IN THE HIGH COURT OF SOUTH AFRICA
WESTERN CAPE DIVISION, CAPE TOWN

REPORTABLE
CASE NO: A138/2021

In the matter between:

PHILIPPA SUSAN VAN ZYL N.O.
obo **A[....] M[....]** Appellant

and

THE MEC FOR HEALTH, WESTERN CAPE
PROVINCIAL DEPARTMENT OF HEALTH Respondent

Bench: P.A.L. Gamble, T.D.Papier and J.D. Lekhuleni, JJ
Heard: 17 January 2022
Delivered: 4 July 2022

This judgment was handed down electronically by circulation to the parties' representatives via email and release to SAFLII. The date and time for hand-down is deemed to be 10h00 on 4 July 2022.

JUDGMENT

GAMBLE, J:

INTRODUCTION

1. On 8 August 2007, A[....] M[....] (then 12 years old and hereinafter referred to as “the patient”), underwent routine surgery at the Tygerberg Hospital in Bellville for repair of a left inguinal hernia. The operation, which required the administration of a general anaesthetic, proceeded without any problems. As the patient was being revived from the anaesthetic he experienced a laryngospasm[1], causing his brain to be deprived of oxygen for an appreciable time – so-called hypoxia – which, it is claimed, resulted in the patient suffering anoxic brain damage.

2. In 2014 proceedings were brought on behalf of the patient to recover damages from the defendant, who bore responsibility for any acts or omissions by staff at the hospital resulting in injury and damages to its patients. The patient was assisted in those proceedings by Ms. P.S. van Zyl, a member of the Cape Bar, who was appointed as his curator ad litem. The defendant denied liability and the matter eventually went to trial on the merits, with the quantum to stand over for later determination.

3. The trial proceeded before Nuku J who heard the expert evidence on behalf of the plaintiff of, inter alia, an anaesthetist, a neurosurgeon and a clinical neuropsychologist. At the conclusion of the plaintiff’s case, the defendant successfully applied for absolution from the instance. As will be seen more fully hereunder, the plaintiff and the defendant each appointed, inter alia, specialist anaesthetists as expert witnesses to assist the Court in determining the question of professional negligence and these two experts prepared a joint minute during the pre-trial stage setting out their points of agreement and disagreement.

4. At the close of the plaintiff’s case, and before adducing any evidence on its part, the defendant successfully persuaded the Court *a quo* that there was no longer any difference of opinion between the experts, due regard being had to certain points of agreement allegedly concluded in the joint minute and the cross-examination of

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[1] Morgan & Mikhail, Clinical Anaesthesiology, describe a larygospasm as “*a forceful, involuntary spasm of the laryngeal musculature caused by stimulation of the superior laryngeal nerve*.” The laryngeal musculature is commonly referred to as the vocal chords.

the plaintiff's anaesthetic expert, and that the plaintiff had thus failed to establish a *prima facie* case for negligence which required an answer from the defendant.

5. Although the Court *a quo* heard the evidence of a neurosurgeon and a clinical neuropsychologist, which was adduced by the plaintiff in relation to the causation component of her delictual claim, no finding was made on this aspect. Absolution was granted solely on the basis that the plaintiff had failed to adduce sufficient evidence to make out a case for negligence on the part of the defendant.

6. The Court *a quo* having refused an application for leave to appeal, the patient is before this Court with the leave of the Supreme Court of Appeal ("SCA") granted on 1 April 2021. The patient was represented on appeal by Mr. P. Corbett SC and the defendant by Ms. S. Witten, both of whom appeared in the court below. We are indebted to counsel for their helpful heads of argument and submissions during the virtual hearing held on 17 January 2022. For the sake of convenience, I shall continue to refer to the parties as they were *a quo.*

ABSOLUTION FROM THE INSTANCE

7. Before proceeding to consider the merits of the appeal against the judgment granting absolution from the instance, it is as well to consider first principles in relation thereto.

8. In De Klerk[2], the SCA commented as follows on the approach on appeal against an order for absolution in the court below.

"[1] Counsel who applies for absolution from the instance at the end of a plaintiff's case takes a risk, even though the plaintiff's case be weak. If the application succeeds the plaintiff's action is ended, he must pay the costs and the defendant is relieved of the decision whether to lead evidence and of having his body of evidence scrutinized should he choose to provide it. But time and time again plaintiffs against whom absolution has been ordered have appealed successfully and left the defendant to pay the costs of both the application and the appeal and with the need

[2] De Klerk v Absa Bank Ltd and others 2003 (4) SA 315 (SCA)

to decide what is to be done next. The question in this case is whether the plaintiff has crossed the low threshold of proof that the law sets when the plaintiff's case is closed but the defendant's is not."

9. The authorities on this point go back more than a century and they are clear, as Claude Neon[3] demonstrates.

"(W)hen absolution from the instance is sought at the close of plaintiff's case, the test to be applied is not whether the evidence led by plaintiff establishes what would finally be required to be established, but whether there is evidence upon which a Court, applying its mind reasonably to such evidence, could or might (not should, nor ought to) find for the plaintiff. (*Gascoyne v Paul and Hunter,* 1917 T.P.D 170 at p173; *Ruto Flour Mills (Pty) Ltd v Adelson (2)* 1958 (4) SA 307 (T))".

10. It has been said that, because the enquiry here is only whether a *prima facie* case has been set up by the plaintiff, the bar for the avoidance of absolution is set fairly low in that party's favour. In Supreme Service Station[4] the erstwhile Rhodesian Appellate Division dealt with an appeal against an order for absolution by a magistrate at the conclusion of the plaintiff's case. Beadle CJ dealt extensively with the authorities, stressing that the test was different at that stage of proceedings as compared with the close of the defendant's case. The question, emphasized the Chief Justice, was "what might a reasonable court do" at the close of the plaintiff's case as opposed to "what ought a reasonable court to do" at the close of the defendant's case.

11. Beadle CJ went on to remark about the importance of the court hearing the defendant's evidence in circumstances where certain of the material events might be said to fall peculiarly within that party's knowledge.[5]

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[3] Claude Neon Lights (S.A.) Ltd v Daniel 1976 (4) SA 403 (A) at 409G-H. See too Levco Investments (Pty) Ltd v Standard Bank of SA Ltd 1983 (4) SA 921 (A) at 928C.

[4] Supreme Service Station (1969) (Pvt.) Ltd v Fox and Goodridge (Pvt.) Ltd 1971 (4) SA 90 (R,AD)

[5] At 93D *et seq*

"A feature of applications of this sort which must always be borne in mind is that the defendant is giving no evidence. If the defendant closes his case without giving evidence in a proper case, an inference must always be drawn against him from his failure to give evidence contradicting that of the plaintiff and, inasmuch as the onus on the defendant who applies for absolution from the instance before closing his case is greater than the onus placed upon him when he applies for absolution from the instance after closing his case, it follows that in considering applications of this sort the fact that the defendant has not given evidence at all to refute what appears to be in the plaintiff's evidence is often a cogent factor to be taken into account.

Before concluding my remarks of the law on the subject, I must stress that rules of procedure are made to ensure that justice is done between the parties, and so far as is possible the court should not allow rules of procedure to be used to cause an injustice. If the defence is something peculiarly within the knowledge of the defendant, and the plaintiff has made out some case to answer, the plaintiff should not likely be deprived of his remedy without first hearing what the defendant has to say. A defendant who might be afraid to go into the box should not be permitted to shelter behind the procedure of absolution from the instance. I might usefully quote here what was said by Sutton J in *Erasmus v Boss* 1939 CPD 204 at p.207:

> '*In Theron v Behr 1918 C.P.D. 442, Juta, J at p451, states that according to the practice in this Court in later years Judges have become very loath to decide upon questions of fact without hearing all the evidence on both sides.'*

We in this territory have always followed the practice of the Cape courts. In case of doubt at what a reasonable court 'might' do, a judicial officer should always, therefore, lean on the side of allowing the case to proceed."

12. I must confess that, while orders for absolution do not appear to abound in this court's jurisdiction, I am not familiar with this practice in the Cape courts. But then again, there is no authority either of which I am aware, that suggests that the *dictum* of the Chief Justice is wrong or is no longer applicable. Indeed, I would have thought that in the constitutional era where s34 of the Constitution, 1996 ensures access to the courts for the determination of a civil suit in a "fair public hearing", it

would be inimical to the interests of justice ("*cause an injustice"*) not to continue to adopt such an approach. I leave it there.

THE CASE AS PLEADED BY THE PARTIES

13. In the particulars of claim the plaintiff first pleaded the conclusion of an agreement with the defendant in terms whereof it undertook "*to furnish appropriate medical, nursing and hospital care, treatment and supervision*" to the patient. The plaintiff further pleaded an implied term of that agreement that the defendant "*would at all material times exercise such skill, care and diligence as was reasonably required in the circumstances in furnishing such medical, nursing and hospital care, treatment and supervision*."

14. In the alternative, the plaintiff pleaded that the defendant was "*under a legal duty of care to [the patient] to administer medical, nursing and hospital treatment with due professional skill and care and without negligence.*"

15. The plaintiff pleaded further that in breach of the agreement and the duty of care as alleged, the defendant's employees were negligent in failing to treat the patient with the skill, care and diligence reasonably required in the circumstances in one or more of the following respects:

"13.1 whilst intubating [the patient] they failed to diagnose the laryngospasm timeously, adequately or at all;

13.2 whilest extubating [the patient] they failed to diagnose the laryngospasm timeously, adequately or at all;

13.3 they failed to treat the laryngospasm as a medical emergency;

13.4 they failed to treat the laryngospasm by prompt and rapid administration of oxygen;

13.5 they failed to treat the laryngospasm by gentle jaw thrust;

13.6 they failed to treat the laryngospasm by the administration of propofol to increase the depth of anesthesia;

13.7 they failed to act with due care."

16. In his plea, the defendant pleaded that the staff who treated the patient were at all material times acting within the scope and course of their employment at the hospital in question and that they –

"assumed a legal duty to assess, manage and treat [the patient] with the degree of care, skill and diligence reasonably expected of reasonable medical practitioners, nursing staff and/or hospital staff in their position and in accordance with the generally accepted standards and norms of provincial and/or public hospital practice."

17. In respect of the aforesaid allegations made in para 13 of the particulars of claim, the defendant raised a general denial that the staff who treated the patient were negligent in any respects and further pleaded that they had treated the patient in accordance with the duty set forth in para 16 above. There was an alternative allegation that the defendant denied that any negligence on the part of his staff was the cause of the patient's injuries and damages. The issue of causation is not relevant to this appeal.

18. The defendant pleaded the following specific allegations in reply to para's 13.1 and 13.2 of the particulars of claim:

"8.2 In amplification of the above denial but without derogating from the generality thereof, the defendant pleads that:

8.2.1 symptoms of the laryngospasm presented upon extubation; and

8.2.2 the laryngospasm was timeously and adequately diagnosed."

19. Save as aforesaid, the defendant did not plead any further particularity in relation to the allegations made in para's 13.3 to 13.7 of the particulars of claim but

relied on a general denial of a breach of the admitted duty of care as set forth in para 16 above.

20. The exchange of requests for trial particulars and the answers thereto did not take the matter much further as the parties kept their cards close to their chests and repeated, in the main, the oft heard refrain that the particulars sought constituted matters of evidence. Nevertheless, the following emerged from those exchanges.

(i) The defendant alleged that the laryngospasm was diagnosed by the anaesthetist following removal of the endotracheal tube used to ventilate the patient while under anaesthetic;

(ii) The defendant further contended that the laryngospasm was managed by the anaesthetist who provided ventilation to the patient through a bag-mask. However, the defendant refused to be drawn on the question as to how long this was applied;

(iii) The defendant admitted that the anaesthetist administered the following drugs to the patient to manage the laryngospasm –

- 100mg succinylcholine;
- Naloxone;
- Neostigmine; and
- Glycopyrrolate.

(iv) The plaintiff did not persist in her allegation that there was a failure by the defendant's staff to diagnose the laryngospasm;

(v) The plaintiff alleged that the defendant's staff failed to treat the patient's laryngospasm as a medical emergency in that they took too long to successfully oxygenate the patient;

(vi) The plaintiff alleged that the defendant's staff breached the duty of care owed to the patient by failing to adequately oxygenate him to avert hypoxic brain damage.

That then by way of background. I move on now to a discussion of the evidence

THE EVIDENCE OF THE PLAINTIFF'S ANAESTHETIC EXPERT

21. The plaintiff presented the evidence of Prof. Aina Christina Lundgren as her principal expert on the question of the appropriate response by an anaesthetist to the emergence of a larygospasm. Prof. Lundgren is a respected and experienced anaesthetist, having formerly been the head of the Department of Anaesthesia at the University of the Witwatersrand. In that capacity she was responsible, inter alia, for the training and support of many students in anaesthetics, in addition to her own practice as such. She thus has experience as both an academic and a practitioner.

22. Prof. Lundgren explained that as a teacher and moderator in specialist anaesthetic examinations she was familiar with the programmes which the College of Anaesthetists recognized. Firstly, there was an Anaesthetic Diploma which was intended to offer a qualification to medical practitioners who wished to offer their services in the district hospital areas in our country. Then there was the Fellowship of the College of Anaesthetists which recogni~~z~~sed a specialist qualification in anaesthetics.

23. The professor explained in detail the role of the anaesthetist and the administration of an anaesthetic to a patient. The primary function of the anaesthetist is to use drugs to render the patient unconscious in order that surgery may proceed unhindered. In that regard, an anaesthetic comprises three components. Firstly, there is the application of hypnosis i.e. putting the patient to sleep by rendering him[6] unconscious. Secondly, there is the administration of analgesia for the relief of pain during surgery and thirdly there is the necessity for muscle relaxation intra-operatively. When the surgery is complete, the anaesthetist must administer an

[6] Given the patient's gender, this judgment will refer to the masculine where necessary.

antidote to counter-act the effect of these drugs and to render the patient *compos mentis*: the proverbial waking up of the person.

24. The duties of the anaesthetist in relation to the monitoring of a patient commence with the administration of the anaesthetic and continue until such time as the surgery is completed, the patient has recovered in the recovery room and has been taken through to the ward. Those duties include the monitoring of the heart rate, blood pressure, oxygen saturation, temperature, degree of muscle relaxation and the amount of carbon dioxide exhaled by the patient.

25. Prof. Lundgren referred to the well-known adage describing of the plight of the anaesthetist as follows.

"The duties of the anaesthetist, they – M 'Lord, they refer to our speciality as 90% boredom and 10% of sheer terror. And that is because usually the patient is stable and we [need] only to monitor the patent".

The "*sheer terror*" alluded to suggests that when the unexpected happens and things go wrong, the hapless anaesthetist is drawn away from the drudgery of routine monitoring of the patient and spurred into action in which she[7] is confronted with myriad considerations requiring immediate attention.

26. In the case of the patient, oxygen and other gases used during the administration of the anaesthetic were supplied through the use of an endotracheal tube which was inserted through his vocal cords into his trachea whereafter he was ventilated. The process of inserting the endotracheal tube through the vocal cords is termed "*intubation*" and the removal thereof after surgery is called "*extubation*".

27. With reference to the leading text book on the topic by Morgan and Mikhail[8], Prof Lundgren explained the phenomenon of the laryngospasm as follows.

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[7] Given the gender of the anaesthetist in this matter, Dr. Ramklass, the feminine will be used where appropriate.

[8] See footnote 1 above

“Laryngospasm is a forceful, involuntary spasm of the laryngeal musculature caused by stimulation of the superior laryngeal nerve. It may occur at induction, emergence or any time in-between without an endotracheal tube. Laryngospasm is more common in young pediatric patients (almost one in fifty) than in adults, being highest in infants 1 to 3 months old. Laryngospasm at the end of a procedure can usually be avoided by extubating the patient either awake (opening the eyes) or while deeply anaesthetised.”

The professor noted that a laryngospasm can be either complete or partial. A complete laryngospasm, as occurred in this matter, means that the patient’s vocal chords are completely closed and there is no passage of air, either into or out of, the patient’s lungs.

28. Prof. Lundgren was asked to testify about the appropriate treatment of a patient in the event of a laryngospasm. She referred to a leading journal article on the topic by Visvanathan et al[9], a copy whereof was included in the joint medical literature bundle placed before the Court *a quo.* She agreed with the authors of the article that, in light of the fact that it is a relatively well-known and documented phenomenon, the crisis management of laryngospasm is generally regarded by anaesthetists as “*a distinct entity*”. From the context of the article, I understand this to mean that it is an airway obstruction that has its own specific treatment protocol, thereby bringing it within the ambit of the “*blind terror*” analogy.

29. Visvanathan et al issued the following cautionary observation at the beginning of their article.

“While laryngospasm occurs relatively frequently and is nearly always easily recognized and handled, it has the potential to cause morbidity and mortality, especially if managed poorly.”

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[9] T Visvanathan, MT Kluger, RK Webb & RN Westhorpe Crisis Management During Anaesthesia: Laryngospasm. The authors were anaesthetic specialists in Australia and New Zealand and the study was based on some 4000 anaesthetic incident reports submitted for evaluation.

30. The authors made use of the following diagrammatic table in their article to summarise the steps in the suggested treatment protocol, which Prof. Lundgren readily endorsed.

"***MANAGEMENT***

- *Cease stimulation/surgery;*
- *100% oxygen;*
- *Try gentle chin lift/jaw thrust;*
- *Request immediate assistance;*
- *Deepen anaesthesia with an IV agent;*
- *Visualise and clear the pharynx/airway;*
    - *If you suspect aspiration [go to page 16 of the of the Crisis Management Manual]*
    - ***If you suspect airway obstruction*** *[go to page 14 of the Crisis Management Manual]*
- *Try mask CPAP[10]/IPPV[11], if this is unsuccessful*
    - *Give suxamethonium unless contraindicated*
    - *Give atropine unless contraindicated;*
- *Again, try mask CPAP/IPPV;*

[10] Continuous positive airway pressure

[11] Intermittent positive pressure ventilation

- *Intubate and ventilate.*"

31. Prof. Lundgren noted that in the patient's case, surgery had been completed and so the first step referred to in the protocol no longer applied. She was unable to say what stimulation might have caused the laryngospasm but, in any event, that does not appear to have been relevant to the enquiry in this case. The focus of the expert evidence here, rather, was whether Dr Ramklass had managed the sudden emergence of the larygospasm in accordance with good anaesthetic practice.

32. Prof Lundgren explained that the first step to take then was a gentle chin lift and/or jaw thrust. If that did not break, or release, the spasm, then the anaesthetist, suspecting an obstruction of the airway, would be required to make use of a face mask and "*bag*" (or ventilate) the patient manually. As I understand the evidence, this is a mask attached to an elasticised bag (the trade name evidently being an "*Ambu-bag*") which is then placed over the patient's nose and mouth and squeezed manually by the anaesthetist to force air into the airway.

33. The "*bagging*" of the patient must be closely monitored by the anaesthetist because it may lead to air inadvertently going into the stomach and not breaking the spasm in the trachea. Prof Lundgren explained that risk as follows.

"If you are not breathing on your own and you are needing someone to pressurize a bag, for example, an ambu-bag or a circuit with a bag to push oxygen into your lungs and your vocal chords are absolutely closed, the only other - and the mask is tight fitting, the only other place that the gas can go is down the esophagus into the stomach. So you will be applying quite a lot of pressure and the vocal chords are closed and the only place that is potentially a cavity and open is the esophagus, which lies behind the trachea, and that is where the gas may go and it may distend the stomach. And that pushes up on the diaphragm and makes getting oxygen into the lungs more difficult, because the diaphragms are splintered by this gas-filled stomach."

34. If the anaesthetist cannot break the spasm through "*bagging"* the patient, she would be required to consider the use of a drug called Suxamethonium. This was discussed by Prof. Lundgren as follows.

"Suxamethonium is one of the muscle relaxants. There are two groups: depolarizing and non-depolarising. And suxamethonium is a depolarizing muscle relaxant. It is short-acting and works quickly and is considered one of our emergency drugs. It needs to be kept in the fridge, so in a lot of facilities it's not drawn up for in cases of emergency, because our operating theatres are warmer than a fridge. But very often there'll be a cooler-box in the theatre and an ampule of suxamethonium will be in that cooler-box. And we teach anaesthetists to have a 2 millilitre syringe ready in case you need to draw up suxamethonium in a hurry…"

35. According to Prof. Lundgren, if a laryngospasm cannot be relieved immediately through a jaw thrust, the first recommended method of emergency response, would be to use a drug called propofol. If this is available to the anaesthetist, it should preferably be used before the suxamethonium.

"M 'Lord propofol is a drug, an intravenous drug, that induces anaesthesia, puts patients to sleep, induces the hypnosis. It's a white milky solution, often referred to…the trade name is Diprivan, but it's the most commonly used intravenous anaesthetic agent. And what is suggested, if you can't get any oxygen through the vocal chords in the presence of a total laryngospasm, you need to put the patient to sleep quickly. If that doesn't work, then you need to go to suxamethonium, which is a drug we've just discussed. The difference is that propofol is not considered an emergency drug, so it may not have been available - easily available in these circumstances. I don't know. Where suxamethonium is considered an emergency drug and should have been in the theatre and available for immediate use."

36. Prof Lundgren also said that bradycardia – the slowing of the heart rate – is a likely complication of a laryngospasm and hypoxia in children. In that regard, the professor was further referred to the aforementioned table and she commented as follows on the recommended use of a drug called atrophine.

“Atrophine is a cholinergic agent, so it’s an agent that we may give together with suxamethonium to counter-act the slowing of the heart rate that might be caused by the suxamethonium…Bradycardia is the slowing of the heart rate…”

37. Prof. Lundgren was asked to comment on the patient’s haemoglobin level, pre-operatively. She explained that haemoglobin is a substance in a person’s red blood cells which carries oxygen throughout the body, and that a normal level of haemoglobin is required at all times so that the blood delivers sufficient oxygen to the organs. A normal haemoglobin level for a 12 year old child would be of the order of 11 to 13. The patient, who weighed 35,4 kg, only had a haemoglobin level of 8. This is 30% lower than what could have been expected. It was her view that surgery is not advisable in such circumstances.

38. The professor explained that in the case of a haemoglobin level which is below normal, the body has less haemoglobin available to transport oxygen to that patient’s organs. This has implications in circumstances where an event occurs whereby the patient has not been sufficiently oxygenated. Larygospasm would be such an event and the anaesthetist would need to have regard to the low haemoglobin level should this occur.

THE TREATMENT OF THE PATIENT

39. The patient’s condition was such that intubation was not expected to present complications. He was ventilated by means of a size 6 PVC endotracheal tube which was inserted through his vocal cords which enabled him to breathe during the procedure. Prof. Lundgren said that Dr Ramklass’ notes recorded that the anaesthetic endured from 12h15 to 14h05, while the surgical procedure lasted from 12h30 to 13h20.

40. One of the anaesthetist’s core functions, in the discharge of her aforesaid duties, was to keep a complete contemporaneous record of the anaesthetic using a pro forma document provided to her by the hospital in which she was required to note down all of the relevant medical parameters of the patient as the operation

proceeded. These would include blood pressure, temperature, heart rate, oxygen saturation and the like.

41. It was a cause of some concern to the professor that although the surgery was completed by 13h20, and the anaesthetic is recorded as having ended at 14h05, there were no entries made in the anaesthetic record after 13h00. Accepting that the laryngospasm occurred during this time, Prof. Lundgren said one would not necessarily have expected Dr Ramklass to have made contemporaneous notes while dealing with such an emergency, but, certainly after the event, the record should have been brought up to date. In this case, these seem to have been jotted down on a document headed "*Recovery Room Record".*[12]

42. The medical notes record that the anaesthetic proceeded without any problems until the laryngospasm occurred while the patient was still in the operating theatre. In order to attempt to understand what happened there, Prof. Lundgren was obliged to rely on the "*Recovery Room Record*" notes. She noted therefrom that the patient was duly given the relevant drugs to reverse the effects of the anaesthetic and then extubated. It was upon extubation that the laryngospasm occurred, according to the records. This is common cause as per the trial particulars already referred to.

43. The notes record, also via medical shorthand, that the patient's oxygen levels desaturated to zero within less than a minute. That, said the professor, meant that "*the vocal chords have shut and an oxygen saturation of 0, if the [oxygen monitor] probe is still on the finger, is a red light that needs urgent attention*." Thus, it must be concluded, Dr Ramklass was confronted by the proverbial "*sheer terror*" scenario. Having occurred in the operating theatre, the professor was of the view the anaesthetist would have had "*all the instruments and equipment necessary to deal with a laryngospasm and drugs."*

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[12] The patient was not yet in the recovery room when the laryngospasm occurred and the document thus does not purport to be a record of events there. Rather, it appears to have been a form that was handily available and conveniently used by Dr Ramklass.

44. The notes further record that the patient still had an oxygen mask on and that he was given "*100% oxygen*". The anaesthetist is recorded as having tried to bag the patient but there was "*no air movement*". This, said Prof Lundgren, meant that there had been a complete larygospasm "*and that no oxygen was going through the vocal chords into the lungs".* An attempt to intubate the patient again by immediately inserting an endotracheal tube revealed that the chords were indeed completely closed.

45. Prof. Lundgren was asked to comment on the following entry in the notes which was transcribed as "+ *ventilated for plus/minus five minutes with air entry heard bilaterally (but course wet sounds), abdomen distending*." She said the following.

"M 'Lord, I would interpret that as… So the tube was in the mouth but not going through the vocal chords and she was trying to bag. And as I explained earlier, if the oxygen doesn't go through the vocal chords because they are closed, it will go down the oesophagus into the stomach and then the stomach, the abdomen, will extend. And I interpret that as she was bagging, ventilating the stomach, not the lungs, and that the air entry that she heard… So that's when we put a stethoscope on and we listen to the chest. You can - in a thin patient if you're bagging the stomach inadvertently you can get transmitted sounds that sound like breath sounds when you put a stethoscope over the chest."

46. When asked by counsel for the plaintiff to explain the references to "*abdomen extending*", the witness said that this meant that the stomach was becoming bloated. She explained further –

"And I'm sure that was because oxygen was going into the stomach. And then as the abdomen distends the diaphragm moves up and it's increasingly more difficult to try and force oxygen into the lungs."

47. Prof. Lundgren then pointed out that the notes reflect that suxamethonium was given. The dose of 100 milligrams that was administered was regarded as "*quite*

a large dose" in light of the patient's reduced body weight and, upon consideration, said the witness, should rather have been of the order 17,5 to 70 milligrams.

48. Counsel then referred the professor to an entry in the notes which read "*On re-examining about five minutes later ET above chords and unable to push through*" and asked her to comment.

"M 'Lord, so at that stage the suxamethonium had been given. The vocal chords should have been open and it should have been - bearing in mind that the airway assessments done beforehand indicated a good airway, it should be easy to put in the instrument that we use to insert the tube and push the tube through the vocal chords. So I'm not quite sure why she couldn't get the tubes through the vocal chords."

49. Thereafter, said Prof. Lundgren, the tube was removed and Dr Ramklass continued to bag the patient, while the oxygen saturation was increased to 100%. After about 10 minutes, the patient was noted to be breathing spontaneously although irregularly at first. He was seen to be thrashing around and moaning initially and later, at around 15h30, he started opening his eyes when his oxygen saturation was observed to be at 97%. By the following day, the patient was sitting up in bed, fully awake, eating and talking to his mother.

HOW SHOULD THE LARYNGOSPASM HAVE BEEN MANAGED?

50. Before dealing with the witness' evidence on this aspect which is central to the plaintiff's case, it is useful to have regard to a medico-legal report submitted to the plaintiff's attorneys and the expert summary filed under Rule 36(9)(b) in which Prof. Lundgren's evidence was foreshadowed.

51. In June 2014, Prof. Lundgren delivered a detailed medico-legal report to the plaintiff's attorneys in which she commented as follows regarding her assessment of the treatment of the patient.

“Dr Ramklass managed the laryngospasm initially with bag-mask ventilation. This did not break the spasm and according to her notes she continued with this for approximately 5 minutes, which is a long time for the patient to be without adequate oxygenation. Saturations of 0% and approximately 90% are recorded in the handwritten notes, but the intervals between these are not indicated. This is not in keeping certainly not adequate oxygenation.

She then administered 100 mg succinylcholine (25mg would probably have been sufficient). She then also administered naloxone plus neostigmine and glycopyrrolate, none of which is indicated. I am not sure if she panicked? Administering neostigmine after succinylcholine can prolong neuromuscular blockage, which is contra-indicated in this situation.

She describes the chest as sounding ‘wet’ which is probably due to negative pressure pulmonary oedema, a common complication of laryngospasm. She does not mention this diagnosis in her notes. The management however is that you should oxygenate him, which [the patient] received once the spasm had broken.

[The patient] took a long time to wake up fully from the anesthetic. In addition it took until 23h15 before he started to talk properly. The severe hypoxia at the time of the laryngospasm needs to be considered as a cause of this slow recovery.

My concern is the history that his mother has given of slow recovery after his first anaesthetic as has been documented in the notes.

Was Dr Ramklass negligent?

In order to prove negligence one needs to look at the following:

- Was there a duty of care? Yes there most definitely was.

- Was there a breach of this duty? There was most definitely a breach in that [the patient] developed a post-operative problem which was managed, but not very quickly, and it would appear that he sustained a degree of hypoxia.

- Did the breach cause the injury? This is difficult to comment on currently is I do not know what the injury is."

52. Thereafter, on 1 April 2016, the plaintiff's attorneys compiled and filed the prescribed summary under Rule 36(9)(b) setting forth the opinion evidence to be presented on behalf of the plaintiff and recorded the following conclusions arrived at by Prof. Lundgren.

"7. Professor Lundgren will testify that, in her opinion, the treating staff at the Tygerberg Hospital failed to treat Plaintiff with the degree of skill and care expected of them in the particular circumstances, in the following respects:

7.1 bag-mask ventilation was continued although it did not break the spasm;

7.2 inadequate oxygen, resulting in severe hypoxia; and

7.3 medication in the form (sic) neostigmine was administered after the administration of succinylcholine, which was contra-indicated because it would probably have prolonged the neuromuscular blockage; and

7.4 in the presence of a well-known complication of general anesthesia in the form of a post-operative laryngospasm, they failed to act appropriately and timeously.

8. In the further opinion of Professor Lundgren, had (sic) treating staff followed the recommended management guidelines for laryngospasm, the hypoxic brain damage and consequent neuropsychological and neurological deficit would probably have been prevented."

Against that background, I turn to the witness's *viva voce* evidence before the Court *a quo.*

PROF. LUNDGREN'S EVIDENCE-IN-CHIEF

53. In response to a question by counsel for the plaintiff as to what a practicing anaesthetist should do in order to properly manage a laryngospasm, Prof Lundgren said the following –

"Well, a practicing anaesthetist should be able to distinguish between a partial laryngospasm and a total laryngospasm. In a partial laryngospasm when one places the mask over the nose and the mouth and closes the APL valve on the circuit and squeezes the reservoir back, one can usually get some oxygen into the lungs. With a total laryngospasm the vocal cords are absolutely shut and one is unable to manually squeeze the bag and get oxygen into the lungs. So one needs to be able to distinguish between the two. And then one needs to manage it quickly, because - and it depends on if one is dealing with a child. It depends on how much oxygen the patient has been on prior to this event. It depends on the hemoglobin level, because the lower the hemoglobin the less hemoglobin there is to carry the oxygen. And it depends on the heart rate, so the hemodynamic. You know, if there's a slow heart rate and a low hemoglobin one has less time to get oxygen to the vital organ. And then one needs to attempt to bag the patient, so take the circuit, close the valve, put 100% oxygen and squeeze the bag. And if one cannot get any oxygen into the lungs with two or three squeezes of the bag, one then needs to resort to intravenous drugs…

So it's an anesthetic emergency. One needs to get oxygen into the patient as soon as possible…

(T)hey must be able to manage it. M 'Lord, it doesn't matter what level of anaesthetist you are. One needs to be able to administer safe and anaesthetic and therefore one needs to be able to oxygenate one's patient."

54. Counsel then referred Prof. Lundgren to the recordal in Dr Ramklass' notes that, firstly, an attempt was made to intubate the patient which was unsuccessful because the vocal chords were closed, that the patient was thereafter continuously "*bagged*" for about 5 minutes and then lastly, that medication was administered. When asked to comment on this, the professor answered as follows.

"At that point, M 'Lord, when the vocal cords were seen to be shut, intravenous drugs should have been given immediately…

Because you can't get oxygen into the lungs. You already have an anaemic patient. There is no heart rate documented during that period of time but it is highly likely that [the patient] had a slow heart rate. So you've got a low hemoglobin, a slow heart rate and you're not getting oxygen into the patient, so you need to give intravenous drugs. M 'Lord will see in the literature that is in the file, there are various suggestions for which drugs to use. As I stated earlier this morning, suxamethonium[13] is an emergency drug that we have available in all theaters to use in such cases of emergency. And under those circumstances where the chords are tightly shut, suxamethonium is the drug of choice. There are articles which state that a small dose of propofol, which we did discuss this morning. And there is other literature that suggests Lidocaine, intravenous Lidocaine, which is a local anaesthetic. But in circumstances where the oxygen saturation is documented as zero, which it was at that time, and under those circumstances when one cannot get any oxygen into the lungs, suxamethonium is the drug of choice."

55. Prof Lundgren expressed concern about the drugs administered by the anaesthetist when the laryngospasm occurred.

"100 milligrams of suxamethonium is a very large dose for a 35-kilogram child, M 'Lord, and 25 to 50 milligrams would have sufficed. The concern with the 100 milligram dose is that it may have worsened the bradycardia, which one is assuming - I'm assuming [the patient] had at that stage…

Naloxone was administered to reverse the morphine-type drugs, the morphine and the Fentanyl, which is probably unnecessary at that stage, because then morphine needed to be given again in the recovery room when he was thrashing around. And Neostigmine and Glycopyrrolate were totally contra-indicated…(b)ecause they had already been given to reverse the Cisatracurium, the muscle relaxants that had

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[13] Prof. Lundgren noted that the drug which had been used was Succinylcholine, "*which is the same as suxamethonium*", which she termed the "*gold standard*" drug of choice in the circumstances.

already been given earlier to reverse the muscle relaxant. And you don't give Neostigmine after you've given suxamethonium, because it causes profound muscle weakness in the patient."

56. Finally, Prof. Lundgren was of the view that if Dr Ramklass had managed the laryngospasm in the manner she had suggested, "*the probable outcome is that [the patient] would probably (sic) not have been brain-damaged."*

57. I shall deal with the cross-examination of Prof. Lundgren later in this judgment.

COMMENTS ON DR RAMKLASS' QUALIFICATIONS

58. Prof. Lundgren pointed out in her evidence-in-chief that, at the time, Dr Ramklass held the Diploma in Anaesthetics referred to earlier and was not yet a Fellow of the College of Anaesthetists. Evidently, she did later acquire her Fellowship.

59. The professor held the view that the fact that Dr Ramklass held a lower qualification than a Fellow did not in any way affect the yardstick against which her professional duties were to be measured.

"A safe anesthetic is a safe anaesthetic, whatever one's qualifications and status is (sic). If one administers an anaesthetic it is expected to be a safe anaesthetic. And one is judged against those standards in the anaesthetic world. I'm not talking in court but in the anaesthetic world that is how we gauge safe anaesthesia…

M 'Lord the WHO defines an anaesthetist as someone who administers anaesthesia and it defines an anaesthesiologist as a specialist anaesthetist. So she was an anaesthetist in those circumstances and needed to practice safe anaesthesia under those circumstances."

THE JOINT EXPERT MINUTE

60. In accordance with the practice directives applicable in this Division, Prof. Lundgren met before the trial with the expert anaesthetist appointed on behalf of the defendant, Dr. Anthony Reed, whom, she said, she knew well and respected professionally. Dr Reed's expert summary filed on 19 December 2016 records that he has a long career as an anaesthetist in the public health sector in the Western Cape.

61. In accordance with the said practice, the experts compiled a signed joint minute in which they set out their points of agreement – there were evidently no points of disagreement. It is a single page document, the contents whereof I shall recite in full. I should point out that in the original document the four sub-paragraphs under para 2 are unnumbered but identified by small transverse arrows. I have numbered them for purposes of reference herein.

"**JOINT EXPERT MINUTE…**

DR ANTHONY REED and PROF CHRISTINA LUNDGREN

A telephonic discussion was held on the 20th February 2017, with regards to Dr Ramklass' perioperative management of [the patient] on the 8th August 2007.

1. We both agree that the actual anaesthetic management of [the patient] was acceptable.

2. We discussed the laryngospasm and the management thereof, and agreed on the following:

2.1 Dr Ramklass took appropriate action and did not leave the patient;

2.2 Dr Ramklass took appropriate steps to improve [the patient's] oxygenation, but these steps did not work soon enough, even though she escalated the management of the laryngospasm;

2.3 Despite administering oxygen to [the patient], Dr Ramklass did not restore oxygenation timeously, and estimated that there was a period of approximately 5 minutes of inadequate oxygenation;

2.4 The administration of naloxone and a second dose of neostigmine with glycopyrrolate was not ideal.

3. Dr Reed has no evidence that [the patient] has any cognitive dysfunction following this incident."

The minute, although signed by the experts, does not record a date of conclusion. It appears from the cross-examination that it was signed towards the end of February 2017.

CONSIDERATION OF THE EXPERT EVIDENCE

62. The point of departure for consideration of the joint minute must commence with a more general discussion regarding the function of expert witness in a matter such as this. This was usefully summarized by Wallis JA in AM[14] as follows.

"[17] Something needs to be said about the role of expert witnesses and the expert evidence in this case. The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions…

[14] AM and another v MEC for Health, Western Cape 2021 (3) SA 337 (SCA)

[21] The opinions of expert witnesses involve the drawing of inferences from facts. The inferences must be reasonably capable of being drawn from those facts. If they are tenuous, or far-fetched, they cannot form the foundation for the court to make any finding of fact. Furthermore, in any process of reasoning the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation. As Lord Wright said in his speech in Caswell v Powell Duffryn Associated Collieries Ltd:

> '*Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish … But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture*.' (Internal references omitted)

63. In Michael[15] (also a delictual claim arising from alleged negligence on the part of an anaesthetist) the Supreme Court of Appeal dealt with a court's function in assessing the evidence of an expert as follows.

"THE APPROACH TO THE EXPERT EVIDENCE

[34] In the course of the evidence counsel often asked the experts whether they thought this or that conduct was reasonable or unreasonable, or even negligent. The learned Judge was not misled by this into abdicating his decision-making duty. Nor, we are sure, did counsel intend that that should happen. However, it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised.

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[15] Michael and another v Linksfield Park Clinic (Pty) Ltd and another 2001 (3) SA 1188 (SCA)

[35] What must be stressed in this case is that none of the experts was asked, or purported, to express a collective or representative view of what was or was not accepted as reasonable in South African specialist anaesthetist practice in 1994. Although it has often been said in South African cases that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field, that criterion is not always itself a helpful guide to finding the answer. The present case shows why. Apart from the absence of evidence of what practice prevailed one is not simply dealing here with the standard of, say, the reasonable attorney or advocate, where the court would be able to decide for itself what was reasonable conduct. How does one, then, establish the conduct and views of the notional reasonable anaesthetist without a collective or representative opinion? Especially where the primary function of the experts called is to teach, with the opportunity only for part-time practice. In these circumstances counsels were probably left with little option but to elicit individual views of what the respective witnesses considered reasonable.

[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 (H.L (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 evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached “a defensible conclusion” (at 241 G - 242 B).

[38] If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242 H).

[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 243 A-E).

[40] Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of Dingley v The Chief Constable, Strathclyde Police, 200 SC (HL) 77 and the warning given at 89 D-E that: *"(o)ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved - instead of assessing, as a judge must do, where the balance of probabilities lies on a review of the whole of the evidenc*e."

64. In Maqubela[16] the Supreme Court of Appeal, commenting on para 40 in Michael, stressed that -

[16] Maqubela v S 2017 (2) SA SACR 690 (SCA) at [5]

"The scientific measure of proof is the ascertainment of scientific certainty, whereas the judicial measure of proof is the assessment of probability",

and thereby cautioned trial courts not to fall into the trap of demanding too high a measure of proof from a litigant.

PROF. LUNDGREN'S EXPERTISE

65. In this matter, the Court *a quo* only had the expert evidence tendered on behalf of the plaintiff to consider and, for the purposes of this appeal, I shall focus on the testimony of Prof. Lundgren. As the discussion of the professor's evidence has demonstrated, she had no direct testimony from an eye-witness or the like to rely on. Rather, she studied the available medical records and offered her interpretation of the material facts to be inferred therefrom on the strength of her vast experience in the field of anaesthetics. She then offered the Court *a quo* her expert opinion on the basis of those factual assumptions.

66. As will appear more fully hereunder, it does not appear from the cross-examination of Prof. Lundgren that the factual inferences she drew were in dispute. It must be borne in mind that the defendant had the benefit of access to factual evidence from its hospital and theatre staff who were involved in this matter, as well as Dr Ramklass herself. This suggests that the facts that Prof. Lundgren relied on were either effectively common cause, or not disputed by the defendant.

67. Further, there was no suggestion from the defendant that the professor was not duly qualified to testify in an anaesthetics matter nor that she favoured the plaintiff's case. Having regard to the pre-trial opinions expressed by the witness, it is reasonable to infer that the plaintiff's legal team must have believed that the evidence of Prof. Lundgren would assist the court in coming to the conclusion that Dr Ramklass' treatment of the patient's larygospasm did not measure up to the required standard and that the defendant was thus liable to her in delict, otherwise they are unlikely to have called her.

THE STATUS OF THE JOINT MINUTE

68. A joint minute compiled by the experts has a particular status in a matter such as this. The Court *a quo* relied on the judgment of Rogers AJA (as he then was) for the majority in Bee[17] which sets out that status and the approach thereto as follows.

"**Effect of agreement between experts**

[64] This raises the question as to the effect of an agreement recorded by experts in a joint minute. The plaintiff's counsel referred us to the judgment of Sutherland J in Thomas v BD Sarens (Pty) Ltd [2012] ZAGPJHC 161. The learned judge said that where certain facts are agreed between the parties in civil litigation, the court is bound by such agreement, even if it is sceptical about those facts (para 9). Where the parties engage experts who investigate the facts, and where those experts meet and agree upon those facts, a litigant may not repudiate the agreement 'unless it does so clearly and, at the very latest, at the outset of the trial' (para 11). In the absence of a timeous repudiation, the facts agreed by the experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference (para 12). Where the experts reach agreement on a matter of opinion, the litigants are likewise not at liberty to repudiate the agreement. The trial court is not bound to adopt the opinion but the circumstances in which it would not do so are likely to be rare (para 13). Sutherland J's exposition has been approved in several subsequent cases including in a decision of the full court of the Gauteng Division, Pretoria, in Malema v The Road Accident Fund [2017] ZAGPHC 275 para 92.

[65] In my view, we should in general endorse Sutherland J's approach, subject to the qualifications which follow. A fundamental feature of case management, here and abroad, is that litigants are required to reach agreement on as many matters as possible so as to limit the issues to be tried. Where the matters in question fall within the realm of the experts rather than lay witnesses, it is entirely appropriate to insist that experts in like disciplines meet and sign joint minutes. Effective case management would be undermined if there were an unconstrained liberty to depart from agreements reached during the course of pre-trial procedures, including those

[17] Bee v RAF 2018 (4) SA 366 (SCA)

reached by the litigants' respective experts. There would be no incentive for parties and experts to agree matters because, despite such agreement, a litigant would have to prepare as if all matters were in issue. In the present case the litigants agreed, in their pre-trial minute of 14 March 2014, that the purpose of the meeting of the experts was to identify areas of common ground and to identify those issues which called for resolution.

[66] Facts and opinions on which the litigants' experts agree are not quite the same as admissions by or agreements between the litigants themselves (whether directly or, more commonly, through their legal representatives) because a witness is not an agent of the litigant who engages him or her. Expert witnesses nevertheless stand on a different footing from other witnesses. A party cannot call an expert witness without furnishing a summary of the expert's opinions and reasons for the opinions. Since it is common for experts to agree on some matters and disagree on others, it is desirable, for efficient case management, that the experts should meet with a view to reaching sensible agreement on as much as possible so that the expert testimony can be confined to matters truly in dispute. Where, as here, the court has directed experts to meet and file joint minutes, and where the experts have done so, the joint minute will correctly be understood as limiting the issues on which evidence is needed. If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (i.e. fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue.

[67] It is unnecessary, in the present case, to decide whether a litigant needs to have good cause for repudiating an agreement reached by his or her expert. Certainly litigants should not be encouraged to repudiate agreements for 'tactical' reasons. Whatever may have been the attitude to litigation in former times, it is not in keeping with modern ideas to view it as a game. The object should be just adjudication, achieved as efficiently and inexpensively as reasonably possible. Private funds and stretched judicial resources should only be expended on genuine issues.

[68] There may be cases where the expert rather than the litigant wishes to depart from what he or she previously agreed. The same rules of fair play apply. The expert

should notify the attorney through whom he or she was engaged and due warning should be given to the other side. In such a case there will often be a further procedural requirement, namely the furnishing of a supplementary report by the expert whose views have changed.

[69] The limits on repudiation, particularly its timing, are matters for the trial court. The important point for present purposes is that repudiation must occur clearly and timeously. The reason for insisting on timeous repudiation is obvious. If the repudiation only occurs during the course of the trial, it might lead to a postponement to allow facts which were previously uncontentious to be further investigated. It might be necessary for a party to recall witnesses, including his or her expert. Whether a trial court would allow this disruption would depend on the circumstances. The trial court would be entitled to insist on a substantive application from the repudiating litigant.

[70] My colleague [Seriti JA, in his minority judgment] has referred to the passage from *Thomas* dealing with the right of a trial court to depart from an expert's opinion. In the present case, however, the important matters on which [the expert witnesses] Edwards and Van der Elst agreed were, in my view, factual, albeit facts which forensic accountants are more adept than others at uncovering and analysing. In *Thomas* the court said that facts agreed upon by the experts are binding unless a litigant timeously repudiates the agreement.

[71] I would add that even where the agreed matter is one of opinion, fair play will, as I have said, generally require that a possible rejection of the agreed opinion be timeously raised. This is for the reason that litigants will quite properly not spend their resources on establishing matters of expert opinion which are not in dispute. Indeed, they would rightly be upbraided for wasting court time by doing so. If a court is minded to reject the opinion on the available evidence, the litigants should be alerted to this so that they can consider adducing further evidence.

[72] I agree with my colleague (para 20) that parties to legal proceedings cannot, by their agreement, compel the court to decide the case on incorrect legal basis. However, that principle is concerned with agreements or concessions as to the law,

not facts and expert opinions. In the present case, the joint minute does not in my view record any agreements on matters of law."

69. It bears mention that the dispute in Bee centred on the plaintiff's loss of earnings – both past and future – and the calculation thereof based on various financial statements analysed by the forensic accountants appointed by the respective parties as their expert witnesses. The agreement in the experts' joint minute in that matter was manifestly in relation to facts, not opinion. The defendant relied heavily on Bee both in the Court *a quo* and before us and it is thus necessary to consider the application of the principles referred to this case in a little more detail.

70. It is important to bear in mind that when a court is called upon to consider the contents of a joint minute, it is not considering a contract between the parties' agents and accordingly the mandated contextual approach to the interpretation of contracts in our law is not warranted.

71. In HAL[18] Wallis JA, in a separate concurring judgment for the majority, discussed the import of Bee in matters involving alleged medical negligence and qualified its applicability thereto as follows.

"[216] It has become a practice in medical negligence cases for parties to arrange for the expert witnesses to meet and to file agreed minutes of their opinions. In some divisions of the high court this may be a requirement. It is a useful practice that may facilitate the running of the litigation by narrowing the issue and enabling the court and the parties to focus on the central issues in the case. That is reflected in the decision of this court in *Bee*. That was a case involving the computation of damages for loss of past and future earnings. Forensic accountants were employed by the parties and they signed a joint minute setting out the facts on which they were agreed and the areas where they were unable to agree. At the trial the Road Accident Fund's forensic accountant sought to depart from the factual agreement by relying on a report not available at the time the joint minute was signed and using

[18] HAL obo MML v MEC for Health, Free State [2022] 1 All SA 28 (SCA). The matter was a delictual claim for hypoxic brain damage suffered by the plaintiff's child, alleged due to the negligence of hospital staff during the plaintiff's confinement and the delivery of the child.

that to recalculate the agreed figures on which the joint minute had been based. Contrary to the agreement, he also sought to contend that there was no gratuitous element to the remuneration Mr. Bee had been receiving since the accident.

[217] In *Bee* the majority judgment, authored by my brother Rogers AJA, rightly held that this could not be countenanced. The trial had been prepared and conducted under this head of damages on the limited issues identified in the joint minute. Those included an agreement as to the basis for calculating the loss of earnings of the business in which the plaintiff was involved and an agreement that a proportion of his earnings after his injuries was gratuitous and paid only because it was a family business involving him and his brother. To permit a departure from that course would have required an adjournment and probably the filing of a supplementary expert's opinion. The decision was expressly based upon the need for fairness in the conduct of legal proceedings and the avoidance of trial by ambush.

[218] The effect of *Bee* in relation to the agreed minutes of experts in this case involved two misconceptions. The first related to the need to call the experts to give oral evidence in support of their opinions and, where experts were called, their entitlement to expand upon and explain the basis for their opinions. The second related to the weight to be attached to the opinions themselves.

[219] There appeared to be a perception, reflected in both the record and the heads of argument that such agreements are contractual in nature. The agreements were described as having been 'struck' and not having been 'repudiated'. That is the language of contract, and the give and take of negotiation, to arrive at a compromise. It is wholly inappropriate to describe the endeavours of independent experts to explain for the benefit of a court the matters on which they hold the same view and those on which they differ. That is why it was suggested in *AM v MEC for Health* that the experts should be required to draft these minutes themselves and that the lawyers should play no part in that process.

[220] A clear distinction in principle needs to be drawn between factual evidence given by an expert witness and the opinions expressed by that witness. As to the former, there is no difficulty in applying *Bee* to the facts on which the experts agree,

any more than there is a difficulty where the parties themselves reach agreement on factual issues. The opinions of the experts stand on a completely different footing. Unlike agreements on questions of fact, the court is not bound by such opinions. It is still required to assess whether they are based on facts and are underpinned by proper reasoning. *Bee* endorsed a remark by Sutherland J in *Thomas* that the occasions on which that occurs are likely to be rare, but that will only be in cases where the opinion is clear and there is nothing in the evidence to controvert it. Before a court accepts an opinion, it must pay close attention to the qualifications attaching to it. Furthermore, agreement by two experts on an opinion cannot preclude another expert with appropriate qualifications from expressing a different view, either in a report or in oral evidence. That is especially so when the third expert's views are based on their own speciality, which differs from that of the other two. The only constraint on that is that it should not result in unfairness to the party that has relied on the agreed opinion…

[226] In *Huntley v Simmons* Waller LJ said in relation to expert minutes that:

'The evidence of experts is important evidence but it is nevertheless only evidence which the judge must assess with all other evidence. Ultimately issues of fact and assessment are for the judge. Of course if there is no evidence to contradict the evidence of experts it will need very good reason for the judge not to accept it and he must not take on the role of expert so as to, in effect, give evidence himself. So far as Joint Statements are concerned parties can agree the evidence but (as happened in this case) it can be agreed that the joint statements can be put in evidence without the need to call the two experts simply because they do not disagree; but either party is entitled to make clear that the opinion expressed in the joint statement is simply evidence that must be assessed as part of all the evidence…

[229] In summary, the position in regard to agreements between experts, is as follows. In accordance with *Bee*, if they agree on issues of fact and the appropriate approach to technical analysis, the litigants are bound by those agreements, unless they have been withdrawn in circumstances where no prejudice results, or any prejudice can be cured by an adjournment or other means. If the experts have reached agreement on a common opinion on a matter within their joint expertise, that

is merely part of the total body of evidence. The court must still determine whether to accept the joint opinion. The existence of that agreement between the experts will not ordinarily preclude evidence that qualifies or contradicts their opinion, unless the case has been conducted on the basis of the agreement and the admission of that evidence will prejudice the other party in a manner that cannot be cured. If the parties choose to place an agreed minute before the court reflecting both shared opinions and areas of disagreement and do not call the parties to the minute to deal with the areas of disagreement, the minute will do no more than reflect that there is disagreement on the point. While it is for the parties to determine which witnesses they call, if they fail to call the authors of a joint minute they cannot object when other witnesses express views that qualify or dissent from the views in the minute.

[230] The existence of joint minutes may not be used to prevent witnesses from explaining the reasons for the conclusions expressed in the minute. For example it would have been most helpful for one or both of [the expert witnesses in this case] Prof Andronikou and Dr Kamolane to have explained how they arrived at the view that the injury occurred in the perinatal period. That is the sort of question that a court would ask in order to understand the degree of certainty about this opinion. They could also have been asked to comment on Dr Mogashoa's view that the nature of MML's disability was more consistent with injury occurring to the preterm brain and inconsistent with hypoxia. The passage from *AM* cited in para 212 identifies the second purpose of expert evidence as being 'to provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation'. The existence of a joint minute of experts cannot be used to prevent that function from being fulfilled, whether by the experts who were party to the minute or by another expert. The decision in *Bee* does not relate to the admissibility of expert opinions, but to the fairness of the trial. Expert opinion evidence should only be excluded when it impacts adversely on the latter.

[231] My final point is that the joint minute does not render the whole of the expert's report admissible in evidence. Unless the expert gives evidence, or it is agreed that the report will be admissible, it remains inadmissible. The deficiencies in a joint minute cannot be resolved by reference to the report of the expert. As the trial judge

remarked in *Huntley* a joint minute is a useful document, but by its nature it is never more than a summary." (Internal references omitted.)

ANALYZING THE JOINT MINUTE OF FEBRUARY 2017

72. In the instant matter, the joint minute records that the two anaesthetic experts discussed a matter of medical opinion – whether Dr Ramklass managed the anaesthetic during the operation, as well as the subsequent larygospasm, in accordance with accepted anaesthetic practice.

73. In para 1 of the minute there is agreement that the anaesthetic administered during the operation was "*acceptable*". This suggests that the experts were viewing the matter from the perspective of whether the administration of the anaesthetic itself was within acceptable parameters from a medical perspective, and they agreed that it did. In any event, I do not understand the plaintiff's case to constitute an attack on the conduct of Dr Ramklass during the operation itself, only on her response to the emergency presented by the larygospasm.

74. In para 2.4 of the minute the experts are critical of Dr Ramklass' use of the two drugs referred to and describe it as "*not ideal*". The phrase is somewhat equivocal and a court would be entitled to ask either of the experts to expand on the statement in order to assess whether it may be considered to be below the standard expected from a reasonable anaesthetist. It was, after all, as I have attempted to show through the authorities referred to, for the Court *a quo* to decide ultimately whether Dr Ramklass' treatment of the patient measured up to the requisite standard, or not.

75. Para's 2.2 and 2.3 of the joint minute both focus on the time taken by Dr Ramklass to respond to the emergency presented by the laryngospasm. The experts agreed in para 2.2 that the anaesthetist adopted the correct treatment protocol to improve the patient's oxygenation and, in so doing, she "*escalated the management of the larygospasm*". Further, the experts held the view that "*these steps did not work soon enough."* Manifestly, the minute suggests that the experts were concerned about the lapse of time and, besides the persuasive evidence of Prof. Lundgren in

that regard, common sense tells one that the longer a person is deprived of life-giving oxygen, the higher the risk of brain injury (or ultimately death) ensuing. To employ a phrase borrowed from the law of contract, "time was of the essence" in this matter.

76. Turning to para 2.3, as I read the minute, the experts noted that Dr Ramklass did not restore oxygenation "*timeously*"[19], thereby implying that she took longer than was expected of her. The word is, after all, an adverb which is essentially critical of the anaesthetist's steps not being taken "*sufficiently early.*" That is consonant with the language of negligence – an enquiry as to whether a party's conduct was reasonable or not in the circumstances.

77. The experts go on to comment that they "*estimated that there was a period of…inadequate oxygenation"* which lasted "*approxiamately 5 minutes".* When this is read in the context of the earlier remark regarding a failure to restore oxygenation in time, it appears to me that the minute is to be interpreted as saying that both experts were critical of Dr Ramklass' response time in dealing with the emergency.

78. Given the approach advocated by Wallis JA in para 220 of HAL, the Court *a quo* was not bound by the opinions expressed in the minute and was still required to assess whether they "*were based on facts and underpinned by proper reasoning."* Similarly, in conducting that exercise the Court *a quo*, was entitled to receive oral evidence from the experts to explain the medical facts and the basis for their opinions to the court.

79. The defendant contended in the Court *a quo* and on appeal that the minute reflected a joint view that Dr Ramklass' treatment of the patient was within acceptable parameters and, importantly, did not constitute negligence. That contention is at odds with the *dicta* in AM and Michael - it is for the court to consider the evidence of the experts and to decide whether negligence (which includes the element of causation) has been established or not. This is not the prerogative of the medical experts.

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[19] The Concise Oxford English Dictionary defines "timeously" as "in good time; sufficiently early".

80. In any event, and as I have suggested, on the face of it the joint minute does not suggest agreement on the fact that Dr Ramklass' treatment of the laryngospasm fell within reasonable parameters; on the contrary, the minute rather suggests the opposite. No doubt sensing the problems inherent in a literal reading of the minute, counsel for the defendant cross-examined Prof. Lundgren in an endeavour to demonstrate that the substance of the minute was in fact to reflect agreement on the reasonableness of Dr Ramklass' treatment of the laryngospasm, and it is to that part of the case to which I now turn.

THE CROSS-EXAMINATION OF PROF LUNDGREN

81. The extracts from the pleadings, medico-legal report and expert summary which I have recited above clearly articulate the plaintiff's case: Dr Ramklass was dealing with a medical emergency and she failed to respond thereto with sufficient celerity, thereby delaying the restoration of the patient's oxygenation. The defendant acknowledged in its plea that the anaesthetist was dealing with a medical emergency and claimed that she had "*timeously and adequately* ***diagnosed*****"** the laryngospasm.

82. The word "diagnosed" is emphasized because there is no positive assertion by the defendant in its plea that Dr Ramklass had treated the diagnosis in time. That much must rather be concluded from the general denial made in relation to the remaining allegations made by the plaintiff in para 13 of the particulars of claim. At the end of it all, the crux of the case is whether the appropriate steps were taken by Dr Ramklass in time to avoid hypoxic brain damage to the patient.

83. The cross-examination of Prof. Lundgren was lengthy and wide-ranging, lasting more than 2 days. For the purposes of this appeal, it is necessary to focus on the cross-examination in relation to the joint minute. That aspect was dealt with by counsel for the defendant towards the end of the witness's cross-examination, but before traversing that it is best to deal with certain preliminary aspects of the cross-examination.

84. It was suggested to the professor that, as an experienced expert witness in matters of this kind, she –

“would surely know that the role of an expert witness is not to apply an armchair approach and evaluate or assess treatment with hindsight. You’ve got to evaluate the treatment on the basis of what was reasonable at that time, in that moment. Correct?”

To this Prof. Lundgren answered as follows –

“M ‘Lord, I teach anaesthesia. I still teach anaesthesia to all levels of anaesthetists, and one of the pass/fail scenarios in the Diploma of Anaesthesia, even with our fifth-year medical students who do anaesthesia, is management of a laryngospasm. So, I’m not sure what the armchair anaesthesia is about, but treatment of a laryngospasm is a pass/fail for an undergraduate medical student and for the diploma.”

85. It was put to Prof. Lundgren that in evaluating Dr. Ramklass’ treatment of the laryngospasm –

“we must consider whether her treatment was reasonable at that time, in those circumstances, and not now, with the benefit of hindsight. Correct?”

Her reply was –

“M ‘Lord, none of us were there, and until Dr. Ramklass testifies, we will not know exactly what the circumstances was (sic) and what she was thinking at the time…

I have given a report based on the interpretation of the records, and the records that were written up afterwards, I have said, are not good records. And so it’s very difficult to know what exactly happened. So we would need Dr. Ramklass to testify. All I had, was the transcript – an anaesthetic record up until 13:05, and the transcript of notes written on a recovery room record.”

86. Prof. Lundgren confirmed that her conclusion that Dr Ramklass was negligent in her treatment of the patient’s laryngospasm was based on the notes contained in the document headed “*Recovery Room Record*” and written up by Dr Ramklass after the event. She said she based her opinion of sub-standard care on the fact that Dr

Ramklass "*took a long time"* to oxygenate the patient and stressed that it was necessary for Dr Ramklass to give her version of events before she could come to a final conclusion.

87. I should mention in that regard that counsel for the defendant was initially not particularly forthcoming in putting Dr Ramklass' version to Prof Lundgren, all the while promising to do so in due course, while at the same time taking the witness to task for entering the realms of speculation. But, it is very clear from a general reading of the cross-examination that Prof Lundgren considered that there was an undue delay in oxygenating the patient and that this was the cause of the hypoxia resulting in the brain injury.

88. When asked by counsel for the defendant to explain how she reached the conclusion that the patient suffered hypoxia, Prof Lundgren replied as follows.

"M 'Lord I reached the conclusion because I read the records; I had a telephone discussion with the expert for the defendant, and we both agreed the patient was without adequate oxygenation for five minutes. That is what my report was based on, and I did say that yesterday as well."

89. This allegation of an agreement with Dr Reed regarding inadequate oxygenation for five minutes was not challenged there and then by counsel for the defendant. But this is hardly surprising for that is what the experts recorded in para 2.3 of the joint minute. What counsel rather sought to do through cross-examination was to undermine the integrity of this agreement in the joint minute by referring to anterior discussions between the parties which preceded the conclusion of the minute.

90. In a sequence of emails commencing on 15 February 2017, the experts agreed to discuss the matter telephonically at 10h00 on Monday 20 February 2017. They exchanged reports in advance of that meeting and Prof. Lundgren undertook to draft the minute and circulate it for comment thereafter. This she did by way of email at about 11h30 on 20 February 2017.

91. On 25 February 2017 Dr Reed responded with his first comments on the draft minute to which Prof Lundgren responded. The experts then discussed the matter back and forth and made use of tracked changes on the professor's draft, with Dr Reed inserting his comments in the body of the document and Prof Lundgren utilizing a series of numbered blocks on the right of the page under the rubric *"[WUS 1]"* and following. The copies of these exchanges in the record are not all clear and counsel for the defendant provided this Court with improved copies with her heads of argument.

92. When counsel for the defendant commenced pressing Prof. Lundgren on the contents of her discussions with Dr Reed by examining their email correspondence, the witness expressed some disquiet with the approach, a concern which counsel seemed to glibly rebuff.

"Ms. Lundgren: …M 'Lord, I must say, I've never, ever had (sic) seen that the e-mail correspondence between the experts prior to the final minute being discovered in a court case before (sic)…. That is usually professional communication, and I was astounded to see this being discovered, the actual e-mail correspondence.

Ms. Witten: Well, just like in medicine anything is possible, in law anything is possible…"

93. It was never suggested to the witness that para 2.3 was either equivocal or that it did not record what she and Dr Reed had agreed. Nor was it put to Prof Lundgren that in criticising Dr Ramklass' failure to re-establish oxygenation in time, she had "*repudiated"* the agreement reached with Dr Reed in the joint minute, or, most importantly, that she and Dr Reed were in agreement that Dr Ramklass had restored oxygenation to the patient quickly enough to avoid any hypoxia.

94. Rather, towards the end of the cross-examination counsel for the defendant sought to suggest to Prof. Lundgren that the joint minute was only capable of being understood if one had regard to the exchange of emails between the experts which had preceded its conclusion.

"MS WITTEN: And so you would agree with me when I say that in order to understand the context of the joint minute, you actually have to read the document at pages 8 and 9 of section 11 in order to understand exactly what is meant in arriving at the contents of the final joint minute. Correct?

MS LUNDGREN: That's open to interpretation, M 'Lord, but this is what happened"

Prof. Lundgren's continued scepticism with the line of cross-examination is thus manifest.

95. Counsel's suggestion to Prof Lundgren that it was necessary to have regard to the discussions which preceded the finalization of the minute was manifestly not predicated on an allegation that the document was incapable of being understood. Nor was it said that the document did not record what the parties had agreed upon. In my view then, it was not only unnecessary to go behind the joint minute, it was impermissible to do so given the clarity with which the experts had expressed themselves in para 2.3.

96. In this regard, I express just one ground of reservation and that is the question of credibility. If it was being suggested that Prof. Lundgren had changed her stance, then in those circumstances the defendant might have been entitled to interrogate her as to what she had said earlier in other situations or documents. But that is not the case here – Prof. Lundgren's credibility was never impugned as would have been required of the defendant in accordance with the approach mandated in SARFU[20]. For that reason the question of credibility need not be considered further at this stage.

97. In the result, whatever Prof. Lundgren may have felt about the probity of reviewing the discussions which she and Dr Reed had conducted, no useful purpose would be served by reviewing the substance thereof because it is not relevant. The final joint minute is clear and unequivocal – para 2.3 records that the experts were in agreement that "*Dr Ramklass did not restore oxygen timeously, and [they] estimated*

[20] President of the Republic of South Africa and others v South African Rugby Football Union and others 2000 (1) SA 1 (CC) at [61] – [65]

that there was a period of approxiamately 5 minutes of inadequate oxygenation" – and their consensus view did thus not require any elucidation with reference to collateral sources.

98. On this score, it is important to bear in mind, as Wallis JA pointed out in HAL[21], that the joint minute did not constitute a contract concluded by the parties' agents and so any attempt at referral to context and background circumstances as our courts have countenanced in matters involving the interpretation of written instruments (and as one finds in cases such as Endumeni[22] and those which follow it) is misplaced. The experts here were not involved in a bargaining process intended to arrive at a negotiated position. Rather, they were expressing their professionally informed views about the reasonableness of the conduct of a colleague in a similar discipline and considering whether they thought that she had negligently caused the patient to suffer a brain injury through a state of hypoxia resulting from insufficient oxygenation post-operatively.

99. In any event, and even if one has regard thereto, the transcript reflects that in the interchanges between defendant's counsel and Prof. Lundgren the speakers frequently interrupted one another and so the professor's line of reasoning is not always clear. For example, in cross-examining Prof Lundgren, counsel for the defendant seized upon a cryptic remark made by the witness in comment box *"[WUSU6]"* in reply to a lengthy comment made by Dr Reed in relation to para 7.4 of the professor's expert summary filed under Rule 36(9)(b)[23]. Prof. Lundgren's comment was "*Anthony, we have agreed that she acted appropriately and timeously.*

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[21] At [219] *et seq*

[22] Natal Joint Municipal Pension Fund v Endumeni Municipality 2012 (4) SA 593 (SCA)

[23] See para 52 above:

> *"(i)n her opinion the treating staff…failed to treat the [patient] with the degree of skill and care expected of them…in the following respects:*
>
> *…7.4 in the presence of a well-known complication of general anaesthesia in the form of post-operative laryngospasm, they failed to act appropriately and timeously*."

However, the outcome what (sic, was?) not what it should have been? The fact that she was a medical officer, etc. is not relevant?"[24]

100. Having drawn the witness's attention to the contents of that comment box, counsel for the defendant then remarked as follows.

"MS WITTEN: So you didn't think the fact that she was a medical officer had anything to do with it, because you'd already agreed that she acted appropriately and timeously. Correct?

MS LUNDGREN: M 'Lord, I've already stated that the conduct of a medical officer… It doesn't make a difference what one's status is: if one undertakes to administer anaesthesia, one needs to administer anaesthesia appropriately and safely.

MS WITTEN: Which is what you said she did. She took the appropriate steps, and she did so timeously.

MS LUNDGREN: It's in the final minute… [intervenes]

MS WITTEN: Correct? Correct, so you – I'm correct?

MS LUNDGREN: Yes, yes.

MS WITTEN: Thank you. No, it's not in the final minute. This paragraph is not in the final minute. So, based on your agreement with Dr. Reed in terms of your comment, WUSU6, he was satisfied that you both agreed that Dr. Ramklass had acted timeously and appropriately, and so he was happy that it wasn't necessary for that to go in. And so when we look at the final minute on page 1[25], it's not there, because Dr. Reed was satisfied that you had already agreed that Dr. Ramklass had acted appropriately and timeously in her management of [the patient]. Correct?

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[24] The oblique reference to a "medical officer" was in relation to Dr Reed's expressed view that, as the holder then of only a Diploma in Anaesthetics, Dr Ramklass' duty of care towards the patient was not elevated to the level expected of the holder of a Fellowship in Anaesthetics.

[25] This is a reference to the signed joint minute referred to in [61] above

MS LUNDGREN: Yes."

101. The suggestion to the witness by counsel for the defendant was thus that she and Dr Reed had already agreed in their exchange of emails (and the tracked changes to the proposed minute) that Dr Ramklass "*had acted timeously and appropriately*" in her treatment of the patient. For that reason, it was suggested by counsel to Prof. Lundgren, the joint minute did not need to reflect what they had agreed, because they had already agreed that point *inter se* in their prior discussions.

102. With respect, the proposition put to the witness by counsel did not make sense in the circumstamces. Firstly, the purpose of the minute was to present to the parties' legal representatives (and ultimately the Court) the areas on which the experts were in agreement as to the appropriateness or short-comings in the anaesthetist's treatment of the laryngospasm. In that regard, the minute expressly recorded in para 2.3 that the experts were agreed that Dr Ramklass "*did not restore oxygenation timeously*" and that there was "*5 minutes of inadequate oxygenation*."

103. Furthermore, nowhere in the pre-trail procedures did the defendant suggest that the minute was wrong and, importantly, that the parties had agreed on the absence of negligence (as they preferred to call it) on the part of Dr Ramklass. After all that was what the case was about and the rules of engagement required that it be done to avoid the plaintiff being taken by surprise during the trial and to avoid unnecessary evidence being presented.

104. Importantly, the view held throughout by Prof. Lundgren (i.e. in her expert report to the patient's attorneys, her expert summary and her *viva voce* evidence) was that Dr Ramklass had not restored the patient's oxygen supply in time so as to avoid the onset of hypoxia. She never deviated from that view. Yet, the defendant would have it that Prof. Lundgren readily digressed from that view in an off-the-record exchange with her colleague? And, further, the defendant's suggestion is that that was a view which the experts kept to themselves and did not record in the very document which was expressly intended to reflect their areas of agreement. What

purpose, it might be asked, was then served by recording a contrary view in the minute? The proposition has only to be stated for its perversity to manifest.

105. In any event, given the complexity of the statement put to her by counsel in the exchange referred to above, and given the number of issues which required to be addressed in the answer thereto, it is not clear just what was regarded by Prof Lundgren as "correct". Trial experience informs one that witnesses often offer an answer to a question that is not necessarily the pertinent one.

106. So, in the circumstances here, one would have expected, at the very least, that the cross-examiner would have clarified the answer with reference to the agreed minute and in particular with the apparent digression from the agreement expressly recorded therein. Then it might have been put to the witness that she was in fact "*repudiating*" the terms of the minute (as the defendant would have it), thereby giving her and the plaintiff's legal team an opportunity to appreciate the import of the point, there and then, rather than having to deal with it in argument, where the point appears to have been opportunistically seized upon.

107. In the result, I am driven to conclude that the view held by Prof Lundgren that Dr Ramklass did not treat the laryngospasm quickly enough was not disturbed in cross-examination.

THE RE-EXAMINATION OF PROF. LUNDGREN

108. At the commencement of re-examination Prof. Lundgren was asked about the level of competence reasonably expected from a holder of a Diploma in Anaesthetics in managing a laryngospasm. The question was posed in the context of whether it might be expected (as suggested by Dr Reed in his off-the-record discussions with the professor) that the treatment might have been expected to have been otherwise if Dr Ramklass held a Fellowship at the time. Her reply was as follows.

"M, Lord, anyone who is administering anaesthesia at any level, should be able to diagnose – make the diagnosis of a laryngospasm, and then to treat it appropriately. And the most important aspect is to be able to oxygenate the patient. So in other

words to ensure that oxygen gets into the lungs. Be that by bag mask, ventilation and drugs."

In other words, Prof. Lundgren considered this to be an emergency that might be expected to confront any qualified anaesthetist, regardless of the level of qualification, and the treatment thereof was well-known to any such anaesthetist. Incidentally, the suggestion by Dr Reed in his off-the-record discussions with Prof Lundgren that a less stringent test might apply to the holder of a Diploma in Anaesthetics, implicitly suggests that Dr Reed regarded the treatment by Dr Ramklass as sub-standard.

109. During the course of her re-examination Prof. Lundgren was further asked to comment on certain of the propositions put to her under cross-examination regarding the version allegedly to be deposed to by Dr Ramklass. Her answers to these questions only served to re-inforce her views of sub-standard treatment of the larygospasm by the anaesthetist.

110. Firstly, she said that if it had been found that the patient's vocal chords were closed, intubation would not have been possible. Hence, she considered the comment on the Recovery Room Record that the patient was "*Intubated, but chords closed*" did not make sense in the circumstances.

"Intubation *per se* is defined as introducing the tube through the vocal chords. So if the vocal chords are closed, one cannot intubate the patient…

"[And]…if the tube was truly through the vocal chords, then the – and one is bagging and has the attachment attached to the endotracheal tube, then one would expect the lungs to inflate and not the stomach to distend"

111. When asked to assume the correctness of Dr Ramklass' contention put in cross-examination that she had indeed managed to force the endotracheal tube through the vocal chords and ventilated the lungs, Prof. Lundgren queried the necessity for the subsequent administration of medication.

“M ‘Lord, that was the query I had yesterday [during cross-examination] and I did state so that if in fact the patient had been intubated and the tube had gone through the vocal chords, I didn’t understand why suxamethonium would be necessary because the total obstruction at the level of the vocal chords would have been relieved, but it wasn’t.”

In other words, the administration of the suxamethonium is a clear indication that the attempt to intubate the patient had been unsuccessful.

112. When Prof. Lundgren was then asked to comment on the length of time taken to administer medication, she said the following.

“M ‘Lord, that is a long time to be inadequately oxygenating any patient and medication should have been administered after two or three compressions of the bag when it was evident that the chest was not filling with oxygen. So in other words two to three compressions not getting oxygen into the lungs, therefore medication must be given.”

The witness explained that two to three pumps would take at most a minute whereafter medication should immediately have been administered.

113. Prof. Lundgren further expressed serious misgivings in re-examination about the suggestion put to her by defendant’s counsel in cross-examination that the whole process of managing the laryngospasm did not take more than a minute. She said that this was manifestly not borne out by the available notes which suggested that the bagging of the patient alone took at least five minutes. Of course, the joint minute records that Dr Reed was in agreement that Dr Ramklass took five minutes to oxygenate the patient.

114. Finally, counsel for the plaintiff traversed the compilation of the joint minute in re-examination. Prof Lundgren explained the process as follows.

“M ‘Lord, a discussion between two experts is exactly that, it’s a discussion. We each have our own opinions based on the facts before the Court in the documentation, as

well as our individual reports and we – it was a collegial discussion between two colleagues, both on the phone once and then via email.

And ultimately the signed minute is what we agreed on, except for point 3 where Dr Reed was not aware that [the patient] had any dysfunction after – cognitive dysfunction after the anaesthetic."

115. When asked to explain how the minute was to be understood in relation to her agreement with Dr Reed that the steps taken by Dr Ramklass did not work soon enough, Prof. Lundgren explained as follows.

"M 'Lord, it meant that we both agreed that there was a period of approxiamately five minutes of inadequate oxygenation and therefore despite the fact that she took the steps, the oxygenation to [the patient] should have been restored sooner. And we both agreed on that."

116. As Wallis JA explained in HAL, the purpose of presenting the evidence of an expert in circumstances where there is an agreed joint minute is to enable her to explain what the terms of agreement are intended to convey. This is contrary to the ordinary rule that a witness may not be asked to explain what the parties to a contract intended their words to mean, and it is for that reason that joint minutes are not to be treated contractually and to speak of a witness "*repudiating*" the terms thereof.

117. As I have said, there may be questions raised in cross-examination in regard to a witness's credibility – did she say ABC to Dr Reed and then commit herself to XYZ in the minute – but that is not the case here, since Prof. Lundgren's credibility was not impugned during the cross-examination. In any event, an issue of credibility is usually only capable of determination at the end of the case when all the evidence is in.

WAS A PRIMA FACIE CASE ESTABLISHED BY THE PLAINTIFF?

118. It follows from what has been set out above that I am satisfied that the plaintiff presented the Court *a quo* with sufficient evidence to meet the low threshold that is set in the test for absolution at the close of a plaintiff's case. The approach which the Court *a quo* was required to apply was, in the words of Beadle CJ in Supreme Service Station, "*what might a reasonable court do*", particularly in circumstances where the "*defence [version] is particularly within the knowledge of the defendant"*.

119. Prof Lundgren delivered her expert opinion based on her extensive experience in the field of anaesthetics and explained to the Court *a quo* what the recommended treatment regime embraced. The professor remained of the view throughout that the treatment administered by Dr Ramklass in response the patient's sudden laryngospasm was not delivered timeously. She considered that the records available to her established that Dr Ramklass bagged the patient for a protracted period of time (more than 5 minutes) when she should have taken no longer than a minute at the most before administering the drugs which she ultimately did. When those drugs were administered, she considered the dose of suxamethonium was excessive while the other drugs (naloxone, neostigmine and glycopyrrolate) were not considered an "*ideal"* response in the circumstances.

120. Importantly, Prof Lundgren and Dr Reed were in agreement that Dr Ramklass did not restore the patient's oxygen supply in time and they agreed that there was a period of about 5 minutes when he was inadequately oxygenated.

121. On a number of occasions Prof. Lundgren was heard to remark that, notwithstanding her view that the care of the patient was sub-standard, Dr Ramklass was the only person who could explain what had happened. She appeared to accept that once she had heard that explanation she might reconsider her view of sub-standard treatment. But until that happened, Prof. Lundgren's views carried the day and a prima facie case was established. In the circumstances, I consider that the further remark by Beadle CJ that "*(a) defendant who might be afraid to go into the witness box should not be permitted to shelter behind the procedure of absolution from the instance*" is apposite in these circumstances.

CAUSATION

122. The defendant placed the question of causation in issue in the pleadings. It appears further from the cross-examination of Prof Lundgren that the defendant held the view that there may have been brain damage already present at the time of the laryngospasm, possibly as a consequence of an earlier anaesthetic given to the patient for a different operation. In addition, para 3 of the jiont minute reflects that Dr Reed was not convinced, one way or the other, that the patient's hypoxia resulted in anoxic brain damage.

123. To meet this issue, the plaintiff adduced the evidence of Dr Edeling, a neurosurgeon, and Ms. Coetzee, a neuropsychologist. This evidence was not traversed in the judgment of the Court *a quo* and it does not appear to have been an issue in the application for absolution. It is thus not necessary to address that evidence further at this stage other than to say that I am satisfied that such evidence similarly passes the low bar set for the absolution test at the conclusion of the plaintiff's case. There is thus nothing which stands in the way of the matter being referred back to the Court *a quo* for the further conduct of the trial.

CONCLUSION

124. For the reasons already advanced, I respectfully consider that the Court *a quo* erred in finding in paragraphs 20 and 22 of the judgment that Prof Lundgren and Dr Reed agreed that, in treating the laryngospasm, Dr Ramklass acted appropriately and timeously. The Court *a quo* ought to have found that the plaintiff had made out a *prima facie* case of negligence in that Dr Ramklass did not treat the laryngospasm in time and should have refused the application for absolution from the instance with an appropriate costs order.

125. The order of the Court *a quo* accordingly falls to be set aside, the appeal must be upheld with costs and the matter remitted back to the Court *a quo* for further hearing before Nuku J.

ACCORDINGLY, THE FOLLOWING ORDER IS MADE:

A. The appeal succeeds with costs, such costs to include the costs of the application for leave to appeal before the Court *a quo* and the Supreme Court of Appeal.

B. The order of the Court *a quo* is set aside and replaced with the following order – "**The application for absolution from the instance is refused with costs**."

C. The matter is remitted back to the Court *a quo* for further hearing.

GAMBLE, J

I AGREE:

PAPIER, J

I AGREE:

LEKHULENI, J

APPEARANCES;

Appellant:

Mr P.A. Corbett,
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Cape Town.

Respondent:

Ms S. Witten,
Instructed by the State Attorney,
Cape Town.