REPORTABLE

CASE NO: SA 46/2014

IN THE SUPREME COURT OF NAMIBIA

In the matter between:

MINISTER OF HEALTH AND SOCIAL SERVICES N.O. **Appellant**

and

IVAN KASINGO **Respondent**

Coram: DAMASEB DCJ, HOFF JA and MOKGORO AJA

Heard: **8 July 2016**

Delivered: **6 July 2018**

Summary: The respondent successfully instituted an action in the High Court in which he claimed damages based on the negligence of medical staff employed by the appellant. The court *a quo* was required to decide only the issue of negligence.

The appellant and the respondent each called one expert witness.

The approach to expert evidence enunciated in *Michael & another v Linksfield Park Clinic (Pty) Ltd* endorsed namely that the determination of negligence and reasonableness involve the examination of the opinions and the analysis of the reasoning of the expert witnesses and to what extent their opinions advanced are founded on logical reasoning.

The court must be satisfied that the expert witness 'has considered comparable risks and benefits and has reached a defensive conclusion'.

It is wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support.

The negligence of a medical practitioner must be proved in view of the particular circumstances prevailing at the time. The standard of care expected from a general practitioner is not the same as that which is expected from a specialist.

Court *a quo* accepted expert evidence on behalf of plaintiff/respondent in view of the fact that the witness was a specialist in vascular surgery. The witness on behalf of defendant/appellant not expert in vascular surgery, but expert as orthopaedic surgeon. Injury sustained by plaintiff/respondent both of vascular and orthopaedic nature. Court *a quo* failed to consider what impact the orthopaedic injury would have had on the salvageability of the respondent's leg. The mind of expert on behalf of plaintiff/respondent was not directed to the question of comparable risks and benefits in view of the evidence of expert witness called on behalf of defendant/appellant.

The *onus* is on plaintiff to prove negligence on a preponderance of probabilities. Where at the conclusion of a case the evidence is evenly balanced onus is not discharged. The issues of factual causation and legal causation are considered.

Held on appeal – plaintiff/respondent did not prove negligence by defendant/appellant or its employees, and on assumption of negligence, that such negligence in the circumstances caused the amputation of respondent's lower right leg.

Appeal succeeds.

APPEAL JUDGMENT

HOFF JA (DAMASEB DCJ and MOKGORO AJA concurring):

[1] The respondent successfully instituted an action in the court *a quo* in which he claimed damages against the appellant based on the negligence of medical staff employed by the appellant. The court *a quo* was required to decide the issue of negligence only. The parties had agreed to separate the merits from the quantum of the respondent's damages.

[2] In the court *a quo* the Minister of Health and Social Services was cited in the combined summons as the first defendant and The Superintendent of the Katutura State Hospital as second defendant. The court *a quo* found that the first defendant was liable to compensate the plaintiff for such damages in such amount as may be agreed between the parties or as determined by a court. The appeal lies against the whole judgment of the learned judge *a quo*.

Background facts

[3] On 12 April 2009 at approximately 04h00 the respondent accidentally shot himself in the right leg just above the knee. The bullet severely fractured the femur and damaged the popliteal artery to such an extent that it caused the vessel to occlude, cutting the main supply of blood flow to the lower leg. At about 06h00 the respondent was admitted to the Luderitz State Hospital where he was seen by Dr Marais at pproximately 06h15. Dr Marais' clinical examination showed the respondent to have had a cold, blue, pulseless and paralysed right leg with a femur injury and an acute vascular injury.

[4] The respondent was seen as a State Medical Aid patient and for this reason Dr Obholzer, the Chief Medical Superintendent of the Windhoek Central Hospital complexes, which includes the Katutura State Hospital, (the hospital) was consulted by Dr Marais. Subsequently Dr Marais contacted Dr Orlando, the surgical officer on call, at the hospital and the latter accepted the transfer of the respondent as an acute vascular injury. The respondent was evacuated by air and arrived at the hospital at 13h00 on 12 April 2009.

[5] Upon arrival at the hospital the respondent was received by nursing staff and was seen by Dr Jario. The right leg was put in traction and a 'Brown splint' was inserted to stabilise the fracture.

[6] The following notes were made on the orthopaedic record card:

> ‘Single entrance wound; thigh hard and tender; cold limb; no dorsalis pedal pulse; no movement; no sensation.
> Diagnosis: threatened limb.
> P: Called Dr Domingues’

[7] At 18h00 on 12 April 2009 Dr Domingues, together with the surgeon on call, saw the respondent. Dr Domingues made the following clinical record entries: ‘right leg is warm (normal temperature), the popliteal and pedis pulses are present and strong’, and that the respondent was stable. Instructions were given to continue with skeletal traction and antibiotics and strict observations.

[8] The respondent remained in the hospital and on 14 April 2009 was scheduled for an operation.

[9] On 15 April 2009 the respondent was transferred to Windhoek Central Hospital where he was seen by private doctors, Dr Burger and Nel. Dr Nel observed a fixed discolouration of the skin of respondent’s right foot, that the calf muscles were in rigidity, i.e. that *rigor mortis* had set in, and concluded that respondent’s leg was not salvageable.

[10] Dr Burger disagreed on the viability of the respondent’s leg, and on 16 April 2009 a revascularisation was performed by Dr Nel. Unfortunately the respondent subsequently became feverish as a result of toxins which dead tissue from his leg had fused into the rest of his body and on 19 April 2009 in order to save his life, respondent’s right leg was amputated above the knee.

The pre-trial order[1]

[11] On 11 February 2014 the plaintiff and defendants identified the following issues to be resolved during the trial:

1. Issues of fact to be resolved during trial:-

1.1 Whether the amputation of plaintiff's right leg was inevitable and that the injury was of such a nature that the loss was inevitable.

1.2 Whether the first defendant, alternatively its employees, acted with the necessary skill as is reasonably expected from a medical practitioner and nursing staff during the period of plaintiff's admission and care with defendants and that the said acts resulted in the amputation of plaintiff's leg.

1.3 Whether Dr Domingues acted negligently in the treatment of the plaintiff as contemplated in terms of paragraphs 13.1 to 13.4 of plaintiff's particulars of claim and whether this negligent treatment resulted in the amputation of plaintiff's leg.

2. Issues of law to be resolved during trial:-

[1] In terms of rule 26 of the High Court Rules.

2.1 Whether defendants were negligent in their medical treatment of the plaintiff and whether their acts or omissions resulted in the amputation of the plaintiff's leg.

2.2 Whether the defendants discharged their duty of care towards the plaintiff, during all relevant times the plaintiff was under defendants' care and whether this resulted in the loss of the plaintiff's leg.

3 Relevant facts not in dispute:-

3.1 That plaintiff was admitted to Katutura State Hospital from 12 April 2009 to 15 April 2009.

3.2 That plaintiff suffered a gunshot wound to his right leg on 12 April 2009.

3.3 That plaintiff's leg was amputated above the knee on 19 April 2009.

3.4 While at Katutura State Hospital, plaintiff was under the medical care of Dr Domingues, who acted within the course and scope of his employment with defendant.

3.5 Plaintiff was in a critical state of health when admitted and needed urgent medical attention due to the nature of the injury.

These issues were made orders of court on 13 February 2014.

[12] It is alleged in the particulars of claim in para 13 that Dr Domingues acted negligently vis-a-vis his medical treatment of the respondent and/or supervision of such medical treatment by:

‘13.1 failing to provide the necessary medical treatment timeously to the plaintiff upon the plaintiff’s admission to the hospital;

13.2 failing to correctly diagnose the nature of the injury and accordingly failing to provide the appropriate treatment to the plaintiff;

13.3 failing to appreciate the severity and effect of the injury and accordingly failing to provide the appropriate medical treatment to the plaintiff;

13.4 failing to properly take cognisance of the fact that the plaintiff’s right leg was at critical risk of being amputated in order to save the life of the plaintiff and accordingly failing to provide the appropriate medical treatment to the plaintiff in order to avoid the amputation of the plaintiff’s right leg.’

In the particulars of claim the allegation of negligent conduct was directed at Dr Domingues only, however in the pre-trial order the alleged negligent conduct was broadened to include also employees, i.e. medical practitioners and nursing staff of the appellant without amending the particulars of claim and it was on the basis of this extension of issues in dispute that the court *a quo* heard the matter.

Proceedings in the High Court

[13] The respondent (as plaintiff) in the court *a quo* called two witnesses namely Dr Jeremy Nel and the respondent himself.

[14] Dr Nel testified that he is a specialist surgeon (the bulk of his work is abdominal surgery and vascular surgery) and that he was asked during the afternoon of 15 April 2009 by Dr Burger, an orthopaedic surgeon, to assess the viability of the leg of the respondent. As a result of his observations[2] he concluded that respondent's leg was not salvageable and he suggested an amputation. Dr Burger disagreed and was of the view that the leg could still be saved. They decided to do an arteriogram[3] which confirmed an interruption of the blood flow above the knee. In view of the opinion of Dr Burger it was decided to revascularise the artery. This was done the next day i.e. on 16 April 2009. Dr Nel testified that the 'bullet' itself did not go through the artery but that the shockwave ruptured the inner layer of the artery which caused a complete occlusion of the blood supply to the lower leg. The nerve itself also was intact but as a result of the shock wave 'it would have had some malfunction which probably would have recovered with time'. This was important because if one loses 'an artery and the nerve even if you re-vascularise the leg the chance that you are going to get a leg that is . . . functional is small'.

[2] See para 9 supra.
[3] A procedure involving X-rays of an artery or arteries after injection of a radiopaque medium in order to determine exactly where blood flow is and where not.

[15] Dr Nel was referred to the orthopaedic record card (referred to in para [6] supra)[4] and testified that these are all hard symptoms of a vascular injury.

[16] In view of the conflicting observations (referred to in paras [6] and [7] supra), Dr Nel was of the view that in order to eliminate any uncertainty, whether or not there was a vascular injury, Dr Domingues should have called a consultant and a doppler test[5] or an arteriogram should have been done. Dr Nel's testimony was that a doppler test is the quickest as it could have been done in a ward. This however was not done. Time was of the essence. He stated that at the hospital at that time it would have taken a whole day to get an arteriogram. Dr Nel expressed his concern that there was a big delay between the admission of the respondent and the time Dr Domingues saw him and since this was an urgent matter the respondent had to receive immediate medical attention. Dr Nel testified that if one is injured where the respondent was injured it was probably the worst vascular injury one could sustain. Dr Nel in his 'medicolegal report'[6] stated the following under the heading 'Comment': 'The delay hereafter'[7] is not acceptable today. A complete vascular injury to the main vessel gives one 4 – 6 hours before damage is inevitable'. Dr Nel however when asked during his evidence-in-chief whether the 4 – 6 hours period referred to in his report is a 'threshold', replied it was not 'absolute' and further testified that a 6 – 8 hours delay is not a 'cut off point' before damage to a limb becomes irreversible and amputation inevitable. He stated that if collateral blood flow is intact and respondent has good blood pressure there is a good

[4] Received as exhibit 'C'.
[5] A doppler is a ultrasonic device that can detect and measure the circulation of blood flow e.g. decreased or obstructed blood flow to the legs.
[6] Received as exhibit 'D'.
[7] 'The delay hereafter' refers to the delay after respondent's admission to the hospital.

chance that his leg will remain viable for some time after 6 to 8 hours. He explained that, in his experience, even after a delay of 24 hours patients had been presented to him and that he had saved legs 'but not without some permanent damage to the limb.[8] Respondent's leg was probably salvageable as a functional limb on admission'.

[17] Dr Nel disagreed that the amputation of respondent's leg was inevitable at the time of his admission to the hospital since from the notes made, there were no contrary indications to revascularisation. His opinion was that there was poor handling of the respondent after admission to the hospital. His view was that 'rapid response by receiving doctors could have saved his leg'.[9] Dr Nel testified that once a doctor has seen a patient such doctor is 'responsible for that patient'.

[18] It appears from exhibit 'O' that on 13 April 2009 at 09h00 a senior doctor came and noted the following findings:[10]

> 'loss of sensation
> Right forefoot unable to wiggle toes -
> Balbina'

At about 17h45 an anaesthetist was requested by concerned nurses to assess the respondent. This was done. A note was made that the right limb was cold, weak pulses (dorsalis pedis). The intern came and said she would call Dr Domingues.[11] On 14 April

[8] An extract from the joint report by Drs Nel and Walters received as exhibit E.
[9] Extract from exhibit 'D' – Dr Nel's expert report.
[10] See exhibit 'C' and exhibit 'O' – Preliminary report – evaluation of admission records by M. Tobias – Chief Control Registered Nurse.
[11] Exhibit 'O' and exhibit 'C'.

2009 at 01h00 an evaluation was done by nurses. It was observed that the right thigh was warm but the lower leg below the knee was very cold. The respondent was unable to move his toes and felt no sensation. At 08h00 the respondent was seen on doctor's rounds. The respondent was feverish and dorsal paedis pulse very weak. The plan was to wait for an operation. At 10h30 the respondent received a blood transfusion. On 15 April 2009 the respondent was transferred to Windhoek Central Hospital to a private ward on the request of family members to been seen by a private doctor.

[19] Dr Nel was asked with reference to the inscriptions made by Dr Domingues to express a professional opinion on what should have happened at that stage. He replied as follows: 'Well as I said before I think this is first of all too late and second of all he should have had a doppler or arteriogram done straight away . . . .'.

[20] During cross-examination Dr Nel was firm in excluding the possibility that rigor mortis and severe ischemia[12] of the limb could have been present at the time the respondent was seen by Dr Marais in Luderitz. It was too soon.

[21] Dr Nel expressed the view that the hospital knew that the respondent was coming and should have taken him straight to theatre where the vessel should have been explored and a graft done. Had this been done the respondent would have kept his leg. Dr Nel testified that in the absence of any signs of *rigor mortis* there would have been a '80% plus' chance of saving the leg of the respondent.

[12] A local temporary reduction of blood supply to an area due to obstruction of the blood vessels supplying the area.

[22] The respondent testified and his witness statement was handed in as exhibit K. He confirmed that the accident involving a 9 mm pistol occurred about 04h00 on 12 April 2009 and expressed the view that he did not receive proper medical care at Katutura State Hospital.

Evidence on behalf of the defendants

[23] Dr Ludwig Werner Walters testified that he is not a qualified orthopaedic surgeon but works as one and has done so for the past 30 years.

[24] Dr Walters testified that Dr Domingues was one of the Cuban volunteers who worked at the hospital as a doctor but was not an excellent clinician – 'he did not have good hands'.

[25] Dr Walters testified that he did not think that anything Dr Domingues did or did not do caused the respondent to lose his leg. He based this opinion on the time that had lapsed from the incident[13] until the arrival of respondent at the hospital, on Dr Jario's clinical notes, and on the severity of the injury (i.e. damage to the bone and nerve). He testified that he had personally dealt with many injuries of this nature as orthopaedic surgeon over the years. If a femur is fractured there is a lot of soft tissue damage. He explained that at the time the respondent was admitted there was no vascular surgeon at the hospital and that all PSEMAS[14] patients had to be operated on

[13] Based on Dr Marais' report.
[14] ie Public Service Employees Medical Aid Scheme.

at the Windhoek Central Hospital in order to cut costs and because no other hospital in Namibia had the necessary equipment and ‘staff expertise’.

[26] During 2009 at the hospital there was always an intern for surgery on duty, on call 24 hours per day, who was covered by a medical officer (a more senior officer) who was in turn covered by either a consultant or a principal medical officer (like himself). Dr Walters testified that Dr Domingues made a clinical error by noting that the respondent’s leg was warm and that there was a pulse present, but doubt whether this error would have made any difference. He was also unsure whether or not an arteriogram could have been done at the hospital at that stage. According to Dr Walters an arteriogram cannot be done without an X-ray department and during 2009 all patients had to go to Windhoek Central Hospital to get their X-rays. He stated that since the injury sustained by the respondent was not an isolated vascular injury but also a femur fracture that the fractured femur had to be fixed first prior to revasculisation. This in turn would have involved other role players like an anaesthetist, an orthopaedic surgeon, a radiologist and a radiographer in addition to the vascular surgeon. According to Dr Walters in such circumstances the outcome of a vascularisation would have been ‘very different’, than a case in which the only injury was a vascular injury. When Dr Walters was asked the period during which the leg of respondent could have been salvageable he replied: ‘To be sure that he will have a normal functioning limb afterwards then 6 to 8 hours he is outside limits . . . .’

[27] Dr Walters was convinced that nothing individual medical practitioners at the hospital could have done would have saved the respondent’s leg. He was of the view

that even if the respondent had been admitted at the Catholic Hospital[15] where all the necessary equipment[16] and specialist surgeons were available the leg of the respondent would not have been saved.

[28] During cross-examination Dr Walters was of the opinion that in view of the inscriptions made by the intern when the respondent arrived at the hospital at 13h00, that at 18h00, Dr Domingues should have called for a second opinion like that of a consultant. This was not done.

[29] Dr Walter's testimony was that no doppler test or arteriogram was conducted during the period 13h00 until 18h00 but in his view it would have been too late, at the time Dr Domingues saw the respondent, because of the severity of the injury and the time that had lapsed.

[30] Dr Walters conceded that upon admission of the respondent it could not have been excluded that respondent's limb was possibly salvageable as a functional limb. Dr Walters testified that salvaging a limb does not mean a patient is going to have a normal limb afterwards – it means the patient keeps his leg but it will not be a functional limb. To be sure that a patient will have a normal functioning limb afterwards he must be treated within 6 to 8 hours.

[15] A private hospital.
[16] These were not available at the hospital.

[31] Dr Noël Eugene Marais is a registered medical practitioner who had practised for 30 years in private practice and for the state. He confirmed the injuries sustained by the respondent on examination by himself on 12 April 2009 at 06h15 in Luderitz. According to him the oxygenation and survival of the leg of the respondent depended on the injured artery because if that vessel occludes the leg is regarded as 'threatened status'. The primary reason for the urgency and the actions which he undertook was that the case 'revolves around circulation and the vascular injury'. He testified that since the respondent was seen as a State Medical Aid patient he contacted Dr Obholzer, the medical superintendent who required the name of an accepting practitioner. Through the radio room he was put into contact with Dr Orlando to whom he spoke on Dr Orlando's cellphone. According to him he discussed the case with Dr Orlando who accepted that respondent may be transferred to Windhoek.

[32] He testified that it is standard procedure to contact the radio room and to ask for the surgical officer on call, who is the managing officer who must decide what the most appropriate 'disposal of the patient is'. It is 'the duty of the receiving surgical officer on call to know what he needs to do with the patient once he has examined and evaluated him'.

[33] After he had spoken to Dr Orlando he again contacted Dr Obholzer who gave the necessary authorisation that respondent may be airlifted to Windhoek. Dr Marais, himself, never made any further enquiries after the arrival of the respondent in Windhoek.

Joint medical report by Drs J H T Nel and L Walters

[34] In this report both doctors felt that further consultation with a consultant by Dr Domingues would have been the right course of action. Both doctors agreed that the leg of the respondent was 'probably salvageable as a functional limb on admission'. Both doctors 'felt' that the standard of care . . . fell below what would be expected of a reasonable doctor in a major centre'.

The judgment of the court *a quo*

[35] The court *a quo* stated that it is common cause that the diagnosis by Dr Domingues was wrong, but that a wrong diagnosis does not necessarily translate into negligence, unless it is so palpably wrong as to amount to negligence.

[36] The court *a quo* considered the respective testimonies of Dr Nel and Dr Walters and agreed, 'if regard is had to the totality of the facts and probabilities . . . that their assessment of the standard of care is justified and correct'.

[37] In respect of the divergent opinions expressed whether or not the respondent's leg could have been saved had the blood supply been restored in time the court *a quo* concluded that the view expressed by Dr Nel was to be preferred. This was based on the fact that Dr Nel is a specialist surgeon in vascular surgery, his testimony that through timeous intervention he had saved many limbs, that the blood supply was restored when the surgery was performed, and that the amputation became necessary simply because the surgery was performed too late.

[38] The court *a quo* found that in contrast, Dr Walters does not hold the same specialist qualifications in vascular surgery as Dr Nel, that Dr Walters never saw the respondent, that his view of the severity of the injury is not based on clinical observation and diagnosis but instead on notes made by staff who attended the respondent, and that these factors detracted from the weight of his expertise.

[39] The court *a quo* concluded that there is a direct and close link to the omission of particularly Dr Domingues and the damage caused to the plaintiff and that the appellant was therefore liable to compensate the respondent for such damages.

[40] The qualifications, experience and expertise of Dr Nel (as testified by himself) as a vascular surgeon was never doubted. Similarly the vast experience of Dr Walters as an orthopaedic surgeon was not in issue.

Proof of medical negligence

[41] The *onus* is on a plaintiff to prove negligence on a preponderance of probabilities. 'If at the conclusion of the case the evidence is evenly balanced, he cannot claim a verdict; for he will not have discharged the *onus* resting upon him'.[17]

[42] In *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430G an authoritative test of negligence was formulated by Holmes JA as follows:

> 'For the purpose of liability *culpa* arises if –

[17] See *Van Wyk v Lewis* 1924 (AD) p 444 per Innes CJ.

(a) a *diligens pater familias* in the position of the defendant –

(i) would forsee 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.'

[43] The negligence of a medical practitioner must be proved in view of the particular circumstances prevailing at the time. In *Van Wyk v Lewis*[18] it was stated that:

> 'We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently.'[19]

[44] The standard of care expected from a general practitioner is not the same as that which is expected from a specialist. In *Buls & another v Tsatsarolakis*[20] this aspect was stated as follows at 894D:

> 'The question in the present case is, therefore, not how specialist orthopaedic surgeon would have acted in the treatment of the plaintiff, but how an average general practitioner, carrying on his duties as a casualty officer in a public hospital, would have acted.'

[45] This aspect was stated as follows in *R v Van Der Merwe*:[21]

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[18] At 461 per Wessels JA.
[19] See also *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) p 171 para [20].
[20] 1976 (2) TPD 891. See also *R v Van der Merwe* 1953 (2) PH H 124 (W); *Esterhuizen v Administrator, Transvaal*, 1957 (3) SA 710 (T) at 723H.
[21] 1953 (2) PH H 124 (W).

> '(W)hen a general practitioner is tried, the test is not what a specialist would or would not do in the circumstances, because a general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist has.'

[46] The alleged negligence of Dr Domingues must therefore be assessed in his capacity as general practitioner and not as a specialist surgeon, like Dr Nel.

[47] The appellant as well as the respondent presented expert evidence in the court *a quo*. The approach to expert evidence was considered and expressed in the matter of *Michael & another v Linksfield Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA) as follows at p 1200 and 1201 (paras 34, 36, 37, 39 and 40):[22]

> '34 . . . 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 opinion 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.
>
> 36 . . . 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.
>
> 37 "The Court must be satisfied that such opinion has a basis, in other words, that the expert has considered comparative risks and benefits and has reached 'a defensive conclusion".
>
> 39 . . . 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

[22] Paras 34, 36, 37 and 39 quoted partially.

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.

40 Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty percent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police* 200 SC (HL) 77 and the warning given at 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 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."'

[48] In *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 175H this approach was approved and the court stated the following: 'What was required of the trial Judge was to determine to what extent the opinions advanced by these experts were founded on logical reasoning *and how the competing sets of evidence stood in relation to one another, viewed in the light of the probabilities'*. (Emphasis provided)

[49] It is trite law that a credibility finding may be determinative of issues in dispute in a trial where conflicting views are adhered to by witnesses called by opposing parties. In *Louwrens v Oldwage* at para 14 it was stated by Mthinyane JA that:

> 'On a proper approach, the choice of preference of one version over the other ought to be preceded by an evaluation of the relevant witnesses, their reliability and the probabilities.'

[50] Mr Boonzaier who appeared on behalf of the appellant submitted that the court *a quo* erred on the approach to expert evidence since its reasoning was based on considerations of Dr Nel's credibility. I have perused the judgment of the court *a quo* and was unable to find any part where this submission is borne out. No credibility finding was made by the trial judge and therefore that issue does not arise in this appeal. The trial judge accepted the evidence of Dr Nel merely because he is a specialist vascular surgeon and because he had seen the respondent. This preference of the trial judge can therefore not be equated with a credibility finding.

Mr Titus appeared *pro bono* on behalf of the respondent in the court *a quo* and on appeal.

The evaluation of evidence presented by the parties

[51] One of the issues which the court *a quo* was called on to determine was the question regarding the negligent treatment of the respondent by Dr Domingues.

[52] Dr Walter's testimony was that at the time the respondent was seen by Dr Domingues there was nothing anyone could have done to save the respondent's leg and based his opinion on the factors referred to in para 24 (supra).

[53] Dr Nel during his testimony-in-chief was referred to inscriptions made on hospital records[23] and asked whether the respondent's leg was at that stage still salvageable. He replied that he could not give a definite answer in view of the fact that the relevant information, in order to answer the question, was not recorded.

[54] A simple calculation shows that a period of 14 hours had lapsed since the incident until the time that respondent was seen by Dr Domingues. Although Dr Nel testified that he had saved limbs after a period of 24 hours had lapsed it is common cause that those instances involved isolated vascular injuries, i.e. one not complicated by bone fractures as in the present case. Dr Walters' testimony was that the fact that the respondent suffered a fractured femur complicated the situation as well as the chances of saving the respondent's leg. His evidence that the fractured femur had first to be fixed before the vascular injury could be attended to is not gainsaid by any other evidence. Indeed Dr Nel recognised that an orthopaedic surgeon had to be involved in the process of saving the respondent's leg, but was not specifically asked which procedure (vascular or orthopaedic) had to be performed first. Dr Nel testified that he has the greatest respect for Dr Walters' knowledge and his ability as an orthopaedic surgeon.

[55] Dr Nel testified that a period of 6 to 8 hours is not a 'cut off time' but was of the view during his evidence-in-chief that at the time the respondent was seen by Dr Domingues it was 'too late'. What he meant by it was 'too late' was never explored

[23] Exhibit F.

further during evidence-in-chief or during cross-examination, but in view of his testimony that there was a long delay between the admission of the respondent and the time he was seen by Dr Domingues and in view of the question posed it would be safe to conclude that it was meant that it was too late to save the respondent's leg. The court *a quo* also did not refer to this aspect of the evidence of Dr Nel.

[56] It appears that both Dr Nel and Dr Walters held the view that the period of 6 to 8 hours after the infliction of the injury and the subsequent occlusion of the artery to be critical in order to have saved the leg of the respondent, although Dr Nel qualified this period by stating that if collateral blood flow is intact the leg may remain viable after the aforementioned period.

[57] In view of the testimony that it was too late by the time Dr Domingues saw the respondent the misdiagnosis cannot be a factor in determining negligence. The same would be applicable for the failure of Dr Domingues to call for a second opinion. The only arguable negligent conduct of Dr Domingues may relate to an apparent inaction after he had received a phone call from Dr Jario.

[58] Therefore, an important issue to have been determined in view of the fact that time was of the essence and that remedial action had to be taken urgently was, who was responsible for the delay since the admission of the respondent, and also to establish the reason for such a delay. It appears from the notes made by Dr Jario that the plan was to call Dr Domingues. Dr Jario as well as Dr Domingues were not called as witnesses. We therefore firstly do not know whether Dr Jario succeeded in

contacting Dr Domingues. Secondly, on the assumption that Dr Jario had succeeded in contacting Dr Domingues, we do not know what had been conveyed to Dr Domingues. Was Dr Domingues informed of the urgency of the matter as one may expect, in the circumstances, and if so, what was his response? There is thirdly also no indication of the time when Dr Domingues was called. The reason for the inordinate delay since the respondent was seen by Dr Jario and the time he was seen by Dr Domingues cannot be ascertained from the evidence presented to court. The onus was on the respondent to prove that there was no exculpatory explanation for the delay. This is a lacuna in the evidence in determining whether Dr Domingues had been negligent in the treatment of the respondent.

[59] The second issue which the court *a quo* had to consider was whether the appellant, alternatively, its employees 'acted with the necessary skill as is reasonably expected from a medical practitioner and nursing staff during the period of plaintiff's admission and care' with the appellant.

[60] The evidence presented on behalf of the respondent never alluded to the fact that nursing staff were negligent after the respondent's admission to the hospital. This issue was also never argued in the court *a quo* neither was there any submission on appeal that anyone of the nursing staff was negligent in the treatment of the respondent. The focus was on the conduct of doctors employed by the appellant.

[61] What needs to be considered then is whether the conduct of doctors, who had seen the respondent after he had been admitted to the hospital, lacked the necessary

skill reasonably expected from medical practitioners from which negligence may be inferred.

[62] Even though Dr Nel testified that in the circumstances of this case, a surgeon had to be ready with a scalpel in his hand in order to explore the vessel of the respondent on his arrival it appears firstly, from the evidence presented, that general practitioners could not have done such a procedure, and secondly, on the uncontradicted evidence of Dr Walters there was no vascular surgeon employed by the hospital at that stage, thirdly, the facilities were at that stage not available at the hospital.

[63] The court *a quo* approached the evaluation of the expert testimonies only on the issue of the vascular injury sustained by the respondent and on Dr Nel's expertise in that field, and preferred the testimony of Dr Nel to that of Dr Walters since Dr Walters did not have the same expertise as Dr Nel (as vascular surgeon).

[64] In the matter of *Linksfield Park Clinic* (supra) it was held that it is wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support.

[65] The court *a quo* did not examine the testimony of Dr Walters and what impact or effect the orthopaedic injury would have had on the salvageability of the respondent's leg. Although Dr Walters in the joint medical report agreed that the leg of the respondent was probably salvageable as a functional limb on admission, it appears that the fact

that there was no vascular surgeon available and the lack of facilities were not given due weight to by the court *a quo*. Dr Nel was not required to direct his mind to the question of comparative risks and benefits in view of the evidence of Dr Walters.

[66] Dr Nel's testimony was that he (as specialist surgeon) through timeous intervention has saved many limbs, but sight should not be lost of the fact that a general practitioner could not have explored the vessel at the time respondent was admitted to the hospital.

[67] Dr Nel's testimony was that one had to be ready with a scalpel in hand since '6 to 8 hours had passed and after that we are going to get permanent damage'. This is also in line with Dr Walter's testimony. The respondent was admitted 9 hours after the incident and there could not have been a vascular surgeon ready to explore the vessel. Dr Nel even though he testified that the respondent had to be taken directly to theatre in order to 'vascularise straight away', realised that this depended 'on what your facilities are'. It would without doubt also have depended on the expertise available to perform the suggested medical procedure.

[68] The test formulated in *Kruger* (supra) requires proof that the wrongful conduct or omission caused injury to plaintiff's person or property.

[69] In the present matter the question to be considered is whether respondent proved that the omission of Dr Domingues or other medical doctors employed by the appellant was the cause of the amputation of his leg.

[70] In *International Shipping Co (Pty) Ltd v Bentley*[24] Corbett CJ stated the following in respect of the requirement of causation:

> 'As has previously been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as "factual causation". The enquiry as to factual causation is generally conducted by applying the so-called "but for" test, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; *aliter*, if it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise. On the otherhand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a judicial problem in the solution of which considerations of policy may play a part. This is sometimes called "legal causation".'

[71] In *Tuck v Commissioner for Inland Revenue* [25]Corbett CJ stated that '(one of the factors which may cause the link between the act or omission and the harm to become too tenuous resulting in the harm being too remote) is the intervention of some

[24] 1990 (1) SA 680 AD at 700E-I.
[25] 1988 (3) SA 819 AD at 832I-J to 833A.

independent, unconnected and extraneous causative factor or event, generally termed as *novus actus interveniens*'.

[72] In *Minister of Safety and Security v Van Duivenboden*[26] Nugent JA referred to the requirement of causation as formulated in *International Shipping* (supra) and commented as follows in respect of the first enquiry, namely the factual causation:

> 'There are conceptual hurdles to be crossed when reasoning along those lines for, once the conduct that actually occurred is mentally eliminated and replaced by hypothetical conduct, questions will immediately arise as to the extent to which consequential events would have been influenced by the changed circumstances. Inherent in that form of reasoning is thus considerable scope for speculation which can only broaden as the distance between the wrongful conduct and its alleged effect increases. No doubt a stage will be reached at which the distance between cause and effect is so great that the connection will become altogether too tenuous, but, in my view, that should not be permitted to be exaggerated unduly. 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.'

[73] If the issue of factual causation is considered it appears that the procedure suggested by Dr Nel could in any event not have taken place on admission and could also not have taken place despite the misdiagnosis of Dr Domingues. Thus even if Dr Domingues had made the correct diagnosis or had asked for a second opinion it would not have made any difference in view of the fact of the lack of facilities and available expertise. Sight should also not be lost on the fact that even at the Central

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[26] 2002 (6) SA 431 (SCA) at 449D-F.

Hospital where the facilities were available, the vascularisation of respondent's leg was done the day after he had been seen by Dr Nel.

[74] In respect of the issue of legal causation, in my view the alleged omission of Dr Domingues or the other medical officers employed by the appellant was in any event too remote to attract legal liability in view of the lack of facilities and the requisite expertise staff at the hospital; or put differently, there is not a sufficiently close connection between the alleged omission and the consequence, namely the amputation of the respondent's leg. I am of the view that it is not reasonable or fair in the circumstances to impute the damage suffered by the respondent to the appellant and/or its employees.

[75] In *Medi-Clinic v Vermeulen* 2015 (1) SA 241 (SCA) Zondi JA para 33 referred with approval to a remark by Denning LJ in the matter *Roe v Ministry of Health & others*; *Woolley v Same* [1954] EWCA Civ 7; [1954] 2 All ER 131 CA at 139:

> 'But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.'

[76] I am of the view that the respondent failed to prove on a preponderance of probabilities that Dr Domingues or any other medical officer employed by the appellant

was, through an omission, negligent or that assuming there was negligence, that such negligence was the cause of the amputation of the right lower leg of the respondent.

[77] In the result the following orders are made:

(a) The appeal succeeds.

(b) The order of the court *a quo* that the appellant is liable to compensate the respondent for damages incurred by the respondent is set aside.

(c) The order that appellant pays the costs of the respondent is set aside.

(d) No cost order is made.

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HOFF JA

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DAMASEB DCJ

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MOKGORO AJA

APPEARANCES

APPELLANT:	M G Boonzaier
	Of Government Attorney
RESPONDENT:	I D Titus
	Of Koep & Partners, Windhoek