6.9 Failed to perform the more appropriate procedure to remedy the underlying vascular occlusion;

6.10 Alternatively, and in any event Defendant, in breach of his aforesaid duty of care, unlawfully and negligently acted as set out in the preceding paragraphs.

Alternatively to paragraph 6 above: Plaintiff avers that:

7.1 Plaintiff agreed to undergo the aforesaid femoro-femoral by-pass operation as a result of Defendant presenting to Plaintiff that such operation was essential and that, if Plaintiff did not undergo such operation, Plaintiff would not recover from certain medical complications that Plaintiff was at the time experiencing.

7.2 The said representation was false in that the aforesaid procedure was not essential and in that Plaintiff did not require the said procedure in order to recover from the medical complaints that Plaintiff was suffering from;

7.3 The said representation was material and made with the intention of inducing the Plaintiff to agree to the aforesaid procedure. Relying on the truth thereof, Plaintiff did so agree;

7.4 The said representation was negligently made by Defendant, having regard to the Defendant's professional skill and expertise and the information which could, upon a reasonable enquiry, have been obtained by the Defendant which would have shown that the said representation was untrue;

7A Alternatively to the aforegoing, and in any event, by reason of the fact that Plaintiff was not informed of the aspects set out in paragraph 6.7.1 to 6.7.3 above, Plaintiff's alleged informed consent to the operation performed on the 8th of June 2000 was not procured and such operation accordingly constituted an assault on Plaintiff."

[34] In his plea the Defendant denies having acted in breach of the agreement entered into and further denies having made any misrepresentation, negligent or otherwise, save for admitting that:

"13.1.1 He did not pursuant to the angiogram, hold the opinion that Plaintiff's symptoms as described to him, were indicative of nerve compression in the lower lumbar region with referred pain down the leg;

13.1.2 He did not advise Plaintiff that:

13.1.2.1 The proposed femoro-femoral by-pass operation had a well-known complication of possible claudication of the left leg;

13.1.2.2 The status of the left leg (vascular occlusion) presented a high probability that the said complication would ensue

which advice he did not give because it would have been incorrect."

FACTS IN DISPUTE

[35] Apart from the evidence by five expert witnesses, being the two vascular surgeons, two neuro-surgeons and a radiologist, four other witnesses gave evidence, it being Plaintiff, Plaintiff's former wife, Plaintiff's brother, George and of course the Defendant in person. A number of disputes arose out of the evidence which was tendered over a period spanning eight court days.

[36] As is correctly submitted by both *Mr Gamble* and *Mr Van Riet,* who appeared for the Plaintiff and the Defendant respectively, the correct approach to adopt in the determination of such disputes, in the circumstances of this matter, would be to focus on areas of such disputes rather than the individual disputes themselves. Following this approach and, in broad terms, such areas of disputes are the following:

- Plaintiff's physical condition prior to the onset of pain and the examination by the Defendant on Tuesday, 6 June 2000, it being the Defendant's contention that under no circumstances could Plaintiff have been physically active as he claimed to have been in his evidence particularly in the light of the results of the angiogram.
- The nature, locality and extent of Plaintiff's pain (and other relevant medical complaints) at the time that he saw Defendant on Tuesday, 6 June 2000;
- The question whether there was double pathology;

- Whether the Defendant took all reasonable steps in his examination of Plaintiff and in coming to his diagnosis?
- Whether Plaintiff consented to the operation performed by the Defendant, and if so, whether such consent was properly informed;
- Whether Plaintiff was pain free immediately after the vascular surgery and, if not, when was he relieved of the pain he had initially complained about;
- The causal link between Plaintiff's subsequent (and present) complaint and Defendant's breach of his obligation arising from an oral agreement entered into;

A proper determination of these disputed issues would, in the nature of things, involve making a determination on the credibility of the various factual witnesses, the extent to which such factual witnesses are reliable and, the last but not the least, the probabilities. This would be in line with the approach recently re-stated by the Supreme Court of Appeal in *SFW Group Ltd and Another v Martell et Cie & Others 2003(1) SA 11*(SCA) where the following is said at p141 par 5:

> "The technique generally employed by courts in resolving factual disputes of this nature may conveniently be summarised as follows. To come to a conclusion on the disputed issues a court must make findings on (a) the credibility of the various factual witnesses; (b) their reliability and (c) the probabilities. As to (a) the court's finding on the credibility of a particular witness will depend on its impression about

the veracity of the witness. That in turn will depend on a variety of subsidiary factors, not necessarily in order of importance, such as (i) the witness' candour and demeanour in the witness-box, (ii) his bias, latent and blatant, (iii) internal contradictions in his evidence, (iv) external contradictions with what was pleaded or put on his behalf, or with established fact or with his own extracrucial statements or actions, (v) the probability or improbability of particular aspects of his version, (vi) the calibre and cogency of his performance compared to that of other witnesses testifying about the same incident or events. As to (b), a witness' reliability will depend, apart from the factors mentioned under (a)(ii), (iv) and (v) above, on (i) the opportunities he had to experience or observe the event in question and, (ii) the quality, integrity and independence of his recall thereof. As to (c), this necessitates an analysis and evaluation of the probability or improbability of each party's version on each of the disputed issues. In the light of its assessment of (a), (b) and (c) the court will then, as a final step, determine whether the party burdened with the *onus* of proof has succeeded in discharging it. The hard case, which will doubtless be the real one, occurs when a court's credibility findings compel it in one direction and its evaluation of the general probabilities in another. The more convincing the former, the less convincing will be the latter. But when all factors are equipoised probabilities prevail."

[37] The objective striven for in the determination of these disputes is

obviously with a view to determine whether the Defendant's conduct complained of falls within the permissible limits within which he had to operate in the exercise of his professional duties in his pre-operative advice to Plaintiff, during surgery and in his post-operative treatment of Plaintiff, if any.

[38] The Plaintiff basis his claim on breach by the Defendant of his obligations arising from the oral agreement entered into in one, more or all of the respects set out in paragraph 6 of his Particulars of Claim. In amplification thereof Plaintiff avers in his Particulars that the Defendant failed to exercise the degree of care and skill required of a specialist vascular surgeon in one, more or all of the respects alleged in paragraph 6 of Plaintiff's Particulars of Claim.

[39] As an alternative cause of action to the one set out in the preceding paragraph, Plaintiff avers that he agreed to undergo the surgical procedure performed as a result of false or negligent misrepresentation by the Defendant, such misrepresentation having been made with the intention to induce Plaintiff to agree to the procedure performed, and, relying on the truth thereof, Plaintiff did agree to undergo the operation. Plaintiff thus avers in his Particulars that because of such false or negligent misrepresentation he acted to his detriment and consented to the vascular surgery performed and that such consent, because of such misrepresentation, was not properly informed. It is appropriate at this stage to make some observations about the general principles applicable to the question of breach of duty or otherwise negligence on the part of a medical practitioner both in his or her pre-operative advice, performance of surgery and in the post-operative treatment of a patient.

APPLICABLE PRINCIPLES

[40] Innes, A C J, as he then was, held as far back as 1914 "that a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not. The burden of proving that the injury of which he complains was caused by the Defendant's negligence, rested throughout upon the Plaintiff. The mere fact that the accident occurred was not itself *prima facie* proof of negligence." (See *Mitchell v Dixon 1914* AD 519 at

525)

[41] And at p526, the learned judge further observed "… a medical practitioner is not necessarily liable for wrong diagnosis. No human being is infallible: and in the present state of science, even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect, if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession."

[42] As Strauss correctly points out, this *dictum* still holds good today although medical science has made tremendous strides since 1914 and today's technological aids being vastly superior to those in 1914, that despite such technological advances of our century, medicine still is not - and probably never will be – an exact science comparable to mathematics. Much depends on the skill and experience of the individual practitioner. (SA Strauss: Doctor, Patient and the Law 3rd edition 1999 at 252)

[43] The principle enunciated in *Mitchell v Dixon* supra was followed in a number of subsequent decisions, notably *Buls and Another v Tsatsarolakis 1976(2) SA 891(T); Correira v Berwind 1986(4) SA 60(ZHC); Castell v De Greeff 1994(1) SA 408*(C) amongst others.

[44] Foreign case law, in particular judgments of the English courts, although generally do not constitute a binding precedent to our courts, have always had considerable persuave force and are often referred to by our courts (See *Castell v De Greeff* supra at 416 and a reference therein to the judgment of the English Appeal Court and the House of Lords *in Whitehouse v Jordan and Another (1981) 1 All ER 267(HL))*

[45] In *Whitehouse v Jordan* supra, the English Appeal Court held that a "mere error of judgment" on the part of a medical practitioner does not constitute negligence. In this regard Ackerman J in *Castell v De Greeff* supra, said the following at p416 E-H:

> "It has on occasions been suggested that a 'mere error of judgment' on the part of a medical practitioner does not constitute negligence. In Whitehouse v Jordan and Another (1981) I All ER 267(HL) the House of Lords, inter alia,

considered the correctness of the statement by Denning MR in the Court of Appeal that:

> 'We must say, and say firmly, that, in a professional man an error of judgment is not negligence.'

The House of Lords held this to be an inaccurate statement of the law. At 281a Lord Fraser of Tullybelton expressed the view that:

> "I think Lord Denning MR must have meant to say that an error judgment 'is not necessarily negligent'."

Lord Fraser further observed as follows (at 281b):

> "Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligent. "

[46] With these principles in mind, I shall now proceed in the determination and the resolution of the areas of dispute adopting the approach as stated by the Supreme Court of Appeal in *SFW Group & Another* supra, and in the final analysis, determine whether the Defendant's conduct in his pre-operative advice, performance of surgery and post-operative treatment of Plaintiff, if any, is culpable, and if so, whether such culpability attracts any form of

liability.

PLAINTIFF'S PHYSICAL CONDITION PRIOR TO CONSULTATION WITH THE DEFENDANT

[47] What appears to be common cause between the parties, and indeed this is not disputed by the Defendant, is that Plaintiff experienced considerable pain when he consulted Dr Simons on 5 June 2000; that the pain persisted until his initial consultation with the Defendant on 6 June 2000; that the examination of Plaintiff by the Defendant and the subsequent surgery performed was intended to relieve him of this pain. What is being challenged by the Defendant is the Plaintiff's physical condition, in particular his ability to exercise prior to the manifestation of this intense pain. The crux of Plaintiff's complaint, apart from the fact that he was not relieved of pain after the vascular surgery was performed, is that he now claudicates after walking a distance of somewhat 30 metres; that he did not experience this symptom prior to performance of the surgery; that this symptom manifested immediately after Plaintiff had undergone the vascular surgery and that because of this claudication his ability to exercise to the extent he could before the vascular operation has been compromised.

[48] Plaintiff's health history and lifestyle prior to the onset of pain is set out in paragraphs 8 to 16 of this judgment. Only the salient features thereof will be repeated here for purposes of evaluation. These are the following:

- Plaintiff and his wife occupied a flat situate on the fourth floor of the block of flats; that the flat could only be accessed by four flights of stairs; that Plaintiff utilized a flat on the second floor of the same

building as an office; that he could ascend a flight of stairs from the ground floor to his office and from the office to his flat on the fourth floor with ease, an exercise he no longer could do shortly after the vascular operation was performed;

- during 1999 Plaintiff purchased two mountain bicycles for himself and his wife, this apparently having been at his wife's suggestion, in order that they could exercise regularly, and that his exercise regime included cycling, walking, paddle-skiing and other aquatic activities in and around Clanwilliam;
- on a regular basis Plaintiff and his wife would cycle together prior to the evening meals, an exercise he no longer could do after he vascular operation was performed;
- during one such visit to Clanwilliam Plaintiff and his brother cycled together up a mountain pass, and because of the steepness of the mountain hill, they had to have stoppages and had to rest at regular intervals;
- on one such visit during the long weekend commencing 27 April 2000, Plaintiff and his wife went for a walk next to the Clanwilliam Dam when, in the process, the Plaintiff slipped, landing on his buttocks and hurting his lower back. After the fall Plaintiff was incapacitated for a period of about ten days whereafter he returned to work and resumed his daily vocational duties and his exercise regime;

[49] In short therefore, Plaintiff's case is that he had conducted a normal lifestyle up to the time he fell at Clanwilliam. This lifestyle included regular cycling, walking, paddle-skiing and other aquatic activities in and around Clanwilliam Dam and, notably, he never experienced any problem ascending the stairs to his flat and between the flat and the office on a daily basis. Apart from some discrepancies, which in my view are minor, Plaintiff's ability to exercise and his exercise regime is supported by his wife and his brother. I have already pointed out that Plaintiff's exercise regime is vigorously challenged by the Defendant and this challenge is on the basis of the results of the angiogram which the Defendant performed on Plaintiff on 7 June 2000.

[50] Towards the end of May 2000 Plaintiff began experiencing numbness in the lower back and pain in the right leg which became increasingly severe. Because of this severe pain Plaintiff consulted Dr Simons.

EXAMINATION OF PLAINTIFF BY DR SIMONS

[51] Dr Simons has no independent recollection of symptoms Plaintiff manifested when he examined him. He had to refer to his clinical notes in order to refresh his memory. The notes taken by Dr Simons arising from his examination of Plaintiff indicate that the latter complained of pain both below and above the right knee, particularly on the outer aspect of the lower right leg. In his diagnosis Dr Simons excluded nerve entrapment as the probable source of Plaintiff's pain at the time. Dr Simons further noted that such pain was preceded by numbness, especially when getting out of bed, was aggravated by movement and radiated up into the right buttock.

[52] Dr Simons further noted that there were no foot pulses present in either of Plaintiff's feet, that he could detect femoral and popliteal pulses on Plaintiff's left leg but nothing on the right leg. He made no note of any complaint of claudication on the part of Plaintiff; made no note of any pain in Plaintiff's right foot; made no note of any discolouration of the right foot; made no note of any abnormal temperature present in the right foot nor did he make any note of the precise nature of any neurological tests performed by him. He performed a single leg raise test on Plaintiff and while doing so Plaintiff exclaimed "for heaven's sake don't let that leg drop". Subsequent to this examination Dr Simons arranged an appointment for Plaintiff to consult the Defendant at the latter's rooms at Panorama on Tuesday, 6 June 2000. Dr Simons held the view that Plaintiff's pain was of vascular origin hence his referral of Plaintiff to a vascular surgeon in the person of the Defendant.

EXAMINATION OF PLAINTIFF BY THE DEFENDANT

[53] The Defendant cannot remember the contents of the referral note by Dr Simons except a reference therein to a vascular problem. After the examination of Plaintiff the Defendant also held a view that Plaintiff's problem was of a vascular nature and recommended an aorta by-pass procedure to alleviate Plaintiff's ailment. The Defendant recommended Plaintiff undergoes angiography which the Defendant duly performed on Wednesday, 7 June 2000. As has already been pointed out in paragraph [15] above the angiogram confirmed an occlusion of various arteries in Plaintiff's right iliac system, the internal iliac artery and the superficial femoral artery on the left leg. The Defendant concludes in his evidence that the angiogram pictures confirmed his clinical suspicion of poor blood flow to the right leg. The result of the angiogram show that the left internal iliac artery was totally occluded as is the left superficial femoral artery. It is on the basis of the results analysis of the angiogram that Defendant challenges Plaintiff's physical condition in particular his ability to exercise, prior to performance of the vascular surgery.

[54] What is significant to note is that when the Defendant performed the angiogram, according to his evidence, it was not for the purpose of diagnosing the extent of blood flow in Plaintiff's right lower leg or for purposes of evidence, but to establish the "geography" of Plaintiff's arteries in the iliac system in order to obtain the appropriate site for the location of the by-pass operation.

[55] Prof De Villiers, a vascular surgeon, was called to testify in Plaintiff's case. It was put to Prof De Villiers, under cross-examination, that under no circumstances could Plaintiff ever have been able to be physically active in the manner he claimed he could in his evidence prior to the onset of his pain in the light of the angiographic images. Prof De Villiers refuted this statement and cited as a matter of his personal experience an 85 year old patient of his whose vascular condition was worse than that of Plaintiff on basis of the angiogram, who decided against a vascular operation and had decided on a regular exercise to achieve the required relief. The view of Prof De Villiers is that Plaintiff's ability to exercise prior to undergoing vascular surgery cannot be rejected purely on the basis of the angiographic images.

[56] Dr Harris-Jones, a vascular radiologist, also called to testify in Plaintiff's case highlighted the following features in his interpretation of the angiographic images arising from the angiogram performed by the Defendant and these are that:

- Whilst there is a noticeable total occlusion of the right common iliac and the superficial femoral artery there is good collateral flow of blood in both the left and the right leg.
- He was of the opinion that the second "run" of the angiogram did not give a representative view of the arteries in the right leg.

- The angiogram only reflects the state of the patient's arteries in a resting position whilst the angiogram is being performed. The experts, including those of the Defendant, were agreed that Plaintiff's arteries would have become dilated when he exercised, that this may have improved blood flow and may have resulted in a different picture to the one reflected in the angiogram.

Dr Harries-Jones concludes as follows in his evidence:

> "But what concerned me, was that I believe people on seeing this arteriogram, say it is impossible for this man to ride a bicycle for a kilometer or two kilometers, three kilometers. That is true if you look at this study as it is shown now. But if the study is not representing the real picture, then your impression, one's impression that this man may not be able to exercise, could be incorrect. That's what I'm trying to indicate."

[57] Dr Harris-Jones further observes in the evidence that whilst there is total occlusion of the right iliac arterial system and a total occlusion of the superficial femoral artery on basis of the angiogram, there are nonetheless large collateral arteries supplying both the right and left leg. The interpretation of the angiographic images by Dr Harris-Jones, particularly in the light of good collateral blood flow in both the left and the right leg, casts doubt on any conceivable urgency in the performance of the vascular operation. In view of the fact that the angiogram was performed on Plaintiff in a resting position and whilst his arteries were not dilated, Plaintiff's evidence regarding his exercise regime prior to the onset of pain he experienced before he saw both Dr

Simons and the Defendant cannot, in my view, be rejected purely on basis of the angiogram.

THE NATURE AND EXTENT OF PLAINTIFF'S PAIN

[58] I have already pointed out elsewhere in this judgment the fact that when Plaintiff consulted the Defendant in his rooms on Tuesday, 6 June 2000 he was under considerable pain. This is common cause between the parties. The Defendant conceded as much in his evidence that when Plaintiff limped into the examination room, there was no doubt that he had a severe pain. What I need to determine is the nature and the locality of such a pain and whether the vascular procedure performed by the Defendant was the appropriate measure to relieve Plaintiff of such pain.

[59] There are divergent views amongst the experts as regards the nature and locality of the severe pain Plaintiff presented when he consulted Dr Simons and the Defendant. Prof De Villiers, whose view is shared by Dr Shafiek Parker, a neuro-surgeon, also called to testify in Plaintiff's case, is of the view that that the type of pain Plaintiff experienced pre-and post-operatively is of a neuralgic nature. On the other hand Dr De Kock, whose view is shared by Dr Stein and Prof Immelman, is of the view that the pain Plaintiff presented prior to the vascular surgery is of a vascular nature and that any pain of a neuralgic nature could only have developed afterwards.

[60] The approach to follow in the evaluation of conflicting expert evidence pertaining to the alleged professional negligence of a medical practitioner was recently restated by the Supreme Court of Appeal in *Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another 2001(3) SA1188*(SCA).

[61] On a question of how one establishes the conduct and views of the notional reasonableness of a medical practitioner without a collective or representative opinion, the Court held as follows at p1200 par 36:

> "[36] 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* [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.
>
> [37] The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because of 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' 9at 241G – 242B)

[39] A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not

capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed' (at 243A-E)."

[62] I have already referred to the symptoms Plaintiff presented when he consulted Dr Simons and Dr Kieck in paragraphs [12] and [20] of this judgment. At the cost of repeating myself the symptoms Plaintiff complained of when consulting Dr Simons were five days of pain in the lower aspect of the right leg preceded by numbness especially when getting out of bed; aggravation of that pain which shoots up to the buttock. Dr Kieck also noted that Plaintiff experienced pain (original pain was still there); that the pain was terrible and presented in the buttock/thigh/calf and that Plaintiff was more comfortable at rest while bending was worse.

[63] According to Prof De Villiers, the symptoms which Plaintiff presented to Dr Simons on 5 June 2000, and the pain which manifests from these symptoms, are not related to continued walking or exercise. His view is that the notes as recorded by Dr Simons reflecting pain and the locality of such pain (lower aspect of the right leg preceded by numbness especially when

getting out of bed) are suggestive of “sciatica”, being nerve entrapment related to lumbar disc prolapse. These symptoms were presented when Plaintiff consulted the Defendant on Tuesday, 6 June 2000.

[64] Dr Shafiek Parker shares Dr De Villiers’ view as regards the nature of the symptoms and pain Plaintiff presented both to Dr Simons and the Defendant. He also specifically notes that the notes taken by Dr Simons when he initially consulted with Plaintiff are indicative of “sciatica” and very suggestive of nerve entrapment. Conceding that when Plaintiff consulted the Defendant he(Plaintiff) also presented an extensive vascular disease, his view is that Plaintiff should have been diagnosed with a dual pathology, being a vascular disease and a neuralgic disease and should have been referred to a neurologist for an assessment of the neuralgic disease.

[65] On the other hand, the broad view shared by the Defendant’s experts is that the symptoms and pain Plaintiff presented to Dr Simons and the Defendant are indicative of “ischaemia”. They are of the view that after Plaintiff had undergone the vascular surgery the blood supply to his right leg was significantly improved, that he became more mobile after surgery and possibly exerted himself to the extent he suffered a disc prolapse. In effect what they say is that when Plaintiff consulted Dr Simons and the Defendant Plaintiff presented pain of ischaemic origin as against pain of a neuralgic nature.

[66] I have already pointed out in paragraph [16] of this judgment that on discharge from Panorama on Sunday, 11 June 2000 Plaintiff was still not relieved of pain he experienced prior to the vascular operation being performed. Further, I have already pointed out in paragraph [25] that after performance of the lumbar operation Plaintiff was immediately pain free and was now able to ascend the four flight of stairs to access his flat with much greater ease than after the first operation.

[67] In my view the opinion expressed by Prof De Villiers and Dr Parker as regards the probable source of Plaintiff's pain is based on logical reasoning and, on basis of evidence tendered, their conclusion could very well be said to be defensible. (See *Michael & Another v Linksfield Park Clinic (Pty) Ltd* supra). Based on these views and the probabilities based on evidence, I can conclude with confidence that the nature of pain Plaintiff experienced both pre and post the vascular operation was of a neuralgic nature and not of a vascular origin. For reasons already stated I find the body of opinion as expressed by Drs De Kock, Stein and Prof Immelman in this regard incapable of withstanding logical analysis and support.

DUAL PATHOLOGY

[68] Prof De Villiers has always been of the view that when Plaintiff consulted Dr Simons on 5 June 2000 he presented symptoms suggestive of a neurological disease in the form of "sciatica" and not symptoms indicative of a vascular disease. In his view these symptoms were present when the Plaintiff consulted the Defendant on 6 June 2000 and Dr Kieck on 14 June 2000. Prof De Villiers is accordingly of the view that when Plaintiff consulted the Defendant he (Plaintiff) presented a dual pathology which he understands to mean, and so are Drs Stein, Simons and Prof Immelman, an instance where a person presents symptoms indicative of one of two problems or where symptoms of one problem overlaps or possibly masks symptoms of another disease. So does Dr Britz, the Defendant's neurological expert, understand the term "dual pathology" as is evident in his expert summary. This also seems to be the Defendant's understanding of the term "dual pathology" for, in a letter addressed to Dr Simons dated 26 June 2000, the Defendant concludes with the remarks: "Apparently he continued to experience severe pain after discharge and had to have a second operation by Dr Kieck for a prolapsed disc. His foot pulses were in tact. This may be a case of double pathology but I hope he will now be able to return to work.". But when the Defendant was cross-examined on this point he became evasive, sought to attach a different meaning to this term to the point of downplaying its relevance, suggesting instead that it was simply a "throw away line" and a convenient way to end the letter.

[69] Dr Simons, under cross-examination, and in an answer to the question what he understands by the term "double pathology" went on to say that when

he first saw Plaintiff, he was of the view that there were two pathological processes on the go, the one being the vascular component and possibly a second one which may have been the back or a disc. Plaintiff should have had these symptoms when he consulted with the Defendant the following day, Tuesday, 6 June 2000. There is no way these symptoms could have evaporated overnight. Moreover, Dr Simons agrees that Plaintiff's symptoms, as recorded by Dr Kieck are, in general terms, consistent with his observations, namely, the calf, being the area where the pain is centrally pronounced and radiation up the buttock being the secondary area where the pain was manifestly pronounced.
I have already made the point that on discharge from Panorama Plaintiff was not relieved of pain. The relief only came about after Plaintiff had undergone laminectomy at Vincent Pallotti. The pain was ongoing before and after the vascular operation and the relief only came about after the laminectomy was performed.

[70] Plaintiff states in his evidence that he first complained about the ongoing pain after surgery at about 17h00 the same date the vascular operation was performed. The Defendant does not recall this complaint and indeed his visit to the ward when the complaint ought to have been made. The second complaint Plaintiff made to the Defendant, still about the ongoing pain, was in the morning of Friday, 9 June 2000 before the Defendant departed for America. A similar complaint was made to Dr Michaelowski on Plaintiff's discharge on Sunday, 11 June 2000. All of these complaints, in my view, ought to have excited a suspicion that all is not well in Rome; that the source of Plaintiff's pain could not have been from a source as originally anticipated and, accordingly, would have justified a further investigation which probably would have involved referral of Plaintiff to a neuro-surgeon.

[71] Prof De Villiers' evidence is that if the Defendant had diagnosed the neuralgic pain, the Defendant in all probability would have referred Plaintiff to a neuro-surgeon, and if that would have been done, the neurological problem would have been addressed first.

[72] I am thus of the view that when Plaintiff consulted the Defendant on Tuesday, 6 June 2000, he presented two conditions, namely, that of an extensive vascular disease and a neurological problem arising from the nerve entrapment in the lumbar region, that it was the neurological problem which was the source of pain Plaintiff experienced at the time and that it was this condition which had to be treated for the relief of that pain.

WAS THE DEFENDANT'S EXAMINATION OF PLAINTIFF REASONABLE ?

[73] In the determination of whether the Defendant took all reasonable steps in his examination of Plaintiff, it is perhaps appropriate to cite the remarks made in the introduction to the Medical Law Student Guide presented by Professors S A Strauss and M C Maré of the University of South Africa. Those remarks are to the following effect:

> "… Of all the professions, none is more intimately involved with the law than the medical profession. Protecting man, his life, personality, physical integrity, health, honour and dignity is one of the fundamental objects of the law. Medical Science depends in no small degree on the law to create an atmosphere conducive to practice, research, and advancement, and calls on the law to determine the permissible limits within which it may operate."

If one were to look at the number of guidelines regulating every facet of medical practice, from the initial consultation, medical examination, ethical and professional rules, guidelines for good practice, seeking patients' consent, one's immediate reaction would be that the medical profession is one of the most over regulated professions in the world. But it is specifically because the medical profession deals with protecting man's life, personality, physical integrity, health and dignity that the medical profession appears to be the focus of constant search light.

[74] It is for reasons cited in those introductory remarks that the Health

Profession's Council of South Africa, a statutory body regulating the medical profession, has issued various guidelines regulating good practice, ethical rules and professional self-development, which the medical profession is expected to adhere to.
There is no certainty as to the legal status of these guidelines except to say they constitute general practice accepted in the medical profession.

[75] The Plaintiff first consulted Defendant on Tuesday, 6 June 2000. The consultation could have taken place after 13h30 as Plaintiff had arranged to see the Defendant at that time. According to Plaintiff, this was after he had handed over to the Defendant a referral note given to him by Dr Simons a day before, being Monday, 5 June 2000. The Defendant does recall having been handed Dr Simons's referral note by Plaintiff. He cannot recall what the contents of the letter were except to specifically recall that there was reference in it to a "vascular" problem. Furthermore, the Defendant cannot recall what was said or discussed during such consultation except to say he would have followed a normal pattern during such a consultation. He would have made notes of such a consultation at the back of the admission form and, at a later stage, would have gone through the notes, dictate a formal letter containing all the information gathered during such a consultation to the referring general practitioner and keep such a letter as his notes. He would then keep the handwritten notes for a period of time and, according to his evidence, once the load of paper has built up, he would then dispose of such notes by destroying them for purposes of recycling. Whatever notes he may have made in his consultation with Plaintiff, so did the Defendant say in his evidence, he may either have destroyed or disposed of for recycling.

[76] The guidelines applicable to medical practitioners and dentists on keeping of patients' records, define a "medical record" as follows:

> "A medical record is constituted by any record made by a medical practitioner at the time of or subsequent to a consultation with, an examination of, or the application of a medical or surgical procedure to his or her patient and which is relevant to thereto." .

The notes referred to by the Defendant fall squarely within the definition of a medical record in terms of this definition.

Paragraph 4 of the guidelines already referred to and under the heading "Compulsory Keeping of Records" provide that a medical practitioner shall, amongst other things, enter and maintain records relating to the assessment of the patient's condition and the proposed clinical management of the patient. In turn, paragraph 6 of the guidelines already referred to, provides that such

records shall be stored for a period of not less than 6 years from the date they became dormant. The guidelines further provide that other personal records should be kept for a period of eight years after the conclusion of the treatment.
The Defendant does not have any record relating to the consultation he had with Plaintiff other than a reference to such a consultation in a letter addressed to Dr Simons dated 26 June 2000. He does not have a copy of Dr Simons's referral letter nor does Dr Simons have it in his file.

[77] The Defendant does recall, based on a letter addressed to Dr Simons dated 26 June 2000, that Plaintiff complained of pain on the outer part of the lower leg, just above the ankle; that his foot was painful; that the pain was severe for the past five days; that stepping on the foot made the pain worse. He does recall Plaintiff informed him he smokes 30 to 40 cigarettes a day; he suspected that Plaintiff had a vascular problem; he could not feel any pulses in the right leg, which, according to him, is abnormal; he did feel pulses in the left leg; he could not feel the right pulse at all so that he could not compare the two pulses; that Plaintiff was limping as he walked into the examination room and that he clearly was in pain.

[78] After examining Plaintiff, he came to the conclusion that Plaintiff was suffering from severe peripheral "ischaemia" which required immediate intervention. However, he recommended that an angiogram be performed before the exact course of management could be determined. It is not clear on basis of his evidence how long this consultation lasted.. An arrangement was made for the angiogram to be performed the following day. The angiogram was performed the following day, Wednesday, 7 June 2000. After performance of the angiogram Plaintiff was admitted to undergo an aorta-femoral bypass procedure the following day, Thursday, 8 June 2000.

[79] According to the Defendant's evidence, both as regards the initial consultation and the physical examination of Plaintiff, the enquiry during such consultation seems to have focussed on Plaintiff's professed vascular disease as the proximal cause of the pain Plaintiff experienced at the time. This is not surprising in view of what the Defendant does recall of a reference to a "vascular" problem in a referral letter addressed to him by Dr Simons.

[80] The Defendant directed no enquiry to Plaintiff as regards his ability to exercise, or his ability to perform the ordinary daily physical functions which would be expected of a normal healthy person; no enquiry was made as regards whether Plaintiff had a history of claudication or whether there was a particular incident linked to the cause of Plaintiff's complaint.

[81] I have already made the point in paragraph [54] above that when the Defendant suggested to Plaintiff that the angiogram be performed it was with a view to establishing what the Defendant referred to in his evidence as the "geography" of Plaintiff's arteries in the iliac system so as to obtain the appropriate sites for the location of the bypass prothesis and not for purposes of diagnosing the extent of Plaintiff's blood flow in Plaintiff's right lower leg. After the angiogram had been performed Defendant performed surgery on Plaintiff the following day, Thursday, 8 June 2000. Further, I have already made the point elsewhere in this judgment that after Plaintiff had undergone the operation, he was not relieved of the pain he had prior to undergoing surgery and had subsequently consulted Dr Kieck who had performed laminectomy on him on 21 June 2000 whereafter Plaintiff was relieved of pain.

[82] The Defendant did not make contemporaneous handwritten notes when he consulted and physically examined Plaintiff and, if he did, as he claims to have done in his evidence, he had these destroyed shortly after he had despatched his letter dated 26 June 2000 to Dr Simons or such notes may have been disposed of for recycling. The only indication of the symptoms Plaintiff manifested shortly before the operation by the Defendant are the handwritten notes by Dr Simons made during the consultation he had with Plaintiff on Monday, 5 June 2000.

[83] It is accepted by all the parties concerned that when Plaintiff consulted with the Defendant on Tuesday, 6 June 2000, he manifested an extensive vascular disease which required surgical intervention. The issue to be determined is whether, on the probabilities, the vascular disease Plaintiff manifested at the time was the source of pain and discomfort Plaintiff experienced at the time and if so, whether it required urgent surgical intervention.

[84] Under cross-examination the Defendant initially testified that after he had physically examined Plaintiff he had determined that Plaintiff's vascular disease needed urgent attention. This he said in an explanation as to why he had booked the theatre for an operation the following day, 8 June 2000. Asked why he was of the view that the disease needed urgent intervention he responded that his earlier reference to urgency was a mistake and all that he had meant to convey was that an attempt had to be made to assist Plaintiff as expediently as possible. In his letter to Dr Simons dated 26 June 2000 the Defendant states that Plaintiff's right foot was clearly "ischaemic" with blue discolouration and decreased temperature. He diagnosed a severe peripheral "ischaemia". The Defendant held this view despite the presence of sufficient collateral blood supply as is clearly evident in the angiographic images. In the absence of clear indication of lack of blood supply to the body extremities such as the right foot in the instance of this matter, I fail to see how the Defendant could determine that the source of pain and discomfort Plaintiff experienced at the time of his examination could be of severe peripheral ischaemic origin requiring urgent surgical intervention.

[85] The Defendant omitted to enquire into Plaintiff's ability to exercise; he failed to establish if Plaintiff's complaint was linked to any particular incident; the symptoms Plaintiff manifested at the time were suggestive of a neuralgic disease; he failed to diagnose the neuralgic disease when symptoms suggestive of "sciatica" were glaring; he failed to inform Plaintiff that the vascular operation was not urgent; that Plaintiff could undergo vascular surgery at a later stage probably when he could afford the procedure of his preference; he failed to keep contemporaneous notes when consulting and examining Plaintiff. The cumulative effect of all these factors justifies no other conclusion other than that the standard adopted by the Defendant does not measure to the reasonable standard expected of a man of his calling. Whether Plaintiff consented to the procedure performed, is the next issue to be determined.

CONSENT

[86] In the determination of the issue as to whether or not Plaintiff consented to the operation performed on him by the Defendant it is necessary to make some observations about the general principles applicable to the whole concept of consent to treatment or what generally has become known as the doctrine of informed consent.

[87] For a medical practitioner to be able to invoke a patient's consent as a ground of justification, it must be shown that the patient not only consented to the injury and the medical intervention proposed, but that the patient also consented to the risks and consequences consequent upon such medical intervention. Consent will therefore only be valid where it is based on essential knowledge regarding the nature and the effect of the proposed treatment. This entails that consent must be informed (See Claasen NJB and Verschon, T: Medical Negligence in South Africa p62)

A consent to treatment will only be "informed" if it is based on substantial knowledge concerning the nature and the effect of the act consented to. Thus a medical practitioner is obliged to warn a patient of the material risks and consequences which may ensue during and consequent to the proposed treatment.

[88] In *Castell v De Greef,* already referred in paragraph [43] supra, at *425* Ackerman J formulates the following test in the determination of whether or not consent has been given in any set of circumstances and whether such consent is informed:

> "For consent to operate as a defence, the following requirements must, inter alia, be satisfied:
>
> a) the consenting party must have had knowledge and been aware of the nature of the harm or risk;
>
> b) the consenting party must have appreciated and understood the nature and extent of the harm and risk;
>
> c) the consenting party must have consented to the harm and assumed risk;

d) the consent must be comprehensive, that it extend to the entire transaction, inclusive of its consequences."

[89] There is a duty on the medical practitioner properly to inform the patient of the risks attendant on his or her treatment and its dangers. The object is to enable the patient to decide whether or not to run the risk of consenting to the treatment or procedure proposed (see *Chester v Afshan (2002) 3 All ER 552 at 572e)*. In *Richter and Another v Estate Hamman 1976(3) SA 226*(C) the Court held that a doctor's conduct in informing a patient of the material risks attendant to the proposed treatment or procedure should be adjudged by the standard of the reasonable medical practitioner faced with a problem concerned. The court postulates this approach as follows at 232e "In reaching a conclusion (as regards the disclosure of a risk by the doctor) a court should be guided by medical opinion as to what a reasonable doctor, having regard to all, the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence,"

[90] The full bench in *Castell v De Greef* supra did not follow the approach in *Richter*. It held at 426 that a medical practitioner is obliged to warn the patient consenting to a medical treatment of a material risk inherent in the proposed treatment holding that "a risk is material if, in the circumstances of a particular case:

a) a reasonable person, in the patient's position, if warned of the risk, would be likely to attach significance to it or

b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

This standard which, in my view, and as was indeed held in *Castell v De Greef* supra, focuses on patient autonomy rather than the views of the medical profession, is in conformity with the fundamental right of individual autonomy and self-determination. I am thus bound to follow this approach unless satisfied it is clearly wrong, which is not.

[91] The question as to whether or not consent was given in any set of circumstances is one of fact. The law does not, save in certain specific instances, prescribe how the required consent should be procured. Based on this approach I shall now proceed to determine, on basis of evidence, if the consent purportedly procured from Plaintiff was an informed one.

WAS AN INFORMED CONSENT GIVEN ?

[92] The Defendant did not produce any record or notes of a consultation he had with Plaintiff on Tuesday, 6 June 2000. It appears on basis of evidence that arising from such a consultation and the subsequent examination of Plaintiff, the latter was offered the aorta-bifemoral procedure to address his problem. This offer, so it appears on basis of evidence, was subject to an angiogram being performed on Plaintiff which was done on Wednesday, 7 June 2000. Shortly after the angiogram was performed, Plaintiff was admitted to the ward. According to Plaintiff's evidence no further

discussion took place after the angiogram was performed until the early evening when the Defendant was called into the ward and the discussion of the cost implications of the proposed treatment ensued. It also appears that a Mrs Cloete, who was in the employ of Panorama at the time, was present when the discussion took place. Plaintiff stated in his evidence that it was not clear to him what was being discussed in this discussion except to say only one procedure was suggested to him. Nothing was said to him, according to his evidence, about the precise nature of the procedure suggested or any material risks attendant on the procedure proposed.

[93] When the Defendant was asked when Plaintiff's informed consent was obtained to the procedure performed the Defendant replied that as far as he could recall, the required consent was obtained in the evening of Wednesday, 7 June 2000 after a lengthy discussion about the cost implications. When further asked if the consent was obtained on Wednesday evening in the ward, the Defendant's response was that he is not certain, that it could have been in the evening or it could have been the next morning, that is the morning before the operation. It either could have been late in the evening of Wednesday, 7 June 2000 or the following morning, so the Defendant said. The Defendant stated further that the required consent was discussed with the Plaintiff verbally and once consent was given the patient would sign a form. The Defendant was then referred to the form Plaintiff signed in the morning of 8 June 2000 and asked if that is the consent form relied on and the Defendant

replied in the affirmative. The Defendant states in evidence that the procedure performed on Plaintiff is ilio-femoral by-pass operation but, on basis of the consent form, Plaintiff consented to a femoro-femoral by-pass operation.

[94] The Defendant further states in his evidence that the procedure required to be performed on Plaintiff was not urgent despite the fact that Plaintiff experienced severe pain at the time. There is no evidence to suggest that the Defendant did discuss this lack of urgency or that the procedure could be performed at a later stage in order for Plaintiff to decide when it would be appropriate and convenient for him to undergo the proposed operation.

[95] I have already referred to Plaintiff's version that in the discussion he had with the Defendant, in the presence of Mrs Cloete, only one procedure was suggested to him and no other procedure was discussed with him other than the one the Defendant offered. If consent to the alternative procedure was offered and accepted in this discussion, it would have been accepted and, therefore, consent procured in the presence of Mrs Cloete. Mrs Cloete who could have corroborated the Defendant's version was not called to testify nor was she amenable to be subpoenaed by Plaintiff. The inference is thus irresistible that either her evidence would have supported the Plaintiff's version or would not have supported the Defendant's version. But if she

would have supported the Defendant's version it is inconceivable why she should not have been called (See *Durban City Council v S A Board Mills Ltd 1961 (3) SA 397(A)* at *405F*)

[96] I am unable to find, on basis of evidence before me, that Plaintiff was properly counselled before the vascular operation was performed, that other options, other than the procedure performed, were properly discussed with him, in particular that he did not need to undergo the vascular operation immediately, that he was advised of the material risks attendant to such operation and that he had given an informed consent to such operation.

[97] It is contended on behalf of Plaintiff that the operation performed on him did not relieve him of the pain he experienced at the time; that the Defendant did not advise Plaintiff of a material risk of claudication which could ensue after such a procedure and because the Defendant omitted to inform Plaintiff of this risk, any consent which Plaintiff may have given was not properly informed.

In paragraph 7A of the amended Particulars of Claim Plaintiff alleges that, in the absence of consent which is properly informed, the Defendant's operation on Plaintiff constitutes an assault and, on basis of this assault, Plaintiff is entitled to recover damages. Does the Defendant's conduct, in the absence of informed consent, constitute "assault"? This issue will be determined now.

ASSAULT

[98] In a number of decisions the courts have always held that in instances where a medical practitioner administers treatment to a patient without the patient's informed consent, such conduct constitutes assault.(See *Esterhuisen v Administrator, Transvaal 1957(3) SA 710(T), Lampert v Hefer N.O. 1955(2) SA 507(A), Steffberg v Elliot 1923 CPD 148* amongst others.) As to the requirements for a valid and informed consent see *Castell v De Greef* supra at 425H and cited in full in paragraph [88] of this judgment There is a school of thought that such conduct on the part of a medical practitioner, if it falls short of assault, it nonetheless could amount to a violation of a right to privacy.

[99] In *Broude v McIntosh & Others 1998(3) SA 60(SCA)* Marais JA considered it a strange notion that this type of conduct should be juristically characterised as an assault. He makes the following remarks at 671:

> "Pleading a cause of action such as this as an assault to which the plaintiff did not give informed consent is of course a familiar and time-honoured method of doing so. However, I venture to suggest with respect that its conceptual soundness is open to serious question and merits re-consideration by this Court when an appropriate case arises."

In my view these remarks are no more than an *obiter dictum* so that, bound as I am by the ratio of the Full Bench of this division in *Castel v De Greef* supra,I therefore find that the Defendant's conduct, to the extent that whatever consent which may have been given was not properly informed, constitutes

assault.

WHEN WAS PLAINTIFF RELIEVED OF PAIN?

[100] It is common cause that the Defendant performed an operation on Plaintiff on Wednesday, 8 June 2000. When Plaintiff regained consciousness after the operation he immediately became aware that the pain in his right leg about which he had initially complained to Dr Simons was still present. His evidence is when he informed the Defendant of this fact, the latter responded that he should give the matter time. The Friday morning the pain persisted. He caused the Defendant to be called and had informed him of the persistent pain. The Defendant's response was similar and had indicated to Plaintiff that he should give the matter time. The Defendant had also informed his wife with whom he had maintained constant contact by telephone whilst in hospital that the pain had not abated.

[101] After a visit by the Defendant the Friday morning Plaintiff asked for an equipment which Plaintiff referred to in evidence as "monkey chain" to be installed above his bed to help pull himself up. He had found this useful when he had a lumbar operation back in 1972. A strong pain killing injection was administered at 11.00am. The pain continued unabated. When no relief was forthcoming he decided to bear the pain and had stopped complaining. His intention was to attempt to secure his discharge from hospital as soon as possible. To him the hospital had become the devil's den.

[102] Plaintiff was discharged from hospital during the morning of Sunday, 11 June 2000. His wife was at the hospital to collect him. She had gone to hospital by taxi as she could not drive due to her advanced state of pregnancy. She overheard a discussion between Plaintiff and Dr Michaelowski when the latter was examining Plaintiff on his discharge, when Plaintiff complained that the pain was the same. This aspect of Plaintiff's evidence was not challenged nor was Dr Michaelowski called notwithstanding his availability to testify. The basis for an inference stated in paragraph [94] of this judgment is equally applicable on this aspect of the matter.

[103] Plaintiff's pain persisted at home to an extent that he telephoned Dr Simons on several occasions during the Monday, of 12 June 2000. Dr Simons subsequently saw and examined Plaintiff on Tuesday, 13 June 2000. Dr Simons confirms that when he consulted Plaintiff subsequent to his discharge from hospital, the latter still complained of pain in the right leg stating that it was worse than before; that as far as he could recall the pain was of similar locality, but more pronounced when he saw Plaintiff on this occasion. Dr Simons confirms that Plaintiff's left foot was noticeably cold. He had at that stage assessed Plaintiff's pain to be neurologically based. He prescribed certain pain killing drops. Plaintiff suggested to Dr Simons that the wrong operation was performed.

[104] Subsequent to this consultation Plaintiff telephoned a number of specialists and eventually came into contact with Dr Kieck. He subsequently consulted Dr Kieck. It is common knowledge that Dr Kieck performed neuro-surgery on Plaintiff a week later whereafter Plaintiff was immediately relieved of pain. Plaintiff saw Dr Kieck for a follow-up operation on Monday, 3 July 2000. I accordingly find that Plaintiff was probably relieved of pain on 21 June 2000 when Dr Kieck performed laminectomy on him.

CLAUDICATION AND CAUSATION THEREOF

[105] There appears to be consensus between Plaintiff and Defendant that Plaintiff claudicates. The dispute revolves around the averment by Plaintiff that his current state of claudication is as a direct consequence of the vascular operation. The Defendant, on the other hand, takes the position that Plaintiff's current state of claudication has nothing to do with the vascular operation performed; it is not a risk attendant to or consequent upon the vascular operation in as much as the Defendant did not advise Plaintiff of this risk because such advice would not be correct.

[106] Prof De Villiers ascribes Plaintiff's current state of claudication to a "steal syndrome" caused by the diversion of blood flow from the donor limb to the diseased limb, that this "steal phenomenon" is an inherent risk to the type of operation the Defendant performed on Plaintiff, that this complication should have been anticipated irrespective of whether there is a proximal or

distal stenosis.

[107] On the other hand, the view held by the Defendant and his experts is simply that if the take-off site of the graft is located on or below a proximal stenosis, it will have no effect on the donor limb, and in view thereof, no diversion of blood flow will ensue. This contention causes me great difficulty. In the first instance, the very procedure which the Defendant claims to have performed is in itself in dispute. The consent form signed by Plaintiff indicates that Plaintiff consented to a *femoro-femoral* by-pass operation. The Defendant, on the other hand, contends he performed an *ilio-femoral* by-pass operation. No operation notes were either produced or discovered to verify the kind of procedure Defendant performed on Plaintiff. There is of course a significant difference between these two operations although both are classified or fall in the category of so-called “cross-over” operations, the take-off point of the graft being at differing places, with the ilio- femoral being performed higher up than the femoro-femoral procedure. It is therefore difficult to uphold the Defendant’s contention without, in the first instance, being in the position to determine which procedure was performed. The Defendant was assisted by Dr Charl Dreyer. According to the Defendant Dr Dreyer would have been in a position to testify as to the take-off site of the graft on the left leg and also confirm the type of operation performed. But Dr Dreyer was not called to give evidence on behalf of the Defendant.

[108] Claudication, according to *The World Book Medical Encyclopaedia: Your Guide to Good Health,* is the limping that is usually caused by pain. Intermittent claudication, on the other hand, which is the symptom Plaintiff is currently experiencing, is pain or cramp in the calf muscle after exercise. It is relieved by rest, but the pain recurs when the muscle is again exercised. The cramp like pain is the result of inadequate blood supply with the resultant inadequate amount of oxygen to the calf muscle. Plaintiff contends that he did not experience this symptom prior to an operation and that this symptom only manifested immediately he had undergone vascular surgery.

[109] There is a further difference of opinions amongst experts as regards the cause of Plaintiff's current symptom, Prof De Villiers holding the view that Plaintiff 's current symptoms are as a direct result of the vasculary surgery performed on Plaintiff by the Defendant. Prof De Villiers postulates the position as follows in his evidence:

> "…there is less blood supply to the left leg and therefore you get claudication. So in that respect, in respect of the operation done by Dr Louwrens, in that respect he is responsible for it."

In support of this view Prof De Villiers relies on the view expressed in a recent publication *Vascular Surgery(5th Ed)* by Robert B Rutherford, MD. The passage relied upon at p983 of the aforementioned work reads as follows:

> "It is possible to produce steal in the donor extremity after femoro femoral bypass if there is outflow occlusive disease (eg. Superficial

> femoral artery occlusion) on the *donor* side. Even if this is not likely to become clinically manifest, however, unless there is greater flow demand (eg. with exercise), donor iliac artery stenosis or poor cardiac function."

[110] As I have already pointed out, the Defendant's experts harbour a different view. Dr De Kock, whose view is supported by the Defendant and as well as the Defendant's other experts says the following in his expert summary:

> "When after femoro-femoral bypass procedure, the blood supply to his right leg was significantly improved, he became more mobile as a result of which he developed claudication in the left leg and possible exerted himself to the extent where he suffered a disc prolapse."

Dr De Kock is further of the view that, because Plaintiff had an occlusion of the left superficial femoral artery and relying on the angiographic images of Plaintiff's blood supply, there is no way that Plaintiff could have been active enough prior to undergoing surgery to precipitate symptoms of claudication.

[111] I have already made a comment about the angiogram performed on Plaintiff in paragraphs [54] and [81] of this judgment. My comments and observations made in the aforementioned paragraphs are equally applicable here save to repeat that the angiogram does not purport to establish a detailed investigation of Plaintiff's vascular arterial system on basis of which a conclusion could be drawn on Plaintiff's pre-operative mobility.

[112] Prof De Villiers states in his evidence that the risk of steal arising following an ilio-femoral or femoro-femoral by-pass operation is in the order of 15%. In support of this contention he refers to a clinical study of war veterans, the Veterans Administrative Co-operative Study and the Veterans Administration Hospitals. In this study, so Prof De Villiers testified, three hundred and seventeen patients who had femoro-femoral by-pass surgery were examined for post-operative vascular changes that developed in the donor limb. Unmasked claudication developed in 7%; new claudication related to steal developed in 3,5%; prognosis of pre-operative claudication developed in 1,7% and concludes that the donor limb pressure measurements post-operatively is in the order of 15%. (See Archive Surgery – Volume 126, June 1991 p681)

[113] Plaintiff developed the following symptoms shortly after the operation was performed; his left foot was cold to touch; the right pedal pulse was stronger than the left; Dr Jansen (the anaesthetist) noted that the right pulse was stronger than the left; Plaintiff's left foot was noticeably cold when examined in his office by Dr Simons; when examined by Dr Kieck on 14 June 2000 he noted a weak pulse in the left limb and when further examined by Dr Kieck on 3 July 2000 Plaintiff complained of claudication all of which are symptoms indicative of compromised blood supply in Plaintiff's left lower leg.

[114] In my view the opinion expressed by Prof De Villiers is based on logical reasoning, has a logical basis, accords with objective evidence and capable of

logical support. I am further of the view that the symptoms of claudication Plaintiff is currently experiencing are as a consequence of the vascular operation performed by the Defendant, that Plaintiff's current symptoms are an inherent risk of a significant nature and that the Defendant failed to inform Plaintiff of this risk adequately or at all.

SUMMARY OF FINDINGS

[115] In paragraph [36] of this judgment I listed a number of areas of disputes which would first have to be determined before arriving at a conclusion as to whether or not Plaintiff has succeeded in proving the issue of the alleged breach by the Defendant of his contractual obligations; whether Plaintiff agreed to undergo the operation performed as a result of any form of misrepresentation by the Defendant, negligent or otherwise, and if so, whether Plaintiff acted to his detriment and whether Plaintiff consented to the procedure performed by the Defendant and if not, whether, in that event, Defendant's conduct constitutes assault.

[116] As to Plaintiff's physical condition, in particular Plaintiff's ability to exercise prior to the onset of pain and to seeing the Defendant, I have in paragraph [57] of this judgment determined that Plaintiff's ability to exercise prior to experiencing severe pain and subsequent consultation and operation by the Defendant cannot be rejected purely on basis of the angiogram; as to the nature, locality and source of pain Plaintiff experienced prior to the

vascular operation and which pain continued unabated after the vascular surgery, I have determined in paragraph [67] that that pain was of neuralgic origin rather than of vascular origin; in paragraph [72] I have determined that when Plaintiff consulted Defendant, Plaintiff presented a dual pathology in that a vascular disease and a neuralgic disease co-existed at the time of such consultation; that the Defendant for reasons stated in paragraph [85] of this judgment, failed to take reasonable steps in his examination of Plaintiff and in doing so failed to diagnose dual pathology; in paragraph [96] I have determined that the Defendant failed to procure Plaintiff's informed consent and that, on the probabilities, Plaintiff was relieved of pain immediately or shortly after the laminectomy was performed, the latter being an answer to the question what medical intervention was reasonably required to relieve Plaintiff of the severe pain.

[117] Based on my findings which I have summarised in the preceding paragraph, I therefore conclude that the Defendant, in his consultation and pre-operative advice to Plaintiff, acted in breach of his contractual obligations in the respects set out in paragraph 6 of Plaintiff's Particulars of Claim and, in particular, the Defendant failed to procure Plaintiff's informed consent in respect of the operation performed on Plaintiff and, in absence of consent which is properly informed, the Defendant's conduct constitutes assault. In the light of the finding I have made, it is not necessary for me to determine the issue of misrepresentation alleged in paragraph 7 of Plaintiff's Particulars of

Claim.

[118] As a result of the Defendant's breach of his contractual obligations Plaintiff suffered damages as more fully set out in paragraph 9 of Plaintiff's Particulars of Claim the extent and quantum of which, per agreement between the parties, is still to be determined and which damages are as a result of failure by the Defendant to discharge his contractual obligations as has already been pointed out

[119] Based on the evaluation of evidence tendered and various findings made in the process of such evaluation I therefore find as follows:

[119.1] The Defendant acted in breach of his contractual obligations arising from the oral agreement entered into between Plaintiff and the Defendant on 6 June 2000.

*[119.2] The Defendant is ordered to pay Plaintiff's costs on a party and party scale such costs to include the qualifying expenses of:

[119.2.1] Prof D R De Villiers

[119.2.2] Dr S Parker

[119.2.3] Dr E P Harris-Jones

…….

N J Yekiso, J