**THE REPUBLIC OF SOUTH AFRICA**

**IN THE HIGH COURT OF SOUTH AFRICA**

**(WESTERN CAPE DIVISION, CAPE TOWN)**

Case No: 12009/2013

In the matter between:

**PAULUS VLOTMAN** **Plaintiff**

**And**

**DR M BAKER** **Defendant**

**Coram**: **KOEN AJ**

**Heard:** **23 – 29 February & 1 March 2016**

**Delivered:** **7 March 2016**

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**JUDGMENT**

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***KOEN AJ***

[1] This is an action for damages for alleged medical negligence. All that is in issue, at this stage, is the question whether the plaintiff has established negligence on the part of the defendant and, if so, whether such negligence was the cause of the damages claimed by the plaintiff.

[2] On 14 September 2010 the plaintiff in this action, Mr Vlotman, presented with symptoms of a strangulated inguinal hernia. He was treated by the defendant, Dr Baker, who repaired the hernia surgically, using synthetic mesh to cover the hernia site.

[3] Five days later, on 19 September 2010, Mr Vlotman was discharged from hospital after the hernia repair. However, on 24 September 2010, he was readmitted to hospital complaining of pain and an infected discharge from the operation site. Dr Baker treated him again on this occasion. The extent of the infection was unknown and aggressive conservative treatment was commenced by irrigating the wound with peroxide, and the use of betadine and antibiotics. Mr Vlotman was discharged from hospital after this course of treatment appeared to have resolved the infection on 3 October 2010.

[4] However, after what appeared to be persistent infections of the operation wound site, Mr Vlotman was readmitted to hospital, just over a year later, on 25 October 2011, again under the care of Dr Baker. The purpose of this operation was to remove the mesh which had been used in the initial repair of the hernia because it was considered that it was the mesh which played a significant role in the perpetuation of the infection. Although Dr Baker set out to remove all of the mesh on this occasion he did not do so, for reasons which will appear from what follows. When the infection persisted a further operation was scheduled for 28 December 2011. Again, the object of the operation was to remove the mesh which was considered to be involved in the persistent infection at the operation wound site. Again, Dr Baker did not remove all of the mesh.

[5] The infection persisted. During January 2013 Mr Vlotman consulted Dr Ebrahim, another surgeon. After treatment with antibiotics proved to be unsuccessful in resolving the infection Mr Vlotman was admitted to hospital on 8 May 2013. Dr Ebrahim excised the sinus, or channel, through which infected material was passed from its source to the surface of Mr Vlotman's skin after injecting the sinus with blue dye. Aided in establishing the location of the source of the infection by using the dye, Dr Ebrahim discovered a total of three sinuses, all of which he opened, and at the source of which were discovered three further pieces of the mesh. In so doing it was necessary for Dr Ebrahim methodically to work his way through what he described as dense scar tissue in order to locate the offending pieces of mesh and to remove them. Dr Ebrahim described the surgery as *"very difficult high risk surgery"* and his notes, made at the time, reflect that he was concerned that he might cause damage to other important physical structures such as Mr Vlotman's iliac vein or artery, epigastric vessels, or that he might have penetrated into the plaintiff's bowel. Any error on his part in operating on Mr Vlotman would have had obviously undesirable consequences. Ultimately, there is no dispute that the surgical procedure aimed at removing the mesh, which was undertaken by both Dr Baker and Dr Ebrahim, was intricate, difficult and complex.

[6] It is common cause that the procedure performed by Dr Ebrahim during May 2013 was successful. Mr Vlotman's wound has healed and he has not had a recurrence of the infection which had persisted since his hernia was originally operated upon by Dr Baker during September 2010.

[7] During August 2013 Mr Vlotman instituted these proceedings against Dr Baker in which he claimed damages, alleging that Dr Baker had been negligent. The parties agreed that the questions of liability and causation should be determined separately from quantum, and an order to this effect was made in terms of Rule 33 (4).

[8] It is apparent from a reading of the pleadings that the grounds of negligence alleged by Mr Vlotman were, initially at least, cast far and wide. The particulars of claim, as amended, allege that Dr Baker had been negligent in that he had failed to diagnose the cause of the symptoms with which Mr Vlotman and presented post operatively; failed to diagnose that the symptoms in question were due to infection associated with the mesh; failed to conduct adequate special investigations to ascertain the cause of the persistent post- operative symptoms; failed to perform the inguinal hernia repair with reasonable skill, care and diligence; failed to keep Mr Vlotman under close, regular and careful observation post operatively; failed to remove all the mesh from the operation site; and, finally, failed to act with due care.

[9] As the case evolved, however, it became apparent that only two of the grounds of negligence originally relied upon were in issue. These were the allegation that Dr Baker had failed to remove all of the mesh from the site of the hernia repair, an allegation that was introduced by way of an amendment on the second day of the trial, and that Dr Baker had failed to act with due care.

[10] What is in issue, therefore, is the question whether the plaintiff has proved on a balance of probabilities, that Dr Baker was negligent in failing to extract all of the synthetic mesh when he operated upon him during October and December 2011.

[11] Two witnesses were called by the plaintiff to testify on this issue. They were Dr Ebrahim, who, as stated above, had performed the successful mesh extraction during May 2013, and Professor Warren, an expert in the field of surgery. It should be noted that Dr Ebrahim was not called to testify as an expert. His evidence was restricted to what it was that he did when he performed the successful mesh extraction surgery during May 2013.

[12] Referring to a note he had made Dr Ebrahim testified that he executed the operation by using blue dye to colour the sinus tracks and make it possible for him to follow the tracks accurately. Dr Ebrahim managed to detect side sinus tracks and, having located remnants of synthetic mesh, with the use of scissors, undertook the difficult task of dissecting the mesh from the tissue in which it was located. It must be noted that the mesh contains a large number of tiny perforations, and that as the tissue into which it is placed heals, the mesh and tissue become almost inextricably intertwined.

[13] When questioned about the advisability of the use of blue dye to assist in the location of a sinus attract Dr Ebrahim was not willing to express an opinion that the method which he chose could be said to be preferred over a surgical technique which did not entail the use of dye. He agreed that some surgeons did not use dye and I understood him to testify that this was a matter of individual choice among surgeons.

[14] Professor Warren testified that the desired object of the surgery undertaken by Dr Baker would have been to remove all of the synthetic mesh. In the end, there was no quarrel about this. Professor Warren testified that the use of dye would have facilitated the process of finding the mesh although he conceded that some surgeons did not use dye. I did not understand Professor Warren to suggest that choosing not to use dye in the procedure was a decision which could necessarily be criticised. The high water mark of Professor Warren's testimony was that with careful planning, patience and execution, and reasonable skill, he would have expected it to be possible to remove all of the mesh during one operation.

[15] Drs Baker, Simonz and Stein testified on behalf of the defendant. Dr Baker described the procedures he had undertaken during October and December 2011. He described how he made an incision around the scar in order to cut the scar out and how he cut out a wedge of tissue, dissecting a V shaped opening. He explained that he used a scalpel as he was accustomed to it

and he felt comfortable with the use of this instrument. He described the scar tissue as being dense. Having located the mesh which was enclosed in a dense ball of scar tissue he carefully excised it. Dr Baker described that this required meticulous concentration and care and that he was making small excisions, not even 1 mm deep, in order to gradually expose as much of the mesh as he could. What emerged in the evidence is that the mesh becomes "puckered" during the course of the healing process and that it is not found in the form of a flat sheet. Eventually, Dr Baker testified that he was cutting into normal tissue and not infected scar tissue. Dr Baker then testified that he considered that the time had come to say enough is enough, to use his words, and he stopped the operation at that stage.

[16] In regard to the second mesh extraction procedure, performed at the end of December 2011, Dr Baker testified that he followed the same procedure as beforehand looking for sources of infection. He identified a further four small pieces of mesh, removed them, and again discovered that he was cutting into healthy tissue while searching for more mesh. Again, he decided that it was wiser to stop operating and considered that at that stage he might have removed sufficient mesh to prevent the recurrence of infection. Once again, Dr Baker chose to conduct the procedure without using blue dye.

[17] Dr Baker was not able to have regard to any notes or medical records which had been contemporaneously made to assist him with his recollection of the procedures he had conducted. He testified that although he had made notes he could not locate them. He suspected that they had become lost when he moved rooms or later, when he retired from practice. Counsel for the plaintiff submitted that the absence of notes to assist Dr Baker in his recollection impacted negatively on the reliability of his evidence. He also pointed to various inconsistencies in trial particulars which had been furnished in order to bolster the submission that Dr Baker was quite unable to recall what he had done.

[18] It is self-evident, I think, that Dr Baker cannot be expected to recall, blow by blow as it were, everything that he did during two procedures performed over four years ago. But it is also clear from the medical evidence taken as a whole that the procedure involved essentially the excision, or laying open, of the sinus through which infected material flowed in order to locate the source of the infection. None of the expert witnesses in respect of whom notices were filed testified to it having been possible to have performed the procedures in any other materially different way. I do not think, therefore, that too much turns on the fact that Dr Baker was not able to refer to contemporaneous notes in describing the procedures he had undertaken in minute detail.

[19] In Dr Baker's case, having located the source of the infection, being synthetic mesh, he used a scalpel to dissect it from the tissue. In Dr Ebrahim's case, having located the source of the infection with the assistance of blue dye, and after laying open, as opposed to excising the sinus, Dr Ebrahim chose to use scissors to dissect the mesh from the tissue. In the end what differentiated the two procedures was that Dr Baker, having concluded that he had removed sufficient infected mesh, made the decision to stop. Dr Ebrahim, on the other hand, managed to remove the remaining three pieces of synthetic mesh which he found in Mr Vlotman in May 2013.

[20] Dr Baker explained that his decision to stop cutting into further tissue was motivated by a number of factors. Firstly, Mr Vlotman and had not presented with a dangerous or life-threatening condition. The discharge of pus from the infected surgical site was not a serious medical condition requiring urgent surgical intervention. Secondly, the operation was intricate and difficult and carried with it the risk of causing damage to important physiological structures at the site of the operation. When he noticed that he was cutting into normal healthy tissue he considered that he had done enough to resolve the persistent infection and decided to stop operating further. That decision, as I understood his evidence, was motivated by a balancing of

the advantages of operating further against the disadvantages of causing other damage with the resultant surgical complications.

[21] Drs Simonz and Stein, in their testimony, described what they thought it would be necessary to do in order to remove the infected synthetic mesh. Their evidence was helpful in gaining an understanding of the physiology of the surgical site, the difficulties of the operation, and the risks which went with it. But both conceded, quite fairly, that they were not able to express an opinion about the wisdom of the decision which Dr Baker had made not to continue with the surgery. Not knowing exactly what Dr Baker was confronted with meant that they could not say whether his decision to stop was one which a reasonable surgeon in his position would have made.

[22] It is also necessary to observe that all the medical experts were agreed that the site of the hernia repair would have changed over time and that the condition of the site would be affected by the degree of the infection which was present. Thus, immediately after the hernia had been repaired the wound would have been fresh and pliable. Over time, new tissue would have infiltrated the mesh forming scar tissue. As time progressed, the scar tissue becomes more dense and tough. Infection adds another dynamic to the evolving wound site. Infection causes the tissue to become loose and degraded and results, even, in the complete separation of the mesh from the scar tissue, the mesh floating loose, as it were, in a collection or pool of infected fluid. Thus, mesh located within fresh and pliable scar tissue is easier to remove than mesh located within dense and relatively old scar tissue. And mesh located within an infected area containing pus might have separated from the tissue by itself, without the necessity for dissection. What this goes to show, in my view, is that on each of the three occasions on which Mr Vlotman underwent surgery for the removal of the infected synthetic mesh the surgeon was not confronted with an identical set of circumstances.

[23] In argument, counsel for Mr Vlotman submitted that the evidence established, *prima facie*, a case of deviation from the reasonable standard of care expected of a surgeon in the circumstances. It was argued, firstly, that on the basis that Dr Baker had failed to remove all the mesh in two operations, notwithstanding that this was his objective. Secondly, it was contended on behalf of the plaintiff, that Professor Warren had produced evidence of the way in which the procedure ought to have been performed for the successful and safe removal of all of the mesh.

[24] The relevance of this line of argument lies in the fact that the plaintiff was not in a position to adduce evidence regarding what it was, precisely, that Dr Baker had done or not done during the course of the two mesh extraction operations he performed. This was because of the lack of any written record relating to the two operations. In the circumstances, and where the facts are peculiarly within the knowledge of a defendant, it is well established that less evidence will suffice to make out a *prima facie* case (see *Gericke v Sack* 1978 (1) SA 821 (A) at 827). If a *prima facie* case is made out in these circumstances, then, as was stated in *Goliath v MEC for Health in the Province of the Eastern Cape* (1084/2012) [2013] ZAECGHC 72 (14 June 2013) *"our law places an evidentiary burden on the defendant to indicate for example what steps were taken to comply with the appropriate legal standard"* (at para [84]). Of course, none of this changes the onus, which rests upon the plaintiff throughout.

[25] That these principles are of application in medical negligence cases is established. In *Van Wyk v Lewis* 1924 AD 438 Kotzé JA said (at 452) *"...where a plaintiff has proved certain facts from which, if not satisfactorily rebutted or explained, the conclusion may reasonably be drawn that there has been an absence of the necessary care or skill on the part of the medical man, a case of negligence against the defendant has been established, rendering him liable in damages."*

[26] Because of the unreliability of Dr Baker's evidence, a question to which I have adverted above, so the argument went, Dr Baker had not discharged the evidentiary burden under which he laboured, and thus even though minimal evidence of negligence had been put up by Mr Vlotman, enough had been done to discharge the onus of proving that Dr Baker had been negligent in failing to remove all of the synthetic mesh.

[27] It would, in my view, be unrealistic to expect in the absence of notes, that Dr Baker's recall of every step taken by him during the operations in question would be perfectly accurate. The operations took place over four years ago. They were difficult and intricate and required high levels of concentration. It seems to me to be unlikely that a surgeon confronted with such a task could recall with accuracy exactly what action he took at every step of the procedure. But that does not mean, in my view, that Dr Baker's recall should be entirely discounted. In particular, I see no reason not to accept that Dr Baker decided at a stage during the procedure that, to use his own words, *"enough is enough"*, and that the risks inherent in continuing outweighed any benefits which would thereby be achieved. In fact, as I understood the evidence, that such a decision was made by Dr Baker, for the reasons outlined, is common cause. Moreover, save for the fact that Dr Ebrahim used dye, and scissors to lay open the sinuses he found, and that Dr Baker did not use dye, and used a scalpel to excise the sinus he found, there is not much, in my view, to differentiate the procedures decided upon by each doctor.

[28] The real issue, then, is whether it can be said that Dr Baker was negligent in taking the decision to stop cutting further. Before dealing with that question it is necessary to deal with a proposition put to me in argument by counsel for Dr Baker. I was referred in argument to a statement of Denning MR in *Whitehouse v Jordan and Another* [1980] 1 ALL ER 650 at page 658 where it was said that *"we must say, and say firmly, that, in a professional man, an error of judgment is not negligent…."*

[29] However, what was not addressed in argument, was that the case went on appeal to the House of Lords where that statement was expressly disapproved of. The judgment of the House of Lords is reported as *Whitehouse v. Jordan* [1981] 1 All ER 267 (HL). In the House of Lords Lord Edmund-Davies said this: *"The principal questions calling for decision are: (a) In what manner did Mr. Jordan use the forceps, and (b) was that manner consistent with the degree of skill which a member of his profession is required by law to exercise? Surprising though it is at this late stage in the development of the law of negligence, counsel for Mr. Jordan persisted in submitting that his client should be completely exculpated were the answer to question (b), " Well, at worst he was guilty of an error of clinical judgment ". My Lords, it is high time that the unacceptability of such an answer be finally exposed. To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising "clinical judgment" may be so glaringly below proper standards as to make a finding of negligence inevitable.*"

[30] It is thus clear that the exercise of judgment in a medical context is not exempt from scrutiny and that the exercise of judgment made by medical and other professionals receives no special treatment in our law.

[31] How, then, does our law require that the decision of Dr Baker to cease operating upon Mr Vlotman be treated? In *Van Wyk* Wessels JA said this about the standard of care expected of a surgeon: *"... The surgeon will perform the operation with such technical skill as the average medical practitioner in South Africa possesses and that he will apply that skill with reasonable care and judgement...*(he) *is not expected to bring to bear on the case entrusted to him the highest possible professional skill but is bound to employ reasonable skill and care and is liable for the consequences if he does not"*(at 456). The learned judge went on to say: *"We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care.*

*We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently"* (at 461 to 462).

[32] Also apposite to this case is the following statement in *Van Wyk*: *"It is therefore necessary for a plaintiff who seeks to recover compensation for the damage done to him to show that the defendant was in all the circumstances of the case in the wrong when he left the swab in abdomen after he sewed it up and that in so doing he had failed to use that reasonable skill, care and judgement which it was incumbent upon him to employ. ' If at the end he leaves the case in even scales and does not satisfy the court that it was occasioned by negligence or fault of the other party he cannot succeed…'"* (at 462).

[33] Much reliance was placed by counsel for the plaintiff on the fact that Dr Ebrahim had successfully managed to remove all the mesh, although it was not suggested, I should add, that that fact in itself suggested that Dr Baker had been negligent in failing to remove the mesh. It is common cause that Dr Ebrahim exhibited a high degree of skill in performing the mesh extraction surgery during May 2013. But to compare what Dr Ebrahim did with the operations performed by Dr Baker is not, in my view, entirely helpful. He was not faced with exactly the same circumstances as those which confronted Dr Baker when he operated during October and December 2011.

[34] Firstly, the wound site, having been the subject of three previous surgical procedures, would in the process of healing have changed. As I understood the evidence of the medical experts that change could have involved either the toughening of scar tissue or the weakening of scar tissue where mesh surrounded by pus was found to be present. Although Dr Ebrahim described the scar tissue he encountered to be extremely dense it is not possible, in my view, to draw reliable conclusions about whether or not it was denser, or less dense, than the tissue

encountered by Dr Baker. Nor can one safely draw conclusions about the effects on the tissue and entrapped mesh brought about by the presence persistent infection. Secondly, Dr Ebrahim managed to locate the three remaining pieces of mesh by following each of three sinuses. Dr Baker had been confronted with one large and intact piece of mesh at the end of only one sinus. And thirdly, Dr Ebrahim had less mesh to remove than Dr Baker, because Dr Baker had managed previously to remove some of the mesh.

[35] I have referred to these differences in the circumstances confronted by Dr Baker and Dr Ebrahim because it was made clear in *Van Wyk*, in the passage quoted at paragraphs [31] and [32] above, that it is necessary to examine the circumstances of each case in order to determine whether or not a surgeon has acted negligently. Thus using what was done by Dr Ebrahim as a measure to judge what was done by Dr Baker is, as stated above, not entirely helpful.

[36] Some emphasis was placed on the fact that Dr Ebrahim had used dye to assist him to locate and follow the sinus to the source of the infection, and scissors and not a scalpel to excise the mesh from the tissue in which it was located. To turn, then, to question whether a reasonable surgeon in the position of Dr Baker would have used blue dye, to locate and follow the sinus, and scissors, as opposed to a scalpel, with which to perform the surgery.

[37] The difficulty which the plaintiff faces in regard to these questions is that Professor Warren who was called to give medical expert evidence on his behalf did not express any opinion about them in the expert summary filed in respect of his testimony, nor was the question addressed in any of the joint minutes filed by the medical experts. To the extent that these questions were touched upon in the expert evidence it became clear that there are a range of techniques and instruments available to a surgeon performing an operation and that, in many respects, what a particular surgeon chooses to use is a matter of choice and preference, and that choice cannot be said to unreasonable simply because another surgeon using different

instruments or techniques achieved a more satisfactory result. In the result it appears to me that there is no evidence to suggest that Dr Baker's choice of technique and instrument can be said to have been one a reasonable surgeon in his position would not have made.

[38] For these reasons I am not satisfied that the plaintiff has discharged the onus of proving that Dr Baker was negligent, and that he should be therefore be held liable for any damages which might be proved. This being the case, questions of causation do not arise.

[39] As to costs I see no reason why they should not follow the result. The case could not have proceeded with without assistance from medical experts. Although I was not addressed by any of the parties in regard to the qualifying expenses of the expert witnesses I think it is fair and reasonable that these be included in such costs.

[40] I therefore make the following order:

> The defendant is not liable for the damages claimed by the plaintiff in this case.
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> The plaintiff must pay the defendants costs of suit, such costs to include the qualifying expenses of the witnesses in respect of whom the defendant filed notices in terms of Rule 36(9)(a) and (b).

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**KOEN AJ**

APPEARANCES

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| For the Applicant: | Mr J.A. van der Merwe SC |
| | Instructed by: |
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| For the Respondents: | Mr G.P. van der Merwe |
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