CONSTITUTIONAL COURT OF SOUTH AFRICA

Case CCT 185/14

In the matter between:

CHARLES OPPELT Applicant

and

HEAD: HEALTH, DEPARTMENT OF HEALTH, PROVINCIAL ADMINISTRATION: WESTERN CAPE Respondent

Neutral citation:	*Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33
Coram:	Mogoeng CJ, Moseneke DCJ, Cameron J, Froneman J, Jappie AJ, Khampepe J, Madlanga J, Molemela AJ, Nkabinde J and Theron AJ
Judgments:	Molemela AJ (majority): [1] to [86] Cameron J (minority): [87] to [150]
Heard on:	26 February 2015
Decided on:	14 October 2015
Summary:	Delict — wrongfulness and negligence — delayed treatment of spinal cord injuries resulting in permanent paralysis — both wrongful and negligent

ORDER

On appeal from the Supreme Court of Appeal (hearing an appeal from the then Western Cape High Court, Cape Town):

1. Leave to appeal is granted.
2. The appeal is upheld.
3. The order granted by the Supreme Court of Appeal is set aside.
4. The applicant's claim against the respondent succeeds and the respondent is declared liable to pay damages as the applicant may prove to have suffered as a result of the neck injury sustained in the rugby match on 23 March 2002.
5. The respondent is to pay 50% of the applicant's costs in the High Court and full costs in both the Supreme Court of Appeal and in this Court. In all instances costs arising from the use of two counsel is included.

JUDGMENT

MOLEMELA AJ (Mogoeng CJ, Moseneke DCJ, Froneman J, Khampepe J, Madlanga J, Nkabinde J and Theron AJ concurring):

Introduction

[1] This is an application for leave to appeal against the decision of the Supreme Court of Appeal[1] which upheld an appeal and set aside the order by the then Western Cape High Court, Cape Town (High Court) in favour of Mr Oppelt

[1] *The Head: Health, Department of Health, Provincial Administration: Western Cape v Oppelt* [2014] ZASCA 135 (Supreme Court of Appeal judgment).

(applicant).[2] The case concerns a delictual claim arising from delayed medical treatment after the applicant sustained spinal cord injuries that left him paralysed. The High Court held that Mr Oppelt's claim against the Head of the Western Cape Provincial Department of Health (Department) must succeed, while the Supreme Court of Appeal found that the causal link between the harm Mr Oppelt suffered and the conduct of the Department had not been established and that no delictual liability could be found. The latter decision is the subject matter of this application.

[2] The applicant is an adult male who was 17 years old at the time of the injury that gave rise to the claim. The respondent is the Head: Health, Department of Health, Provincial Administration: Western Cape (respondent). He is cited in his capacity as the administrator of the Western Cape Province. There were other defendants in the High Court proceedings. These were organisations responsible for the administration of the game of rugby. Their identity and the grounds of negligence levelled against them by the applicant warrant no mention as the action against them was dismissed by the High Court. That decision is not challenged on appeal.

Background facts

[3] On 23 March 2002, at approximately 14h15 the applicant – who was representing his community rugby club, Mamre Rugby Football Club, in a rugby match – struck his head against an opponent's shoulder in a scrum collapse. He sustained spinal cord injuries that left him paralysed below his neck. He has since been medically classified as quadriplegic.

[4] The applicant received treatment at three hospitals which were under the respondent's control. He arrived at Wesfleur Hospital (Wesfleur), at 15h15 and was attended to by a nurse and Dr Venter, a junior doctor at Wesfleur at the time. At 16h00, Dr Venter phoned Dr Rothemeyer, a training neurosurgical registrar at the

[2] *Oppelt v The Head: Health, Department of Health, Provincial Administration: Western Cape and Others* unreported judgment of the then Western Cape High Court, Cape Town, Case No 2094/07 (21 November 2012) (High Court judgment).

second hospital, Groote Schuur Hospital (Groote Schuur). Dr Rothemeyer suggested that the applicant be transported by helicopter to Groote Schuur, a transfer that would have taken 12 minutes, had it materialised. The applicant was instead transported to Groote Schuur by ambulance. The ambulance departed from Wesfleur at 16h55 and arrived at Groote Schuur at 17h40.

[5] The applicant was examined by Dr Rothemeyer at 18h00 at Groote Schuur. A note from the ambulance records shows that Dr Civitanich, an orthopaedic surgery registrar, made a call for an ambulance at 20h22 for the applicant's urgent transfer to the specialised spinal cord injury unit at Conradie Hospital (Conradie). The call was marked highest priority. This was connoted by the words "at once". The ambulance was dispatched only on the morning of 24 March 2002 at 00h25. It departed from Groote Schuur at 01h08 and arrived at Conradie at 01h23. There, the applicant's spinal cord injury was treated by a closed reduction procedure at about 03h50. The object was to relieve the pressure on the spinal cord by re-aligning the vertebrae, thereby restoring the blood supply to the nerve cells in the spinal cord.

Litigation history

In the High Court

[6] The applicant instituted an action against the respondent in the High Court for the failure of the three hospitals to provide him with prompt and appropriate medical treatment. The applicant claimed damages for negligence arising from the injury.[3] He

[3] The applicant's pleaded claim was that:

> "The hospital personnel at Wesfleur Hospital and Groote Schuur Hospital acted, or omitted to act, wrongfully and negligently in the following respects:
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> 16.1 The hospital personnel at Wesfleur Hospital—
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> 16.1.1 *delayed unreasonably* in having the [applicant] transferred either to Groote Schuur Hospital or to the Conradie Hospital spinal unit; and
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> 16.1.2 only arranged for his delivery to Groote Schuur Hospital by ambulance at about 18h00, some 3 hours after his arrival at Wesfleur Hospital;
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> 16.1.3 failed to take any steps to have the [applicant] transferred to Groote Schuur Hospital or the Conradie Hospital spinal unit *timeously*;
>
> 16.1.4 failed to ensure that the [applicant] was transferred to the Conradie Hospital spinal unit *within 4 hours of the injury*;

averred that the respondent owed him the legal duty to ensure that low velocity spinal cord injuries were treated at Conradie with "the greatest possible urgency, and where possible within four hours of the injury".[4] For the assertion that he should have been treated within four hours, the applicant relied on the evidence of Dr Newton, an orthopaedic surgeon who was in charge of the Conradie Spinal Cord Injuries Unit from 1988 to 2002.

[7] The High Court found that Dr Newton's method of treatment was "well-reasoned and logical" and that "no acceptable evidence gainsaying his theory was presented by the respondent".[5] It further found that the unreasonable delays on the part of the respondent's employees justified the conclusion that the applicant was refused emergency medical treatment as provided for in section 27(3) of the

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16.1.5 failed to seek any advice or guidance from the Conradie Hospital spinal unit;

16.1.6 failed to seek any assistance from the SA Rugby Spine Line.

16.2 The hospital personnel at Groote Schuur Hospital—

16.2.1 failed to seek advice or guidance from the Conradie Hospital spinal unit, or to consult with anyone there *timeously* or at all;

16.2.2 delayed unreasonably for a further two hours until about 20h00 to advise the orthopaedic registrar of the need to see the [applicant];

16.2.3 thereafter the orthopaedic registrar saw the [applicant] only at about 21h00, some five and a half to 6 hours after his first arrival at a hospital operated or controlled by the [respondent];

16.2.4 thereafter further delayed unreasonably until approximately 00h30 on 24 March 2002, to arrange for the [applicant's] transfer to the Conradie Hospital spinal unit;

16.2.5 failed to take steps to have the [applicant] transferred to Conradie Hospital spinal unit *timeously*;

16.2.6 unreasonably delayed further in having the [applicant] transported to Conradie Hospital, where he was received and treated only at about 05h00 on 24 March 2002;

16.2.7 failed to seek assistance from the SA Rugby Spine Line and/or the SA Red Cross Air Mercy Service." (Emphasis added.)

[4] The essence of the claim is that where low velocity spinal injuries are treated within four hours, the patients had a substantially better prospect of not suffering permanent damage, or of suffering damage to a lesser degree than those that are not treated within the four-hour period; that Conradie had a specialist 24-hour spinal cord unit; helicopter transport was available for patients who had suffered neck and/or spinal cord injuries from anywhere in the Western Cape to Conradie; and that recourse could have been made to the South African Rugby Spine Line service and/or the South African Red Cross Air Mercy service for emergency transfer of the applicant to the spinal cord unit at Conradie.

[5] High Court judgment above n 2 at para 64.

Constitution.[6] The High Court upheld the claim on the basis that the employees of the respondent had wrongfully and negligently failed to treat the applicant's spinal cord injury by way of a closed reduction procedure, within four hours of its occurrence. It concluded that the respondent was liable for the applicant's proven damages.

In the Supreme Court of Appeal

[8] Dissatisfied with the High Court's findings, the respondent lodged an appeal to the Supreme Court of Appeal. The Supreme Court of Appeal reversed the decision of the High Court and found that the applicant failed to prove, on a balance of probabilities, the validity of Dr Newton's methods. It held that Dr Newton's theory was based on too small a sample and that his statistical approach was not reliable. It further held that the applicant had not shown that he probably would have recovered but for the fact that the respondent's employees failed to treat him with Dr Newton's method within four hours of his injury. It concluded that "[c]ommon sense dictates that a failure to prove the validity of Dr Newton's theory means that a failure to apply it could not be a factual cause of Mr Oppelt's [the applicant's] paralysis".[7] Finally, the Court held that because the conduct of the respondent's employees was not the factual cause of his paralysis, it was unnecessary to determine the wrongfulness and negligence elements of delictual liability. It held that its finding on causation was dispositive of the claim.

In this Court

[9] The applicant asks for leave to appeal on both jurisdictional grounds, namely that the matter raises constitutional issues and that it raises an arguable point of law of general public importance that ought to be considered by this Court.

[10] On the merits, the applicant submits that the Supreme Court of Appeal was wrong on at least two grounds. First, it failed to recognise that the respondent's

[6] Id at para 80. Section 27(3) of the Constitution provides that "[n]o one may be refused emergency medical treatment".

[7] Supreme Court of Appeal judgment above n 1 at para 22 (footnotes omitted).

employees acted wrongfully. They violated his constitutional right not to be refused emergency medical treatment.[8] They acted unreasonably in not taking him to Conradie earlier than they did and certainly not later than four hours. Second, its stance that the applicant failed to establish a causal link between the conduct of the employees of the respondent and his paralysis was incorrect. Its conclusion on causation is premised on an incorrect approach to the evaluation of expert medical evidence and denied him a fair hearing guaranteed by section 34 of the Constitution.[9]

[11] The applicant says that the Supreme Court of Appeal not only made factually incorrect findings unsupported by the evidence, but also fell into the trap cautioned against in *Linksfield*[10] in at least two respects. First, by immersing itself in the details of the statistical method instead of assessing where, on a review of all the evidence, the balance of probabilities lies. Second, by not applying the *Linksfield* standard consistently when it evaluated the opinion evidence of Dr Newton and Dr Welsh. The applicant adds that the Supreme Court of Appeal failed to give due recognition to the scope of Dr Newton's study, without the assistance of any evidence to suggest that the statistical approach he followed was not valid. In fact, Dr Newton's study had already been partially peer-reviewed and was set for imminent publication on 11 December 2011. The applicant says that the Supreme Court of Appeal incorrectly assessed the reliability of the scientific data on which Dr Newton's conclusions were based and overlooked the statistical significance of Conradie's own data on spinal cord injuries. The Court unjustifiably relied on the testimony of Dr Welsh, which was unsupported.

[12] The respondent opposes the application. It submits that there is no evidence indicating that the applicant's right in terms of section 27(3) of the Constitution has

[8] Section 27(3) of the Constitution above n 6.

[9] Section 34 of the Constitution provides:

> "Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum."

[10] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* [2001] ZASCA 12; 2001 (3) SA 1188 (SCA) (*Linksfield*).

been infringed. It says the Supreme Court of Appeal came to the correct conclusion on the validity of Dr Newton's theory and that its approach to the medical evidence was sound. The respondent supports the finding that the applicant had not proven the causal link between the conduct of its employees and the applicant's paralysis.

[13] The respondent elaborates that there was, at the time, no consensus in the medical world that Dr Newton's specific procedure was the best and required treatment.[11] The respondent adds that the applicant did not show that Dr Welsh, Dr Rothemeyer and Dr Wallis[12] knew or ought to have known about Dr Newton's theory. Even if they had known about Dr Newton's method, there was no protocol at the time that provided for direct referral to Conradie, nor was it the desired path to be followed.

[14] The respondent claims that the normal route for referring a patient from Mamre is through Wesfleur then Groote Schuur and, only thereafter, to Conradie. It says that if this route were followed then treatment within four hours would not be possible. There was no helicopter to transport the applicant from Wesfleur to Groote Schuur – he had to be taken by ambulance. This factor plus the time he had spent at Wesfleur shows that Dr Newton's cut-off time of four hours would not have been possible. The respondent further argues that even if it is shown that Dr Rothemeyer, Dr Civitanich and Dr Dunn, an orthopaedic surgeon, merely knew about "urgent intervention" and not the four-hour cut-off time, that still does not assist the applicant. This is because Dr Newton was clear that "it's four hours or nothing". Their referral of the applicant to Conradie at 20h22 would thus still have fallen outside of this standard. The respondent asserts that the applicant's treatment at Groote Schuur is irrelevant to his claim because he arrived after the four-hour cut-off time.

[11] During the trial, reference was made to several articles that supported early reduction. Articles by Aebi et al and by Dunn alluded to the benefits of a reduction within four to six hours after the injury. Aebi et al "The Internal Skeletal Fixation System: A New Treatment of Thoracolumbar Fractures and Other Spinal Disorders" (1988) *Clinical Orthopaedics* 227 and Dunn and Van der Spuy "Rugby and cervical spine injuries – has anything changed? A 5-year review in the Western Cape" (2010) *South African Medical Journal* 235.

[12] Dr Wallis is a professor and head of the division of emergency medicine at the University of Cape Town and Stellenbosch University. He is also a chief specialist and head of emergency medicine for the Western Cape Provincial Government.

[15] The respondent points out that it has vast public responsibilities and limited resources. It should not be expected to focus, for a certain time each year (the rugby season), on an extremely limited number of patients – rugby players who suffer a specific form of spinal injury – and provide for them a highly specialised service protocol, based on the personal preference for treatment of one of its employees, Dr Newton. The respondent claims that a patient on the side of the road had a higher priority than a patient who was already in a medical facility.

[16] The respondent submits that even if the Supreme Court of Appeal had come to the wrong conclusion on causation, as a result of its interpretation of Dr Newton's theory, the applicant had, in any event, not proved the remaining elements of delictual liability and his claim ought to fail.

Issues

[17] This case raises the following issues:

(a) Should leave to appeal be granted?

(b) Has delictual liability been established? This in turn entails a consideration whether the following elements of delict have been established:

(i) wrongfulness;

(ii) causation; and

(iii) negligence.

Leave to appeal

[18] This matter implicates the rights enshrined in section 27(3) of the Constitution pertaining to access to healthcare services and emergency medical treatment. I am satisfied that it raises constitutional issues of significant public importance. Furthermore, the marked departure of the Supreme Court of Appeal from its earlier jurisprudence on the evaluation of expert medical evidence constitutes an arguable

point of law of general public importance which ought to be considered by this Court. Legal certainty on this issue will benefit the public. The applicant has prospects of success. I am thus satisfied that leave to appeal must be granted.

[19] Next to be determined is whether a delictual claim can be founded on the facts. It is necessary to recount the salient points of evidence.

Dr Newton's evidence

[20] Dr Newton testified that spinal cord injuries are divided into two categories: low velocity and high velocity spinal cord injuries. Low velocity spinal cord injuries are those sustained during a low speed impact. Rugby spinal cord injuries are low velocity injuries. Frankel grades are used to assess the level of spinal functioning. Frankel level A signifies complete lack of motor and sensory function below the level of the injury. Frankel level B is slightly better than the former in that there would be sensation below the injury but no motor function. Frankel level C is "motor useless" and Frankel level D is "motor useful". Frankel level E means that the patient is normal. High velocity spinal cord injuries are those sustained from a high speed impact, for example, as a result of a motor vehicle accident. Cervical spinal dislocation sustained in a game of rugby causes spinal cord compression and ischaemia. Typically, in facet dislocations sustained as a result of low velocity injuries, the spinal cord is not transected or severed.

[21] A further element to be understood about the nature of this injury is that there is general consensus amongst medical experts that in cases like the one presently before us, there are two injuries that occur. The first is the primary injury. This is whatever trauma caused to the neck resulting in the dislocation, for example, a blow to the neck or a twisting and bending of the neck. The secondary injury is what is called "ischaemia" – deprivation of oxygen to the cells – caused by interference of blood flow to and from the spinal cord. Permanent damage to the spinal cord is due to the secondary effects of the initial injury. Relief of the primary injury is called a "reduction of the dislocation" or "decompression".

[22] According to Dr Newton, spinal canal decompression is absolutely necessary in order to relieve pressure on the spine. Decompression of the spinal cord by closed reduction benefitted patients whose spinal cords were compressed but not severed. The injury to the applicant was a low velocity trauma caused by a forced flexion or rotation and his spinal cord was not severed. He was therefore an appropriate candidate for closed reduction.

[23] Reductions may be open or closed. During an open reduction, there is a surgical incision made and the vertebrae are re-aligned to restore the spinal canal to its normal dimensions. The closed reduction method of treatment entails subjecting the patient's compressed spine to incremental traction by applying heavy weights attached to a pulley system, connected via callipers to the patient's skull. The patient's body would be kept immobile by straps attached to the bed. The movement of the bones in the spine under traction would then be monitored by x-ray, and manipulated so that the dislocated vertebrae could be re-aligned in the spinal column. In layman's terms, the patient's spine is stretched so that the vertebrae that have been forced out of position can be pulled back into alignment. Dr Newton's theory propounds that if the closed reduction procedure is done within a period of four hours, neurologic recovery is drastically improved.

[24] Dr Newton also testified that a number of authors had advocated for early operative intervention for patients with acute spinal cord injuries. He alluded to an article by Aebi et al[13] where it was stated that "early intervention within hours after [a spinal cord injury] is critical to attain a neuro-protective effect".[14] The same authors referred to a retrospective review of 100 patients and recorded as follows:

> "A manual or surgical reduction was performed within the first six hours after the accident in only 25% of the cases and within the first 24 hours in 57%. Overall 31%

[13] Aebi et al above n 11.

[14] Id at 32.

> of the 100 patients recovered and 75% of the recoveries were in patients reduced within the first six hours".[15]

[25] In the same article, the authors also stated that Class II data suggested "a role for urgent decompression in the setting of bilateral facet dislocation and incomplete spinal cord injury with a neurologically deteriorating patient".[16] There are three classes of scientific data: Class I being the most reliable and Class III being the least reliable.

[26] In his testimony, Dr Newton said that several journal articles, including the conclusions made by Hacke in relation to a study on stroke patients, emphasised the importance of blood perfusion within the first four hours of central nervous system injury in determining the neurological outcome.[17] In another article, Dr Dunn, who was also a neurosurgeon at Groote Schuur, stated that:

> "Once the spinal cord is injured by an indirect mechanism such as described above, a relentless physiological process occurs. There is an inflammatory process which further injures the [spinal] cord. This is referred to as the secondary injury. The inflammatory process further damages the cells and thus the spinal cord function. There is associated swelling and cell death. In addition, the damaged [spinal] cord loses the ability to maintain basic bodily functions such as pulse and blood pressure control. This reduced blood pressure has a further negative effect on the [spinal] cord. Thus, a self-perpetuating downward spiral occurs."[18]

[27] Dr Newton preferred the rapid closed reduction technique on spinal cord patients. He said that spinal cord injuries sustained in a low velocity impact could be reversed if a decompression procedure was performed within a period of four hours

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[15] Id at 30.

[16] Id at 32.

[17] Hacke et al "Association of Outcome with Early Stroke Treatment: Pooled Analysis of ATLANTIS, ECASS, and NINDS rt-PA Stroke Trials" (2004) 363 *Lancet* 768.

[18] Dunn "Acute Spinal Cord Injury: The 4-6 Hour Window Debate" *Boksmart* (2010), available at http://www.sarugby.co.za/boksmart/pdf/BokSmart%202010-The%2046%20hour%20window%20of%20ASCI%20Treatment.pdf at para 20.

after the injury. The basis for Dr Newton's four-hour cut-off theory was that neurological cells that had been deprived of glucose and oxygen for more than four hours could not be brought to life again. The period within which the blood supply must be restored to the nerve cells in the spinal cord is the critical factor in Dr Newton's method of treatment. Dr Newton's four-hour theory is underscored by the premise that spinal cord injuries constitute an absolute emergency. His theory was expressed as follows in the published article:

> "Cervical spine dislocation in rugby causes spinal cord compression and ischaemia. The latter is probably the main cause of the spinal cord damage. . . . If the ischaemia is reversed within [four] hours then the spinal cord will recover to a greater degree than with later decompression. After [four] hours the ischaemic spinal cord injury is probably largely irreversible."[19] (Emphasis in original.)

[28] Dr Newton's belief in the four-hour theory was bolstered by a case study concerning 113 patients with spinal injuries sustained from playing rugby. These patients had been treated under his watch at Conradie during the period 1988 to 2002. 57 patients had sustained facet joint dislocations which were amenable to closed reduction. All those patients were in various degrees of tetraplegia (a paralysis of all four limbs also known as quadriplegia). His focus was on a group of 32 patients who were completely paralysed on admission. Nine out of the 14 patients who received closed reduction treatment within four hours completely recovered from their paralysis. Out of the remaining 18 that were not reduced within four hours, only two recovered. Based on this result, Dr Newton concluded that patients with bilateral cervical facet dislocation sustained in low velocity impact have a 64% chance of a complete recovery if the dislocation is decompressed within four hours of the injury. He therefore concluded that the applicant would probably not have become a quadriplegic had the rapid closed reduction procedure been performed within four hours of his injury.

[19] Newton et al "The Case for Early Treatment of Dislocations of the Cervical Spine with Cord Involvement Sustained Playing Rugby" (2011) 93B-12 *Journal of Bone and Joint Surgery* 1646.

[29] According to Dr Newton, it would be ethically impermissible for doctors to withhold what they believe to be good treatment from a patient purely for purposes of comparing data and, for that reason, it would not be possible to have Class I data pertaining to human beings. He denied that his data fell under the category of Class III which is mere opinion because his hypothesis was supported by Class I data pertaining to experiments performed on dogs.

[30] Dr Newton referred to two articles that he had written on spinal cord injuries. The first article in which Dr Newton had advocated for early decompression was written in 1994 and published in the same year in the *Journal of Bone and Joint Surgery*. He had since "evangelised" his four-hour theory at various congresses for orthopaedic surgeons. No dissenting views were raised during his presentations. Although the second article was only published after finalisation of the trial, the unpublished article formed part of the trial record in the High Court and was widely canvassed in Dr Newton's evidence. At that stage, it had already been partially peer-reviewed. The published article subsequently formed part of the bundle of documents that were served before the Supreme Court of Appeal.

[31] According to Dr Newton, medical personnel were always available on Saturday afternoons at Conradie to do closed reduction procedures. He stated that the respondent simply had to refer the applicant to where the resources were (which was to the specialised spinal cord unit at Conradie) in order for him to receive the appropriate treatment. He further pointed out that Conradie was only a few kilometres away from Groote Schuur and thus a protocol that precluded a direct transfer of spinal cord injured patients to Conradie was "shocking".

Dr Welsh's evidence

[32] The respondent's case centred on the evidence of Dr Welsh, a neurosurgeon, who was a consultant in the Division of Neurosurgery at Groote Schuur. In 2002, he was in charge of making decisions and overseeing the management of patients in the neurosurgery department of Groote Schuur. He testified that Dr Newton's theory of a

64% recovery rate in instances where closed reductions are done within four hours was incorrect and flawed. Dr Welsh testified that there was no consensus in medical literature with regard to the relationship between the time of decompression and the neurological outcome following acute spinal injury. He stated that one could not generalise about four hours being the cut-off period for the survival of neurological tissue starved of a blood supply. However, he conceded that the theoretical need to restore the blood supply to the central nervous system tissue did import a sense of urgency in the treatment of patients with spinal cord injuries. Dr Welsh testified that "as a doctor, one would want to intervene quickly" to urgently transfer patients with spinal cord injuries and to decompress their dislocations "as soon as possible".[20] He agreed that the advantage of closed reduction over open reduction at a theatre was speed, as it took only a few minutes to complete. He conceded that the fact that a spinal cord injury is complete, that is, where there is a complete loss of function below the injury, does not preclude recovery even though the prognosis is poorer than where the injury is incomplete, that is, where some function is retained below the injury. Dr Welsh also conceded that a clinical assessment of a complete neurological loss of function does not indicate that the spinal cord has been transected or physically damaged in an irreversible way.

[33] Dr Welsh stated that Dr Newton's study fell into the category of Class III data, which he regarded as the least reliable form of scientific data as it constituted an opinion.

Applicable legal principles

[34] It is trite law that in order to succeed in a delictual claim, a claimant would have to prove the following elements: causation, wrongfulness, fault and harm. The applicant's main attack against the decision of the Supreme Court of Appeal is directed at its finding on causation. I will deal with that element first.

[20] High Court judgment above n 2 at para 56.7.

Causation

[35] A successful delictual claim entails the proof of a causal link between a defendant's actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand. This is in accordance with the "but-for" test.[21] Legal causation must be established on a balance of probabilities.[22] The vital question is whether, as a matter of probability, the applicant's paralysis would not have occurred or been rendered permanent had the reduction procedure been performed promptly and within a time that was reasonably likely to prevent permanent quadriplegia. The answer lies in the Supreme Court of Appeal's evaluation of the expert medical testimony.

[36] The correct approach to the evaluation of medical evidence is the one laid down by the Supreme Court of Appeal in *Linksfield* where it held that—

> "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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> . . .
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> 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.
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> . . .
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> 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

[21] *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700F-I; *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 915B-H; and *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 35C-E.

[22] *Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 39.

of *Bolitho v City and Hackney Health Authority* [1997] UKHL 46; [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.

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 241G-242B). 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 242H).

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

. . .

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* 2000 SC (HL) 77 and the warning given at 89D-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 evidence.'"[23]

[23] *Linksfield* above n 10 at paras 34-40.

[37] The Supreme Court of Appeal deviated from the approach adopted in *Linksfield*. It failed to give due recognition to the scope of Dr Newton's study, even though there was no expert evidence that suggested that the statistical approach he followed was not valid. That Court erred in rejecting Dr Newton's evidence on five grounds.

[38] First, Dr Newton testified that the dislocation of the spinal cord causes pressure and obstruction in the spinal canal which, when left unattended, results in the secondary ischaemic injury of nerve cells to the extent that the cells cease to function. This evidence passes the reasonable and logical requirement for the acceptance of expert evidence set in *Linksfield*.[24] The Supreme Court of Appeal erred when it concluded that the scientific evidence that supports his theory is "questionable". The conclusion deviates from the *Linksfield* principle that where the logic of a medical approach is not in dispute, the court must not assess the cogency of scientific evidence by scientific standards, but by the legal standard of the balance of probabilities.[25]

[39] Second, there was no scientific data or evidence that challenged, refuted or doubted the acceptability of the data Dr Newton collected and relied upon in coming to his expert conclusion. Numerous articles referred to during Dr Newton's and Dr Welsh's evidence confirmed the benefits of early reduction. By the time of the trial, Dr Newton's research had been partially peer-reviewed, accepted and was about to be published in a medical journal that Dr Welsh described as highly reputable. Furthermore, Dr Newton steadfastly maintained that his method did not constitute the least reliable class of data because it was supported by Class I data of the dog experiments. The Court thus erred when it found that Dr Newton conceded that his study constituted the least reliable class of data.

[40] Third, Dr Welsh's testimony was largely limited to the observation that Dr Newton's approach was not the medical norm, because there had not yet been

[24] Id.

[25] Id.

enough opportunity to replicate or refute his findings. This feature does not serve to refute Dr Newton's evidence at the level of factual probability. A lack of general acceptance of Dr Newton's theory cannot, without more, warrant a rejection of his theory.[26] This is especially so because Dr Newton's evidence was largely unchallenged and his conclusions were arrived at on the basis of a case series, the publication of which was imminent at the time of the trial. He gave a plausible explanation on why he could not present Class I data that had a control group because the experiments were based on animal models. Great strides that have been made in the medical field have emanated from experiments on animals and review studies.

[41] Fourth, the Supreme Court of Appeal fell into the trap of focussing on scientific proof instead of assessing where the balance of probabilities lies based on an evaluation of the whole evidence.

[42] Fifth, the Court's criticism of Dr Newton's sample as small is unfounded and fails to take into account that it was isolated to specific spinal cord injuries over a period of about 12 years. The sample was based on the actual number of patients that were treated for rugby injuries at Conradie. Professor Noakes, head of the University of Cape Town's research unit for Exercise, Science and Sports Medicine, who was called by the applicant concerning a passage in his book, confirmed under oath that Conradie was a reliable and good source of data.

[43] Significantly, Dr Newton's study was conducted while he was in the respondent's employ, and his study refers to patients who were treated at Conradie under his watch. This information could therefore be easily verified. At no stage did Dr Welsh dispute that there were, on average, about eight patients treated for rugby-related spinal cord injuries at Conradie per year during that period. Dr Newton's sample could thus not have been any bigger than the number of patients that were actually treated for spinal cord injuries similar to those sustained by the

[26] *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579 (1993) at 16 and 18-9.

applicant. It was not disputed that Dr Newton's study was the largest reported case series of low velocity spinal cord injuries resulting from rugby.

[44] The respondent's criticism that Dr Newton's theory was anecdotal is without proper foundation. It was based merely on Dr Welsh's own opinion, which is not supported by any study or research with specific reference to Dr Newton's theory. Dr Welsh stated that the way Dr Newton's data was collected allowed for a lot of scientific bias, misinterpretation and inaccuracy. This criticism was rather unfair as the bias, misinterpretation and inaccuracy of Dr Newton's data was never put to him under cross-examination. Logical theories put forward by experts, and not gainsaid by other experts, should not be scoffed at without a basis. The Supreme Court of Appeal's preference of Dr Welsh's speculative views over Dr Newton's scientific evidence on bifacet cervical dislocation injuries was unwarranted and cannot be supported.

[45] The Supreme Court of Appeal, in *Van Duivenboden*, observed:

> "A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics."[27]

[46] And in *Gore NO* it held:

> "Application of the 'but-for' test is *not based on mathematics, pure science or philosophy*. It is a matter of common sense, based on the practical way in which the ordinary person's mind works against the background of everyday life experiences."[28] (Emphasis added.)

[27] *Minister of Safety and Security v Van Duivenboden* [2002] ZASCA 79; 2002 (6) SA 431 (SCA) at para 25.

[28] *Minister of Finance and Others v Gore NO* [2006] ZASCA 98; 2007 (1) SA 111 (SCA) at para 33.

[47] In *Lee*, Nkabinde J said the following about causation in the case of a negligent omission:

> "[I]n the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility."[29] (Footnotes omitted.)

[48] While it may be more difficult to prove a causal link in the context of a negligent omission than of a commission, *Lee* explains that the "but-for" test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the "but-for" test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission.

[49] Here, the so-called "mental removal of the defendant's omission" points to an indisputable causal link between the omission and the resultant quadriplegia.[30] Reverting to the present facts, the applicant asserts, correctly in my view, that failure by the respondent's employee to provide him with reasonable medical attention within four hours denied him a 64% chance of probably making a full recovery or substantial recovery from the harm of permanent quadriplegia. In this Court, the respondent's counsel conceded that if a possibility of recovery is about 50% then causation is established. This concession was correctly made.

[29] *Lee* above n 22 at para 41.

[30] Id at para 41.

[50] Dr Newton's unrefuted evidence is that the applicant would have had a 64% chance of making a full recovery from Frankel Grade A – complete paralysis – to Frankel Grade E – complete recovery – or substantial recovery if he had received the rapid closed reduction treatment within four hours of his injury. The omission of the employees of the respondent to provide him with the appropriate closed reduction treatment within four hours of his injury is causally linked to his permanent and complete paralysis. Put differently, the respondent's employees did not give satisfactory explanation for the unreasonable delay which resulted in a failure to perform closed reduction on the applicant within four hours. This denied him a 64% chance of making a full or substantial recovery. The requisite causal link has been established.

Wrongfulness

[51] The next enquiry is whether the "negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm".[31] In *Loureiro,* Van der Westhuizen J explained that the wrongfulness enquiry is based on the duty not to cause harm, and that in the case of negligent omissions; the focus is on the reasonableness of imposing liability.[32] An enquiry into wrongfulness is determined by weighing competing norms and interests.[33] The criterion of wrongfulness ultimately depends on a judicial determination of whether, assuming all the other elements of delictual liability are present, it would be reasonable to impose liability on a defendant for the damages

[31] *Van Duivenboden* above n 27 at para 12. In *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another* [1999] ZASCA 87; 2000 (1) SA 827 (*Sea Harvest*) at para 19, the Court stated:

> "Since the decision in *Minister van Polisie v Ewels* . . . the courts have employed the element of wrongfulness as a means of regulating liability in the cases of omissions."

[32] *Loureiro and Others v Imvula Quality Protection (Pty) Ltd* [2014] ZACC 4; 2014 (3) SA 394 (CC); 2014 (5) BCLR 511 (CC) (*Loureiro*) at para 53. See also *Country Cloud Trading CC v MEC, Department of Infrastructure Development, Gauteng* [2014] ZACC 28; 2015 (1) SA 1 (CC); 2014 (12) BCLR 1397 (CC) at para 21.

[33] *Loureiro* id at para 34.

flowing from specific conduct.[34] Whether conduct is wrongful is tested against the legal convictions of the community which are, "by necessity underpinned and informed by the norms and values of our society, embodied in the Constitution".[35]

[52] The applicant pleaded that the respondent owed at least three legal duties to all victims of low velocity neck or spinal cord injuries, including him. The first duty was to "ensure that such patients were transferred to the Conradie in time for them to be treated within four hours of the injury, or as shortly thereafter as was possible in the circumstances". The second duty was to "ensure that such patients received appropriate treatment at the Conradie with the greatest possible urgency". And the third duty was to "ensure that hospital personnel, particularly those working in trauma and casualty units, were instructed that low velocity spinal cord injuries should be treated with the greatest urgency, and where possible at [Conradie] within four hours of the injury".

[53] In its plea, the respondent admitted the existence of "a legal duty to dispense reasonable medical care". However, the respondent disputed the duty to do so within the four-hour cut-off time and to transfer the applicant within that time to Conradie. In the face of an admitted legal duty of care, the applicant needed to show only that the legal duty was breached.

[54] The respondent's admission of a legal duty to dispense reasonable medical care is properly made. The law requires hospitals to provide urgent and appropriate emergency medical treatment to a person in the position of the applicant. There is no doubt that the legal convictions of the community demand that hospitals and health care practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability.

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[34] *Le Roux and Others v Dey (Freedom of Expression Institute and Restorative Justice Centre as Amicus Curiae)* [2011] ZACC 4; 2011 (3) SA 274 (CC); 2011 (6) BCLR 577 (CC) (*Le Roux v Dey*) at para 122.

[35] *Loureiro* above n 32 at para 34.

[55] Section 27 of the Constitution enshrines the right to health care services. Chaskalson P, in *Soobramoney*, stated that the purpose of the right granted in terms of section 27(3) was to ensure that treatment be given in an emergency. He said:

> "The purpose of the [section 27(3)] right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention, such as the injured person in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*, should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm."[36] (Footnote omitted.)

[56] Proficient health care entails providing urgent and appropriate emergency treatment whenever a medical condition requires it. As Sachs J noted in *Soobramoney*, the right to emergency care provides reassurance to all members of society that emergency departments will be available to deal with the unforeseeable catastrophes that could befall any person, anywhere and at any time.[37] Section 25(2)(m) of the National Health Act[38] outlines some of the duties of the provincial health services and general functions of provincial departments. It provides:

> "(2) The head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province—
>
> (m) *provide and coordinate emergency . . . provision of* medico-legal mortuaries and *medico-legal services*." (Emphasis added.)

[36] *Soobramoney v Minister of Health, KwaZulu-Natal* [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (CC) at para 20.

[37] Id at para 51.

[38] 61 of 2003.

[57] Four factors warrant closer consideration. They are whether—

(a) there was an emergency;

(b) there was a necessity for remedial treatment;

(c) remedial treatment was available and could be provided to avert the harm; and

(d) remedial treatment was not provided or refused.

(a) Was there an emergency?

[58] The Constitution provides no definition of the phrase "emergency medical condition". For present purposes, it would be unhelpful and imprudent to make an attempt to define the phrase. This is so because there is no dispute amongst the parties or their medical experts that the hospitals were dealing with a condition that required "emergency medical treatment". The applicant was, according to the respondent's own triage system, designated as someone in need of emergency care. Dr Newton repeatedly stated that cervical dislocations are an absolute emergency. Professor Noakes described neck injuries as catastrophic. Dr Baalbergen, a medical doctor and co-director of the University of Cape Town Neurorehabilitation Unit, who performed over a hundred closed reduction procedures and worked at Conradie under Dr Newton, said that "[a]ll responsible neurosurgeons would attend to a compromised spinal cord *immediately* unless it can be conclusively shown that the spinal cord has been severed".

[59] None of the respondent's witnesses suggested that they did not know that the reduction treatment had to be done promptly. Dr Welsh in fact conceded that spinal cord injuries are an emergency. A quadriplegic injury seriously impairs bodily functions and squarely falls within the definition of an emergency. The events at Groote Schuur are irrelevant to the negligence enquiry because they occurred beyond the four-hour cut-off point mooted by Dr Newton. And yet the disposition of the medical caregivers points to the widespread awareness amongst them that a neck injury called for an urgent and specified procedure. This is also borne out by Dr Rothemeyer's request, albeit belatedly, that the applicant be urgently transported

from Wesfleur to Groote Schuur by helicopter. Dr Civitanich too requested an ambulance to be urgently dispatched for the applicant's transfer to Conradie. The applicant's emergency condition persisted from the time he was admitted at Wesfleur at 15h15 up to the conclusion of the reduction procedure. This is shown by Dr Civitanich's concerns at 20h22, at which stage he still considered the applicant to be an emergency case warranting "acute referral" to Conradie for a closed reduction procedure. There can be no doubt that the applicant's injuries constituted a medical emergency and all concerned employees of the respondent knew this.

(b) Was there a necessity for remedial treatment?

[60] Spinal cord injuries are very serious and can, according to Dr Newton, lead to serious medical complications with the passage of time, including death. Professor Noakes testified that they are life threatening. Dr Baalbergen expressed the following view:

> "It is the accepted medical position that when dealing with any patient who has sustained a spinal cord injury the reduction procedure, be it an open or closed reduction, is essential and must be performed without delay. Persistent compression of the spinal cord is a cause of potentially irreversible secondary injury. Failure to reduce the dislocation, allows the compression to persist."

[61] The dislocation of the applicant's neck vertebrae rendered him quadriplegic. A reduction procedure was necessary. Dr Newton and Dr Welsh agreed on this. The necessity for the transfer of the applicant to Conradie and the prompt performance of the closed reduction procedure was beyond doubt in the minds of all concerned.[39]

[39] This was also the view of all concerned doctors at Groote Schuur. After a consultation with a neurosurgeon, Dr Dunn, Dr Civitanich gave an instruction that the applicant be urgently transported to Conradie for the closed reduction procedure. Dr Rothemeyer also testified that she thought that the closed reduction procedure and the transfer to Conradie was the correct course of action.

(c) Was remedial treatment available and could it be provided to avert the harm?

[62] It seems plain that the availability of remedial treatment must be assessed in light of all relevant facts about the nature and capacity of a medical or health care facility as a whole. Emergency treatment must be rationally related to the emergency situation or trauma at hand. The mere admission of an acutely ill patient to a hospital does not, in itself, end the characterisation of his condition as "urgent" or "acute". Similarly, the emergency nature of a medical condition does not cease to be so merely because the patient has been examined by a doctor or been supplied with analgesics. Appropriate and reasonable trauma-related interventions have to be made. From the evidence, it was clear to the medical practitioners concerned that the appropriate intervention was a decompression of the dislocation so as to restore the much-needed supply of oxygen to the nerve cells.

[63] I accept that the availability of remedial treatment is informed by the availability of resources, even in the case of an emergency. Here, the respondent does not claim a paucity of resources. Unlike in the case of *Soobramoney*, we are not dealing with a respondent that is advancing a lack of resources as the reason for not dispensing appropriate medical treatment. A disclaimer of limited or unavailable resources would, in any event, be without merit, as uncontroverted evidence showed that the closed reduction method preferred by Dr Newton was inexpensive and of a short duration. The equipment necessary for this procedure was available at Conradie. Dr Newton's evidence that medical personnel were always available at Conradie on Saturday afternoons to do closed reduction was uncontested. Significantly, Dr Newton and Dr Welsh agreed that the closed reductions procedure was sometimes performed at Groote Schuur.

[64] Availability of transport for inter-hospital transfers from Wesfleur to Conradie was not an issue. The respondent's witnesses could not give any plausible reason why on the day concerned the applicant could not be transported by helicopter from Wesfleur to Groote Schuur or directly to Conradie, given Dr Venter's diagnosis of a

spinal cord dislocation. Dr Venter could, of his own accord, have summoned helicopter transport soon after the applicant's admission at 15h15. The helicopter transport was still available at that stage and was only dispatched on another mission at 15h40.

[65] The need to perform this procedure promptly is also apparent from Dr Newton's evidence. In addition, Dr Welsh conceded that a deprivation of oxygen to the nerve cells as a result of a decompression of the spinal cord could result in irreversible damage, and that bifacet dislocations have a better prognosis of recovery than other spinal cord injuries. It is evident that the appropriate urgent remedial treatment that would have probably averted harm is the closed reduction procedure that was available at Groote Schuur, and in a more specialised focus at Conradie. The High Court thus correctly concluded that there was no consistent, rational and acceptable explanation why the applicant was not given medical treatment that was appropriate for low velocity spinal cord injuries.

(d) Was remedial treatment not provided or refused?

[66] No plausible reason was advanced to show why urgent and appropriate remedial treatment needed by the applicant was not dispensed to him. None of the medical personnel of Wesfleur testified. No explanation has been given for keeping a seriously injured patient like the applicant at Wesfleur for nearly two hours when that hospital did not even have x-ray facilities. No reason was advanced for Dr Venter's failure to contact Conradie directly, when it was the known specialised unit for spinal cord injuries.

[67] The minority judgment holds that there has been no breach of the provisions of section 27(3) relating to emergency treatment,[40] nor any proof of negligence.[41] I disagree. Like the respondent, it reasons that because the applicant received medical

[40] Minority judgment [98] and [103].

[41] Minority judgment [150].

treatment at three hospitals, he was at no stage refused emergency treatment. It is crucial to note that appropriate remedial treatment aligned to the medical emergency at hand had to be given promptly. The appropriate remedy was a closed reduction decompression procedure. It is so that the applicant was not turned away from any hospital. However, this does not detract from the fact that a closed reduction, that ordinarily takes 30 to 45 minutes to complete, was performed only at the third hospital. This was 12 and a half hours after his admission to the first hospital. If the applicant had been promptly transferred to any of the two hospitals, the procedure could have been performed within four hours at Conradie or Groote Schuur, both of which had the facilities to perform open and closed reductions.

[68] In essence, the only reason the respondent has advanced for the delays is the protocol that precluded a direct transfer to Conradie. This reason was advanced by Dr Welsh and by way of statements put to Dr Newton under cross-examination. Although protocols are vital for the proper functioning of a health care system, reliance on rigid protocols cannot be allowed to trump section 27(3) of the Constitution. Dr Welsh admitted under cross-examination that referral pathways were not to be blindly obeyed despite the presence of an emergency situation. A hospital protocol that made no provision for a direct transfer of a recently injured spinal patient to Conradie, as a specialised spinal cord unit, was unreasonable because it did not take cognisance of the specialised level of healthcare that Conradie could provide. The unreasonableness of the protocol is even clearer in light of the fact that both Groote Schuur and Conradie are located within a fairly short distance of each other. That protocol was clearly not conducive to the efficient functioning of the health care system. An explanation that is based on this protocol is thus unreasonable. No reasonable explanation has been advanced for the inordinate delays in performing a simple, brief and inexpensive closed reduction procedure that is both available and absolutely necessary. The respondent constructively refused to provide the necessary emergency medical treatment and breached its legal duty to provide the applicant with medical treatment promptly or within the required four hours and thus acted unlawfully.

Negligence

[69] The proper approach for establishing the existence or otherwise of negligence was formulated by Holmes JA in *Kruger v Coetzee*[42] and has been endorsed by this Court.[43] In that case, Holmes JA stated as follows:

> "For the purposes of liability *culpa* arises if—
>
> (a) a *diligens paterfamilias* in the position of the defendant—
>
> (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
>
> (ii) would take reasonable steps to guard against such occurrence; and
>
> (b) the defendant failed to take such steps.
>
> . . .
>
> Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down."[44]

[70] In *Sea Harvest*, the following was stated:

> "[I]t should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. *Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue*. . . . It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case. . . . [I]t has been recognised that while the precise or exact manner in which the harm occurs need not

[42] *Kruger v Coetzee* 1966 (2) SA 428 (A).

[43] *Lee* above n 22 at para 18 and *South African Transport and Allied Workers Union and Another v Garvas and Others* [2012] ZACC 13; 2013 (1) SA 83 (CC); 2012 (8) BCLR 840 (CC) at fn 19.

[44] *Kruger* above n 42 at 430E-G.

> be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable."[45] (Emphasis added.)

[71] In simple terms, negligence refers to the blameworthy conduct of a person who has acted unlawfully. In respect of medical negligence, the question is how a reasonable medical practitioner in the position of the defendant would have acted in the particular circumstances.[46]

[72] In *Pitzer*, the Court stated:

> "What is or is not reasonably foreseeable in any particular case *is a fact bound enquiry*. . . . Where questions that fall to be answered are fact bound there is seldom any assistance to be had from other cases that do not share all the same facts."[47] (Emphasis added.)

[73] The negligence of medical practitioners is assessed against the standards in the medical profession at the time. In this case, the important questions are therefore whether on the facts, the first respondent's personnel foresaw that the applicant would be permanently paralysed, and whether – according to the general level of knowledge then available to them – they took reasonable steps, in the light of that foresight, to prevent permanent paralysis from happening. In answering these questions, the negligence of the respondent's employees will be tested in at least three respects:

(a) it was well known in the medical community at the time that spinal cord injuries like those sustained by the applicant had to be treated within four hours or with the greatest possible urgency;

(b) it was well known that Conradie was best-equipped to administer this treatment; and

(c) the failure to allow for an exception to the Conradie admission protocol to allow for direct transfer to Conradie was negligent.

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[45] *Sea Harvest* above n 31 at paras 21-2.

[46] *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 221A-B.

[47] *Pitzer v Eskom* [2012] ZASCA 44; JOL [2012] 29007 (SCA) at para 24.

[74] The crucial question is whether the respondent's employees knew or ought to have known that spinal cord injuries were to be treated with urgency and not later than within four hours. None of the respondent's medical practitioners and the expert, Dr Welsh, suggested that they did not know the need for urgent decompression treatment for spinal cord injured patients. For instance, Dr Welsh candidly said that as a doctor, one would want "to intervene quickly"[48] to transfer spinal cord injured patients urgently and to decompress their dislocations as soon as possible. It seems plain that a reasonable doctor would have provided or arranged for a prompt intervention and would have foreseen the harm that would flow from delayed intervention. The more intractable question is whether the doctors concerned knew of the specialised role of Conradie, and that an open or closed reduction within four hours was likely to save the applicant from permanent paralysis.

[75] The centrality of Conradie in treating acute spinal injuries was well known within the respondent's health care system. This, according to Dr Welsh, was well known in the provincial setup. Given this widespread knowledge, a reasonable doctor in the position of the respondent's employees would have transferred the applicant directly to Conradie. Dr Welsh also conceded that barring the respondent's protocol, Dr Venter could have contacted Conradie directly instead of Groote Schuur.

[76] Despite the fact that Conradie was nearer to Wesfleur, the applicant was transported to Groote Schuur, evidently out of a slavish adherence to protocol. This rigid approach, which resulted in a failure to recognise circumstances that warranted deviation from protocols, frustrates the provision of emergency treatment.

[77] In *Soobramoney*, this Court held that "[t]he purpose of the right [to emergency treatment] seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities".[49] The

[48] High Court judgment above n 2 at para 56.7.

[49] *Soobramoney* above n 36 at para 20.

evidence showed that there was an established protocol that spinal cord injuries would first be referred to Groote Schuur. This was what happened here as well. As we have seen, the evidence also shows that it was generally known that Conradie was the specialised institution for the treatment of spinal cord injuries, corroborated by the fact that the applicant was eventually referred to Conradie by the doctors at Groote Schuur. There is no explanation for the rigid adherence to protocol in circumstances of emergency. It appears to be a "bureaucratic requirement" or formality that frustrated the giving of appropriate emergency medical treatment in contravention of section 27(3) of the Constitution.

[78] Crucial to the determination of negligence was the four-hour period calculated from the time of the injury, approximately 14h15. Although there is evidence showing that the closed reduction procedure was sometimes performed at Groote Schuur, for all practical purposes, the arrival of the applicant at Groote Schuur at 17h40 followed by his medical examination at 18h00 lessened the probability of a closed reduction procedure being concluded within four hours and thus prevented the probability of recovery by treatment there.

[79] The applicant arrived at Wesfleur Hospital at 15h15. He could have been transferred directly to Conradie and treated there by closed reduction within the four-hour period. Was the failure to do this negligent? The first part of the negligence enquiry,[50] foreseeability of the possibility of harm, has clearly been established. It is the general foreseeability of the possibility that must be established, which is not dependent on specific knowledge of Dr Newton's four-hour theory. And that was common cause on the evidence. The second part, preventability, is somewhat trickier. The minority judgment holds that the applicant failed to discharge the onus of proving this requirement. As I understand the underlying reasoning, it is based primarily on two considerations.

[50] The classic test for negligence was laid out in *Kruger* above n 42.

[80] The first is that there is no evidence that Dr Newton's four-hour theory was generally known even within the Western Cape public medical community and that the alternative medical treatment, by reference to and treatment at Groote Schuur, was thus not contrary to any established medical norm.[51] Given the approach this judgment adopts in respect of negligence, it is unnecessary to subject the conduct of the doctors at Groote Schuur to any further scrutiny.

[81] The second consideration is that there is no evidence that the medical practitioners relied on the Department's protocol in referring the applicant to Groote Schuur rather than directly to Conradie.[52] I disagree. Evidence was led of the contents of the protocol. They required reference first to Groote Schuur. There was no specific evidence to suggest that medical practitioners did not need to adhere to its contents. Dr Venter, the doctor who treated the applicant at Wesfleur, was not called as a witness to explain his conduct in referring the applicant first to Groote Schuur and not directly to Conradie. The other promised witnesses – to explain the situation at Wesfleur – were never called and no explanation for that failure was ever given. Even without specific knowledge of Dr Newton's four-hour theory, it was generally known that Conradie was the specialised institution for the treatment of spinal cord injuries.

[82] Contrary to the approach adopted in the minority judgment, it appears to me that the most probable inference why the applicant was not sent to Conradie is that it was done in accordance with and because of the existing protocol. In view of the general knowledge that Conradie was the more appropriate treatment centre for acute spinal injuries, the failure by the Department to inform its personnel that the protocol was not inflexible and that direct referral to Conradie should have been done in urgent spinal cord injury cases, amounted to negligence. Had it done so, the available evidence suggests that the applicant could probably have been treated at Conradie within four hours of sustaining the injury and the sad and tragic consequences of that injury could probably have been avoided.

[51] Minority judgment [118] to [131].

[52] Minority judgment [133] to [141].

[83] The respondent failed to ensure that all reasonable steps were taken to provide the medical treatment that was required to treat the applicant's spinal cord injuries, namely urgent closed reduction, in order to decompress the ischaemia-causing dislocation. It failed to guard against the eventuation of the harm in the form of permanent paralysis.

[84] Reasonable healthcare practitioners in the position of the respondent's employees, armed with the knowledge that Conradie was the respondent's specialised unit for spinal cord injuries in the Western Cape, and the knowledge that patients who had suffered spinal cord injuries had to be treated urgently, would have transferred the applicant directly to Conradie. This was not done. The inescapable inference is that the applicant was not treated with the reasonable care and skill required of the respondent's employees at Wesfleur. The conduct of the respondent's employees coupled with their slavish adherence to transfer protocols was substantially short of the standard of practice that a member of the public is entitled to expect from a reasonably proficient hospital and reasonably proficient doctors. I am also satisfied that the negligence of the respondent's employees led to the applicant's permanent paralysis.

Costs

[85] The applicant was only partially successful in the High Court, because the claim against the other defendants was dismissed. He is entitled to 50% of the costs in that Court. The applicant has succeeded in his appeal against the decision of the Supreme Court of Appeal. He is thus entitled to costs in that Court and in this Court. The costs will reflect the costs of two counsel.

Order

[86] In the result, the following order is made:

1. Leave to appeal is granted.
2. The appeal is upheld.

3. The order granted by the Supreme Court of Appeal is set aside.
4. The applicant's claim against the respondent succeeds and the respondent is declared liable to pay damages as the applicant may prove to have suffered as a result of the neck injury sustained in the rugby match on 23 March 2002.
5. The respondent is to pay 50% of the applicant's costs in the High Court and full costs in both the Supreme Court of Appeal and in this Court. In all instances costs arising from the use of two counsel is included.

CAMERON J (Jappie AJ concurring):

[87] I have had the benefit of reading the majority judgment of Molemela AJ. I am grateful for its detailed account of the facts and issues, but I do not agree with its conclusion and some of its reasoning. My main sticking points are its approach to the wrongfulness enquiry and its findings on negligence. I do not consider it justified to find that the Department or its employees were negligent in treating Mr Oppelt.

[88] At the age of 17, in a club rugby game on the Saturday afternoon of 23 March 2002, Mr Oppelt was terribly injured. He was the hooker in a scrum when it collapsed. In the press he suffered a bilateral cervical facet dislocation of the vertebrae in his neck. The damage to his spinal cord resulted in paralysis. He is now a quadriplegic. Mr Oppelt seeks damages from the Department on the basis that it is vicariously liable for a delict committed by its hospital personnel. Mr Oppelt's case is that—

> "if he had been treated within four hours of . . . sustaining the injury by means of the rapid close reduction procedure which was routinely performed at Conradie Hospital Spinal Cord Unit under Dr Newton, he would have probably made a full or substantial recovery, and would not now have been a quadriplegic."

[89] He alleges that the Department's personnel were negligent in that they failed to get him to Conradie Hospital (Conradie) within four hours, and that the Department itself negligently failed to inform its personnel of the need to transfer a patient with injuries like his to Conradie within four hours. He also says that the referral protocols within the Department should not have been adhered to blindly.

[90] The High Court found for Mr Oppelt. It concluded that the Department was unreasonable in not taking Mr Oppelt directly and urgently to Conradie within four hours. That finding was based primarily on the evidence of Dr Newton, an orthopaedic surgeon specialising in spinal cord injuries. Dr Newton testified that, had Mr Oppelt been brought to Conradie within four hours, he would have been saved from paralysis. That was because the closed reduction procedure he practised there had been shown to have a 64% success rate in comparable cases. The High Court found Dr Newton's theory to be "well-reasoned and logical".[53] In particular, it found that there was no acceptable evidence controverting his approach.

[91] In coming to this conclusion, the High Court recognised the expertise of the Department's witnesses, Dr Welsh and Professor Wallace, but concluded that their evidence was speculative in many respects. Further, the Court acknowledged that protocols were "vital for the functioning of a proper emergency health system".[54] But it held that protocol should not preclude urgent treatment. In any event, the Court held that the Department's attempt to justify Mr Oppelt's treatment by invoking the protocol was unconvincing. This was because it rejected, as hearsay, evidence that there was no working x-ray machine at Wesfleur (where Mr Oppelt was first taken immediately after his injury – the x-ray being necessary under the protocol for admission to Conradie), and that Mr Oppelt had already been diagnosed as "T2 complete", meaning already paralysed, by the time he arrived there. This was because the evidence was hearsay and therefore rejected because the Department failed to present first-hand evidence from medical staff at Wesfleur to back this up.

[53] High Court judgment above n 2 at para 64.

[54] Id at para 70.

[92] The Supreme Court of Appeal reversed the High Court judgment. It did so solely because it rejected the evidence of Dr Newton. It did that for empirical and logical reasons. It found, first, that the evidence on which Dr Newton based his approach was not reliable, and, second, that Dr Newton's reasoning from that evidence was flawed.[55] Mr Oppelt's claim was dismissed because causation had not been established. The Department was not legally obliged to treat Mr Oppelt within four hours because, even if it had done so, he had not shown that he would have avoided his paralysis. Hence its actions were not wrongful. The Court further held that a reasonable doctor in the employ of the Department could not have foreseen that the failure to treat Mr Oppelt within four hours would have resulted in his paralysis.

Causation

[93] I agree with the majority judgment that the Supreme Court of Appeal erred in not sticking to the approach to the evaluation of expert evidence set out in *Linksfield*.[56] Indeed, the Supreme Court of Appeal failed in evaluating Dr Newton's expert evidence to distinguish between the requirement that there be "logical reasoning"[57] on the one hand, and, on the other, the requirement that evidence be generally accepted as a general medical norm.[58] This led the Court to err in rejecting Dr Newton's evidence.

[94] Dr Newton's evidence that Mr Oppelt would have had a 64% chance of making a full recovery had he received the rapid closed reduction procedure within four hours of the injury was accepted by the High Court.[59]

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[55] Supreme Court of Appeal judgment above n 1 at paras 15-9.

[56] Majority judgment [36] to [42]. The Supreme Court of Appeal returned to the *Linksfield* (above n 10) test in *Medi-Clinic Ltd v Vermeulen* [2014] ZASCA 150; 2015 (1) SA 241 (SCA) (*Medi-Clinic*), a judgment that it handed down the day after its decision in Mr Oppelt's case.

[57] *Linksfield* id at para 36.

[58] Majority judgment [40].

[59] High Court judgment above n 2 at para 64.

[95] I thus agree that causation has been established on a balance of probabilities. However, the caveat is that factual causation has been proved only to the extent that, had Mr Oppelt been treated within the four-hour period, he was likely to recover. What remains is whether the Department culpably erred in not getting Mr Oppelt to Conradie within four hours.

[96] The caveat has implications for the further normative issues of wrongfulness and negligence. Dr Newton's four-hour theory is inextricably linked to the assessment whether liability on the part of the Department follows. This means that finding wrongfulness and negligence after the four-hour period cannot help Mr Oppelt. No negligent conduct would be causally related to the harm he suffered.

Wrongfulness

[97] I agree with the majority judgment's conclusion on wrongfulness. But I differ somewhat in reasoning. Wrongfulness is incontestable.[60] The question is this:[61] if we assume that the Department's personnel could have prevented Mr Oppelt's paralysis but negligently failed to do so, should they (and the Department, which is vicariously responsible for their conduct), as a matter of public and legal policy, be held liable for the loss he suffered because of the harm? Yes. As the Department's plea conceded, medical personnel self-evidently owe their patients a legal duty to dispense reasonable

[60] See *Roux v Hattingh* [2012] ZASCA 132; 2012 (6) SA 428 (SCA) at para 33 where Brand JA noted that the basic principles underlying the element of wrongfulness remain the same in all instances. Brand JA went on to quote the principles as summarised by this Court in *Le Roux v Dey* above n 34 at para 122:

> "In the more recent past our courts have come to recognise, however, that in the context of the law of delict: (a) the criterion of wrongfulness ultimately depends on a judicial determination of whether – assuming all the other elements of delictual liability to be present – it would be reasonable to impose liability on a defendant for the damages flowing from specific conduct; and (b) that the judicial determination of that reasonableness would in turn depend on considerations of public and legal policy in accordance with constitutional norms. Incidentally, to avoid confusion it should be borne in mind that, what is meant by reasonableness in the context of wrongfulness has nothing to do with the reasonableness of the defendant's conduct [which is part of the element of negligence], but it concerns the reasonableness of imposing liability on the defendant for the harm resulting from that conduct." (Footnotes omitted.)

[61] Framed from the judgment of Brand JA in *Hawekwa Youth Camp and Another v Byrne* [2009] ZASCA 156; 2010 (6) SA 83 (SCA) at para 25.

care.[62] Section 27 of the Bill of Rights merely bolsters this.[63] Wrongfulness is established.

[98] On breach of section 27, the majority judgment rightly sets out the test in *Soobramoney*.[64] The reference point is the legal convictions of the community, as informed by the norms and values of our society, embodied by the Constitution.[65] But that test is not satisfied here. Mr Oppelt was not refused emergency medical treatment. In my view it was not established that he was unreasonably refused medical care.

[99] Mr Oppelt was assessed, stabilised, and catheterised. He was given oxygen and a high dose of steroids. The system received him and treated him with due care. It afforded him the standard of treatment the circumstances demanded of reasonable hospital personnel and delivered him to Conradie. He was not refused treatment.

[100] In assessing the availability of remedial treatment, the majority judgment places insufficient weight on the circumstances in which the doctors and medical personnel worked on the critical day. *Soobramoney* acknowledges that the obligations section 27 places on the state depend on the resources available. Chaskalson P, for the majority, expressly noted that lack of resources may limit the rights the provision confers.[66]

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[62] *Van Wyk v Lewis* 1924 AD 438.

[63] Neethling and Potgieter *Law of Delict* 6 ed (LexisNexis, Durban 2010) at 50 and 54 distinguish between two wrongfulness enquiries: wrongfulness as a breach of a legal duty and wrongfulness as an infringement of a right. The former requires: the defendant to be under a legal duty to act positively in order to prevent harm to the plaintiff or be in breach of a statutory duty; and that it is reasonable to expect the defendant to have taken positive measures to prevent the harm. The latter requires the infringement of a subjective right. It must further be established whether the infringement of the right is reasonable and legally permissible with reference to the legal convictions of the community.

[64] *Soobramoney* above n 36 at para 11.

[65] *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies intervening)* [2001] ZACC 22; 2001 (4) SA 938 (CC); 2001 (10) BCLR 995 (CC) at para 56.

[66] *Soobramoney* above n 36 at para 11.

[101] The critical doctor on duty was Dr Rothemeyer, and the critical evidence was hers. She was a registrar specialising in neurosurgery. She testified that at the time, in a single 24-hour shift, she had to serve both Groote Schuur and the Red Cross Children's Hospital. And she accomplished this by driving between the two. Dr Rothemeyer recalled that the nursing staff in the trauma unit at Groote Schuur were usually "incredibly busy". They were treating between six and 10 acutely ill patients at any one time, while trying to assist doctors.

[102] Moreover, Groote Schuur's trauma unit register for the crucial day, which was proved in evidence, confirms that the unit was burdened with acute trauma cases. These included multiple motor vehicle accidents, gunshot wounds, stabbings, assaults and resuscitations.[67] It is in this near-hellish situation that we must pass judgment on the care the medical personnel at Groote Schuur afforded Mr Oppelt – and on the decision Dr Rothemeyer took that Mr Oppelt should be brought from Wesfleur to Groote Schuur.

[103] Given these circumstances, I find it impossible to conclude that Mr Oppelt was refused emergency medical treatment. In light of the desperate situation of resource scarcity and pressure on the medical personnel, we cannot say he was inappropriately treated.

[104] The majority concludes that the observance of rigid protocols was allowed to trump section 27(3)[68] and this frustrated giving Mr Oppelt appropriate emergency treatment. The difficulty is that there is no evidence that the referral pathway Drs Venter, Rothemeyer and Stander adopted was informed by or attributable to the protocol. The statements debated with Drs Newton and Welsh in cross-examination,

[67] The trauma unit register records nine motor vehicle accidents, six assaults, three gunshot wounds and five resuscitations.

[68] Majority judgment [68].

upon which the majority judgment relies,[69] are not first-hand accounts of what transpired on the day. So they are not helpful.

[105] The majority judgment concludes Mr Oppelt was "constructively refused" treatment.[70] But this seems to be another way of saying he did not get the treatment he ought to have received. This leads to the same question: was Mr Oppelt treated negligently? For the reasons that follow, I find he was not. In summary, Mr Oppelt's right to receive emergency medical treatment was not breached, and finding that it was doesn't help us with the crucial question, which is negligence.

Negligence

[106] In our law, *Kruger*[71] embodies the classic test. There are two steps. The first is foreseeability – would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring another and causing loss? The second is preventability – would that person take reasonable steps to guard against the injury happening?[72]

[107] The key point is that negligence must be evaluated in light of all the circumstances.[73] And, because the test is defendant-specific ("in the position of the defendant"),[74] the standard is upgraded for medical professionals.[75] The question, for them, is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it.[76] In *Mitchell v Dixon*, the then Appellate Division noted that this standard does not expect the impossible of medical personnel:

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[69] Id.

[70] Id.

[71] *Kruger* above n 42.

[72] Id at 430E-G.

[73] Id at 430G.

[74] Id at 430E.

[75] Carstens and Pearmain *Foundational Principles of South African Medical Law* (LexisNexis, Durban 2007) (Carstens and Pearmain) at 621.

[76] Id.

> "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."[77]

[108] This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done?[78] We must ask: "what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible".[79] Practically, we must also ask: was the medical professional's approach consonant with a reasonable and responsible body of medical opinion?[80] This test always depends on the facts. With a medical specialist, the standard is that of the reasonable specialist.[81]

[109] In determining whether the Department's personnel were negligent, we must focus on the four-hour cut-off.[82] It was the basis of Mr Oppelt's case. For him to succeed, any negligent conduct attributable to the Department must be causally related to the harm he suffered.[83] So the question is whether Mr Oppelt should have been taken to Conradie within four hours, or shortly thereafter. In more detail, we must ask whether the Department's personnel foresaw the reasonable possibility that Mr Oppelt would be permanently paralysed, and whether – according to the general level of

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[77] *Mitchell v Dixon* 1914 AD 519 at 525. See also *Kovalsky v Krige* 1910 CTR 822 at 823 and *Coppen v Impey* 1916 CPA 309 at 314.

[78] See *Medi-Clinic* above n 56 at para 3.

[79] Carstens and Pearmain above n 75 at 622. See also *Linksfield* above n 10 at para 35; *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 192 and 221; *Van Wyk* above n 62 at 444; *Mitchell v Dixon* above n 77 at 525; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at 81-2; *Castell v De Greef* 1993 (3) SA 501 (C) at 509; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) at 385; *S v Kramer and Another* 1987 (1) SA 887 (W) at 893; *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) at 893-4; *Dale v Hamilton* 1924 WLD 184 at 200; *Coppen v Impey* above n 77 at 314; *Kovalsky v Krige* above n 77 at 823; and *Lee v Schönnberg* (1877) 7 Buch 136.

[80] See *Medi-Clinic* above n 56 paras 3-9.

[81] Carstens and Pearmain above n 75 at 623.

[82] See [117] below. Dr Newton testified that "[f]our hours is the magic number".

[83] See [96] above.

knowledge then available to them – they took reasonable steps, in light of that foresight, to prevent him becoming permanently paralysed.

[110] So, on the negligence test's first question: could the medical officers charged with Mr Oppelt's care have reasonably foreseen a danger that he would be permanently paralysed? The answer is Yes. Clearly. Dr Welsh, Professor Wallis and Dr Rothemeyer gave evidence for the Department and Dr Newton, Dr Baalbergen and Professor Noakes gave evidence for Mr Oppelt. They all agreed that a reasonable medical officer would have foreseen the risk that Mr Oppelt would suffer paralysis from his neck injuries.

[111] The Department's doctors' own diagnoses support this: Mr Oppelt already presented signs of paralysis on arrival at Wesfleur. The records there show that Dr Venter, the casualty doctor on duty, classified him as "T2 complete".[84] Later at Groote Schuur, Dr Civitanich, an orthopaedic registrar, diagnosed Mr Oppelt as having a bifacet dislocation at C5/C6. This diagnosis was eventually confirmed at Conradie. The foreseeability of possible paralysis was obvious.

[112] Given this, the pivotal question is the second part of the negligence test – what steps would a reasonable casualty doctor, registrar, specialist or ambulance attendant have taken to guard against this foreseeable harm? The facts are these:

(a) Forty minutes after the scrum collapsed at Mamre rugby field, an ambulance was called to collect Mr Oppelt.

(b) Ten minutes later, the ambulance arrived.

(c) Mr Oppelt was taken directly from the rugby field to the nearest hospital, Wesfleur, to be stabilised and assessed.

(d) At Wesfleur he was treated by Dr Venter, a casualty doctor.

[84] The High Court, as pointed out in [91], rejected this evidence as hearsay, but it can be accepted for the point about foreseeability.

(e) Dr Venter called Groote Schuur and obtained the advice of Dr Rothemeyer. (We know this from Dr Rothemeyer's evidence, since Dr Venter was not called to give evidence.)

(f) At approximately 16h00, Dr Rothemeyer instructed that Mr Oppelt be brought to Groote Schuur.

(g) She recommended that he be brought urgently – by helicopter specifically.

(h) Groote Schuur had doctors who were specialists in spinal injuries – Dr Dunn in particular.

(i) No helicopter appears to have been available. Instead, Mr Oppelt was brought to Groote Schuur by ambulance.

(j) Mr Oppelt arrived at Groote Schuur at approximately 17h40. That was still within Dr Newton's four-hour period.

(k) About two hours later, Dr Rothemeyer examined Mr Oppelt. She then consulted with other doctors more specialised in spinal cord injuries than she – Dr Civitanich, who discussed Mr Oppelt's case with his consultant, Dr Dunn.

(l) Within an hour of being consulted, Dr Dunn recommended that Mr Oppelt be urgently transferred to Conradie.

(m) Mr Oppelt arrived at Conradie about 12 hours after his injury.

(n) The closed reduction procedure Dr Newton recommended was performed on him two and half hours after arriving at Conradie.

(o) By then it was too late.

[113] This sad chronology shows that the crucial turning point for the harm Mr Oppelt suffered was the decision that he be brought to Groote Schuur, and not taken directly to Conradie. If he had been taken directly to Conradie, and had he received prompt attention there, he would probably have recovered.

[114] What is clear is that reasonable medical officers would not have done nothing: they would have taken any reasonable precautionary steps that they knew should and

could have been taken, fitting the specific case with which they were dealing. The events at Groote Schuur and before show no pattern of inaction or unconcern. On the contrary, Mr Oppelt was moved through the system. Given the circumstances,[85] he was treated as an emergency. This very fact shows that the medical personnel foresaw the risk of paralysis. Their actions show an attempt to guard against it. But the system moved cumbrously. He got to Conradie too late. The question is whether what the personnel did was negligent.

[115] Mr Oppelt had to prove negligence on a balance of probabilities. He had to show that the doctors treating him should probably have acted differently, according to the reasonableness standard set out above. Here, again, as with causation, he relied heavily on the evidence of Dr Newton. At the time of Mr Oppelt's injury, Dr Newton was in charge of the Conradie Spinal Cord Injuries Unit, a position he held for 14 years. Dr Newton had a particular interest in rugby injuries, with extensive knowledge on the subject. The High Court found him to be a credible witness and accepted his evidence.

[116] The nub of Dr Newton's evidence on negligence was that a reasonable medical officer would have ensured that Mr Oppelt was referred to Conradie within four hours so that the closed reduction procedure could be performed on him. In particular, Dr Newton testified that Mr Oppelt should have been sent straight to Conradie from the rugby field. But, since this did not happen, he should have been sent at least directly from Wesfleur.

[117] Dr Newton considered four hours the "magic number".[86] If the procedure was not performed within that period then "[t]he horse was already out of the paddock". Dr Baalbergen, Dr Newton's colleague at Conradie, supported this approach. He differed only in that he suggested a crucial period of four to six hours.

[85] See [101] to [102] above.

[86] Newton et al above n 19 at 1651.

[118] So the question is whether the ambulance and medical personnel, particularly Dr Rothemeyer, knew this in 2002. Dr Newton said Yes. He testified that his approach and the four-hour cut-off should have been well known in the Western Cape. He was, he said, "evangelical" about his approach. He spread the "gospel" at various conferences, to medical students, to teachers, to rugby officials and referees. He told the trial court: "I was like an evangelical preacher of the gospel; I was spreading this good news that there was life for spinal cords after low velocity injury".

[119] But, apart from Dr Newton's fervent assertions about his evangelism, and what it should have achieved, there is no evidence that his approach was well-known. In fact, the contrary is true. As the Supreme Court of Appeal rightly noted, Dr Newton conceded that there was no consensus in the medical scientific literature concerning the relationship between the success of a decompression following an acute spinal cord injury and the timing of the decompression.[87]

[120] More importantly, Dr Newton also conceded that his theory was "brand new". In 2002, there were no academic articles directly supporting his approach. He agreed that contrary specialist opinions were current. Some surgeons advocated for a reduction within 24 hours. Others said within five to seven hours. And some, although few, contended that the treating doctor should not reduce at all.

[121] Dr Welsh was the Department's expert. He accepted that in general, a doctor would want to intervene quickly and transfer a patient like Mr Oppelt urgently so that he can receive treatment. But he testified that there was no consensus in the medical literature relating to the timing of a decompression and consequent neurological improvement. He said that anything between eight and 24 hours for intervention was "early", given the insufficiency of data to support particular treatment standards or guidelines. This was Dr Welsh's evidence at trial. This indicates, so much the more, that at the time of Mr Oppelt's injury there was no consensus or clarity on Dr Newton's theory.

[87] Supreme Court of Appeal judgment above n 2 at para 9.

[122] And, at the end of all this, Dr Rothemeyer's evidence is, again, crucial. The critical focus in determining negligence falls on her decision to have Mr Oppelt brought to Groote Schuur, instead of sending him direct to Conradie. It was she whom Dr Venter phoned from Wesfleur when Mr Oppelt had just been brought in. It was she who so radically appreciated the necessity for speed that she recommended a helicopter transfer.

[123] But Dr Rothemeyer didn't recommend that Mr Oppelt be taken straight to Conradie. She instructed that he be brought to Groote Schuur, where she, along with Dr Civitanich and her superior, Dr Dunn, could give Mr Oppelt the care, treatment and intervention he needed. Did Dr Rothemeyer know – should she have known – that Groote Schuur was the wrong place to bring Mr Oppelt that Saturday afternoon?

[124] Dr Rothemeyer was an exemplary witness. Her professionalism and dedication shine from the record. It is clear that she worked desperately hard, and that she had the best interests of her patients – all her patients – close at heart. She was a young specialising registrar alert to doing the best for her patients. This included Mr Oppelt on that Saturday afternoon, 23 March 2002.

[125] Dr Rothemeyer testified unequivocally that on that afternoon she had never heard of Dr Newton's four-hour theory. More significantly, had there been a formalised protocol giving effect to the theory, she said, she would "most certainly have followed it".[88]

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[88] This is confirmed by the exchange in evidence in-chief between counsel for the Department, Mr Potgieter, and Dr Rothemeyer:

> "[Mr Potgieter:] And then just in this case we have heard a lot about Dr Newton's four-hour cut off time and the procedures that were followed at Conradie. At that time as far as you especially can recall in 2002 were you aware of that – shall I call it that procedure and specifically the four-hour limit as far as you recall?
>
> [Dr Rothemeyer:] No. No, I was not.
>
> [Mr Potgieter:] Can you recall whether you had ever attended seminars or meetings or where it was discussed or propounded . . . ?
>
> [Dr Rothemeyer:] No, I recall no such lectures or seminars.

[126] This evidence is impossible to rebut. How can we ignore it? We can discard it only by finding that Dr Rothemeyer was incompetent or dishonest. In fact, her medical professionalism shows us the opposite. She was exemplary. Her account of medical practice and its limitations in 2002, and the constraints under which she worked at both Groote Schuur and Red Cross Children's Hospital, commands sad respect and attention.

[127] Her ignorance of Dr Newton's theory shows that, despite his evangelical efforts, none of the Department's experts at Groote Schuur – a world-famous treatment centre, and one of the country's leading medical centres – had heard of his four-hour approach in March 2002.

[128] And this casts up a paradox. Dr Newton's fervid account of how he proselytised for the four-hour cut off, how he evangelised and spread the gospel for closed reduction within four hours, itself shows that his was a view, one view, within a contested terrain of surgical practice. It was not the accepted, dominant or orthodox view. He would not have had to evangelise if it was. Dr Newton's own evidence shows that his was a developing insight in an empirically contested area of treatment, rather than an established norm that was unreasonable not to apply.[89]

[129] A further point must be driven home. This is not a case where the Court has to decide which of different "schools of thought" would have been reasonable for the personnel treating Mr Oppelt to follow. In March 2002, Dr Newton's view did not

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> [Mr Potgieter:] And can you recall at that stage and now has there ever been any kind of protocol or policy in – at Groote Schuur relating to that?
>
> [Dr Rothemeyer:] Sorry, are we referring to then or now?
>
> [Mr Potgieter:] Well first let's take then.
>
> [Dr Rothemeyer:] Sure. Then at that time to the best of my recollection as a diligent registrar there was no formalised protocol in place. *I like following protocols, I believe in them, and if there was a formal protocol that I was aware of I would most certainly have followed it.*" (Emphasis added.)

[89] See *Medi-Clinic* above n 56.

even constitute a "school". It was an emerging new doctrine, seeking converts. It was in need of recognition and followers. Hence Dr Newton's evangelism.

[130] Dr Newton's theory was published for the first time only in December 2011.[90] The proofs of his article were handed in as evidence to the High Court – more than nine years after Mr Oppelt's injury.[91] Had Dr Rothemeyer known of the theory in 2002, and ought she to have endorsed it, she would clearly have been negligent not to send Mr Oppelt straight to Conradie. But she did not know of the theory. At best for Mr Oppelt, Dr Newton's theory was a newly emerging school of thought. And as Carstens and Pearmain say:

> "Where there is more than one school of thought or medical opinion about the indicated procedure / technique to be applied to, or intervention to be performed upon a patient, the attending physician is obliged to meet the required standard set by the medical practitioner who subscribes to that particular school of thought. The attending physician who opts for a choice between different, but accepted schools of thought, is not negligent, even though the opted school of thought may be that of an accepted or respectable minority in the medical profession."[92] (Footnote omitted.)

[131] Given that Dr Newton's theory was still being evangelised, and that it had not been published until the trial, the only standard to which the Department's medical personnel can fairly be held is the "general level of knowledge" in 2002.[93] The experts' consensus at the time was that all spinal injuries were urgent, and that earlier intervention was best. But there was no consensus about what point was crucial, or about how many hours would constitute a cut-off – nor was there any consensus then about what delay would be negligent.

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[90] Newton et al above n 19.

[91] The trial commenced on 11 April 2011 and appears to have run until 30 March 2012. The High Court delivered judgment on 21 November 2012. Dr Newton testified on 13 April 2011.

[92] Carstens and Pearmain above n 75 at 641.

[93] *Van Wyk* above n 62 at 444.

[132] This Court's task, in these difficult circumstances, is to assess from all the evidence whether on a balance of probabilities the medical staff took reasonable steps to prevent paralysis.[94] In doing so we must forbear from hindsight.

[133] Does the Department's reliance on the protocol for admission to Conradie show culpable remissness? The protocol required that an x-ray be taken. It was the Department that used the protocol as a defence, to try to counter the Mr Oppelt's averment that he should have been taken straight to Conradie. The Department submitted that he was treated and dealt with according to the protocol. This was to try to show that Mr Oppelt's treatment accorded with acceptable practice at that time.

[134] But what the Department tried to show through the protocol is quite different from the factual question whether the medical doctors who treated Mr Oppelt were actually bound by it, or *felt* bound by it. On that, the evidence is clear. None of those who treated Mr Oppelt suggested that he was brought to Groote Schuur because of protocol.

[135] The majority judgment finds that there was no evidence to suggest that medical practitioners did not need to adhere to the protocol's contents. It infers that the most probable reason why Mr Oppelt was not sent direct to Conradie is that the referral pathway was selected in accordance with and because of the existing protocol.[95] I differ.

[136] First, Dr Newton himself testified that the protocol did not need to be (or should not be) followed in emergencies.[96] Indeed, at the time, Conradie could take patients directly, outside of the protocol, as it had a functioning casualty section. Dr Welsh confirmed both Dr Newton's assertions. The evidence thus established that

[94] *Dingley v The Chief Constable, Strathclyde Police* 2000 SC (HL) 77 at 89D-E.

[95] Majority judgment [82].

[96] Dr Welsh also conceded that the latter parts of the protocol did not relate to an acute (emergency) referral, but rather to a more chronic one.

the Department's personnel were not required to adhere to the protocol in emergency cases.

[137] Second, there is no evidence that Dr Venter – who was not a spinal injury specialist – on duty at Wesfleur casualty, blindly followed protocol. We don't have evidence of what was in his mind. Rightly, the trial court and the majority judgment counts that against the Department, which did not procure his first-hand evidence. But we do know this. Dr Venter checked with Dr Rothemeyer at Groote Schuur. He didn't send Mr Oppelt to Groote Schuur himself. He consulted with the casualty expert on duty there.

[138] And there is no evidence that Dr Rothemeyer had Mr Oppelt brought to Groote Schuur merely because of the protocol. It was not put to Dr Rothemeyer that she did so. And, that being so, an adverse inference cannot fairly be drawn against her. This Court in *SARFU* emphasised the importance of expressly affording a witness the opportunity to rebut a negative inference or imputation:

> "*The precise nature of the imputation should be made clear to the witness so that it can be met and destroyed, particularly where the imputation relies upon inferences to be drawn from other evidence in the proceedings. It should be made clear not only that the evidence is to be challenged but also how it is to be challenged.* This is so because the witness must be given an opportunity to deny the challenge, to call corroborative evidence, to qualify the evidence given by the witness or others and to explain contradictions on which reliance is to be placed."[97] (Footnotes omitted and emphasis added.)

[139] Dr Rothemeyer was not challenged with the suggestion that she brought Mr Oppelt to Groote Schuur because of the protocol. So it seems wrong to find that

[97] *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* [1999] ZACC 11; 2000 (1) SA 1 (CC); 1999 (10) BCLR 1059 (CC) at para 63.

the most probable inference why Mr Oppelt was not sent to Conradie is because of the existing protocol.[98]

[140] When Dr Venter telephoned Dr Rothemeyer from Wesfleur, just after he had examined Mr Oppelt in casualty, it was Dr Rothemeyer who recommended that Mr Oppelt be brought to Groote Schuur. There is no credible basis for finding that Dr Rothemeyer did so simply to follow protocol. She did so, not because of any protocol, or other bureaucratic requirement, but because she thought that at Groote Schuur Mr Oppelt would receive the best treatment available.[99]

[141] The most probable inference is that Drs Venter and Rothemeyer selected Groote Schuur because they honestly and competently considered it the most appropriate option, given Dr Venter's examination and assessment of Mr Oppelt, together with Dr Rothemeyer's view that Mr Oppelt would be best treated at Groote Schuur.

[142] Were they wrong? Yes. Tragically so. Had they struck out the Groote Schuur option, and sent Mr Oppelt straight to Conradie, he would, on Dr Newton's theory, probably not be paralysed today. But were they *negligently* wrong? No. Culpability depends on what they knew or should have known at the time. As shown, Dr Rothemeyer had no notion whatsoever of Dr Newton's four-hour theory. That is why, in Mr Oppelt's best interests, she had him brought to Groote Schuur.

[98] Majority judgment [82].

[99] Dr Rothemeyer's notes simply record that: no x-rays were available at Wesfleur; she suggested urgent helicopter transfer; and an urgent ambulance transfer was rather arranged. In hindsight, Dr Rothemeyer postulated that these notes indicate that she evidently considered that Mr Oppelt should be brought to Groote Schuur as soon as possible for assessment and further management.

[143] So it would be unjust to impose an after-the-fact wisdom on the doctors' best professional judgment at the time. The medical personnel's course of conduct was, at the time, and given their means of knowledge, reasonable.[100]

[144] What is more, Dr Newton conceded that Groote Schuur could be the right place to send a patient: but, he said, this would be more risky, as you could not know whether the specialist on-hand was a "closed reducer". He complimented Dr Dunn, who had evaluated Mr Oppelt at Groote Schuur, as "a brilliant spinal surgeon". But he noted that Dr Dunn was someone who did not do closed reductions. So Groote Schuur had specialists in spinal injuries – Dr Dunn in particular. Given this, and at that time, on her knowledge, Dr Rothemeyer's course of action was reasonable.

[145] Finally, the chronology shows some disquieting delays at Groote Schuur. But the High Court concluded, significantly, that there was no negligence at all in any delays at Groote Schuur.[101] In any event, since the Groote Schuur delays occurred after the four-hour mark, they are not causally related to the harm Mr Oppelt suffered. And so they cannot help Mr Oppelt in his claim for damages based on delict. We cannot rely on conduct on the part of the respondent and its employees beyond the four-hour period to find the respondent liable.

[146] Overall, what emerges is that the medical officers took steps to ensure that Mr Oppelt was treated appropriately. His case was immediately coded red. He was treated as an emergency patient throughout. Acute referral was requested.

[147] Last, can we find the Department directly liable as an institution, rather than vicariously, for negligence on the part of the doctors it employed? Here the question

[100] As Dr Rothemeyer noted when testifying, at the time of the trial, nine years after Mr Oppelt's injury, there were "more well defined guidelines" as to "where spinal cord injury patients should go". This was not the case in 2002.

[101] The Supreme Court of Appeal accepted that there was a heavy workload at Groote Schuur and as a result "[t]here [was] no basis for a finding that the [Department was] liable for any delay at Groote Schuur causing [Mr Oppelt] not to be treated within the four hour cut-off point" (Supreme Court of Appeal judgment above n 2 at para 61).

is: should the Department have ensured its medical personnel knew about Dr Newton's theory? Should it have spread the word that low-velocity injuries should go directly to Conradie? Is it directly liable for negligently failing to do so?

[148] The facts already detailed are in point. Given that experienced medical practitioners in spinal injuries simply did not know about the four-hour theory, and that even a "brilliant" senior surgeon like Dr Dunn did not perform closed reductions at all, it is impossible to conclude that the Department was itself negligent for failing to adopt and disseminate Dr Newton's theory.

[149] Before we find that an institution must take practical steps to inform on-site personnel or to establish a protocol embodying a particular treatment, there must first be some measure of professional consensus – some normativity – about what is proper treatment. In this case, there is none. Dr Newton's theory was new, unpublished, and unknown to the doctors working hard that Saturday afternoon to do the best for their patients.

[150] This means that negligence on the part of the Department and its personnel was not proved. For these reasons, I would have dismissed the appeal.

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