CASTELL v DE GREEF 1994 (4) SA 408 (C)

Citation	1994 (4) SA 408 (C)
Case No	A976/92
Court	Cape Provincial Division
Judge	Friedman JP, ACKERMANN J and FARLAM J
Heard	April 8, 1993
Judgment	February 17, 1994
Annotations	Link to Case Annotations

Flynote : Sleutelwoorde

Medicine - Medical practitioner - Negligence of - Duty of practitioner to warn patient of risks inherent in proposed treatment - Nature and extent of such duty - Whether emphasis should be placed on autonomy and right of self-determination of patient or on right of medical profession to determine meaning of reasonable disclosure - 'Reasonable doctor' test not well-established as standard for disclosure in South Africa - Introduction of patient-orientated approach a necessity - In South Africa question of consent to medical treatment seen as falling under defence of volenti non fit injuria - Accordingly, doctor's duty to disclose material risk must be seen in contractual setting of unimpeachable consent to operation and its sequelae - In order for consent to exclude wrongfulness of medical treatment and its consequences, doctor obliged to warn patient so consenting of material risk inherent in proposed treatment - Risk material when (1) reasonable person in patient's position, if warned of risk, would be likely to attach significance to it; or (2) medical practitioner is or should reasonably be aware that particular patient, if warned of risk, would be likely to attach significance to it - Though expert medical evidence relevant in order to determine what risks inherent in or resulting from particular treatment and may also have bearing on their materiality, question one for Court and not to be determined on basis of medical evidence alone.

Headnote : Kopnota

In deciding whether a medical practitioner has incurred liability for negligence as a result of his failure to warn his patient of the material risks and complications which might flow from a surgical operation or other medical treatment the issue of consent to medical treatment and the question of whether emphasis should be placed on the autonomy and right of self-determination of the patient, on the one hand, or on the right of the medical profession to determine the meaning of reasonable disclosure, on the other, come to the fore. (At 418G-H.) The 'reasonable doctor' test, insofar as it relates to the standard of disclosure, has received, contrary to what was stated by the Court *a quo*, very little attention in our case law: with the exception of a statement in *Richter v Estate Hamman* 1976 (3) SA 226 (C) at 232H and an *obiter dictum* in *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366, there has been no firm judicial pronouncement in South Africa to the effect that disclosure was unnecessary because a reasonable doctor faced with the particular problem would not have

warned the patient. (At 419A-B.) Neither the remark of the Court *a quo* that the 'reasonable doctor' test did not 'leave the determination of a legal duty to the judgment of doctors' nor its observation that there 'can be no justification for adopting' the US doctrine of 'informed consent' (according to which what is required to be disclosed to the patient is determined by reference to the significance a 'prudent patient' would be likely to attach to the disclosure in deciding whether or not to undergo the treatment) can be endorsed: there is not only a justification, but indeed a necessity, for introducing a patient-orientated approach in this connection. (At 419C and 420G-H.)

Whereas in English (and Australian) law the issue of consent to medical treatment is approached on the basis of the doctor's duty of care to the patient, the breach of

which would constitute negligence on the doctor's part, in South African law it is treated as falling under the defence of *volenti non fit injuria*, the enquiry being whether the said defence has been established and, in particular, whether the patient's consent has been a properly informed consent. However, on either approach the same, or virtually identical, matters of legal policy are involved. (At 420H read with 423C-D.)

It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment. It would be equally irrelevant that the medical profession was of the unanimous opinion that it was in given circumstances the surgeon's duty to refrain from bringing the risk to his patient's attention. (At 420I/J and 421C/D-D/E.)

The criticism levelled at expressions such as 'the patient's right of self-determination' on the basis that while they were perhaps suitable 'to cases where the issue is whether a person has agreed to the general surgical procedure or treatment', they were of little assistance in 'the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure' (see the Australian case of *Rogers v Whitaker* (1993) 67 ALJR 47 at 52) does not apply in the context of South African law, where the issue is treated not as one of negligence arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk. Thus, in the South African context, the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its *sequelae*. (At 425C/D-D/E and 425E-F.) For consent to operate as a defence the following requirements must, *inter alia*, be satisfied: *(a)* the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk; *(b)* the consenting party must have appreciated and understood the nature and extent of the harm or risk; *(c)* the consenting party must have consented to the harm or assumed risk; *(d)* the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences. (At 425H-I/J.)

The formulation laid down in Australia in *Rogers v Whitaker (supra* at 52), being in accord with the fundamental right of individual autonomy and self-determination to which South African law

is moving, as well as with developments in common law countries and judicial views in continental Europe, ought to be adopted here, suitably adapted to the needs of South African jurisprudence. (At 426D/E-F.) Accordingly, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case: *(a)* a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or *(b)* the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. (At 426F-H.) This obligation is, however, subject to the so-called 'therapeutic privilege' (which permits medical practitioners to withhold disclosures which in their opinion would be detrimental to the patient in question), whatever the ambit of this 'privilege' may today still be in the light of the inroads that it might make on patient autonomy. (At 426H read with 418D-D/E.)

Although expert medical evidence would be relevant to determine what risks inhere in or are the result of a particular treatment (surgical or otherwise) and might also have a bearing on their materiality, this is not a question that ought to be answered on the basis of expert medical evidence alone: as was stated in the Australian case of *F v R* (1983) 33 SASR 189 '*(t)*he ultimate question' is 'whether (the defendant's conduct) conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community.' (At 426H/I-J.)

The decision in *Castell v De Greef* 1993 (3) SA 501 (C) reversed in part on appeal.

Case Information

Appeal from a decision of a single Judge (Scott J), reported at

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1993 (3) SA 501 (C) . The facts appear from the judgment of Ackermann J.

A C Oosthuizen for the appellant.

R D McDougall for the respondent.

Cur adv vult.

Postea (February 17).

Judgment

Ackermann J: This is an appeal against the dismissal by Scott J on 17 February 1992 of appellant's claim for damages against respondent, a plastic surgeon, based on the latter's alleged negligence in performing a surgical operation on appellant's breasts. Scott J refused leave to appeal, but leave was granted to the appellant by the Appellate Division to appeal to the Full Court of this Division. I shall refer to the appellant and defendant as 'plaintiff' and

'defendant' respectively. At the time of the trial, plaintiff was 44 years of age.

The events leading up to the plaintiff's claim are conveniently summarised in Scott J's judgment *(1) (at 502I-505D) as follows:

> 'On 7 August 1989, the plaintiff underwent a surgical operation known as a subcutaneous mastectomy. The operation was performed by the defendant, who is a plastic surgeon. It was not a success and the plaintiff sues for damages. The circumstances in which the operation came to be performed are briefly as follows. The plaintiff's mother, and probably also her grandmother, died of breast cancer. In 1982 the plaintiff underwent surgery for the removal of lumps in the breast. In 1989 further lumps were diagnosed. In view of the plaintiff's family history, her gynaecologist recommended a mastectomy as a prophylaxis and referred her for this purpose to the defendant who saw her on 14 June 1989. It is common cause that on this occasion the plaintiff and her husband discussed the operation with the defendant at some length. What was proposed was a surgical procedure involving the removal of as much breast tissue as possible with the simultaneous reconstruction of the plaintiff's breasts using silicone implants. Following the discussion the plaintiff decided to go ahead with the operation. Precisely what was said at this consultation with the defendant on 14 June 1989, however, is in dispute and I shall return to this aspect of the matter later.
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> The plaintiff was admitted to the Panorama Medi-Clinic Hospital in the late afternoon of Sunday, 6 August 1989. The operation was performed the next day. It is common cause that breast tissue was removed bilaterally; a 280 ml prosthesis was implanted on each side behind the pectoral muscle, and the areolae and nipples were repositioned. The repositioning of the areolae was achieved by the creation on each breast of a superior pedicle, or flap, which was then folded back on itself resulting in the areolae being repositioned some 3 cm above its former position. The reason for repositioning the areolae was to correct a pre-operative mild ptosis (drooping), the aggravation of which is one of the consequences of an implant. This method, known as "transposition" was employed in preference to the "free grafting" method by which the areolae are simply removed and grafted on in a different position. The former method has the advantage that the areolae are not totally detached from the surrounding skin and in this way the risk of necrosis is reduced. It is common cause that the operation has a high risk of complications, the main one being necrosis of the skin and underlying tissue, including the areolae and nipples. The reason for this is that the removal of the

> breast tissue and lactiferous ducts in which carcinoma may develop results in the cutting off of the main blood supply to the skin and areolar complex (areola and nipple). The only source of blood that remains is the subdermal plexus or layer of fat beneath the skin. The surgeon's dilemma is that the more of this tissue he leaves behind the less risk there is of necrosis but also the less effective the procedure is as a prophylaxis for cancer. Even without repositioning the areolae, they are at risk. If they are removed, the risk is increased, but more so if the "free grafting", as opposed to the "transposition", method is employed.
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> The operation was initially a success in the sense that upon completion all seemed well. On the morning of Wednesday, 9 August 1989, ie some 36 hours after the operation, the defendant observed a discoloration of the left nipple and first became concerned about the blood supply. He expressed this concern to the plaintiff. There was also a "wedge-shaped" area below the right areola which appeared pale and ischaemic. Later the same day, when the dressings were being changed, the plaintiff's husband observed the incision marks around both areolae. The defendant was called to the ward where the plaintiff confronted him with this, saying that he had promised her that he would not "remove" the areolae. He replied that he had not "removed" them but had "moved" them. As I have said, the plaintiff's instructions to the defendant are in dispute, and I shall return to this issue later. In the course of the next few days the discoloration of the plaintiff's left areolar complex worsened and by the time she was discharged from hospital on 13 August it had turned black. By this time, too, the area below the right areola had become discoloured but not to the same extent as the left areolar complex. Upon discharging the plaintiff from hospital, the defendant advised her that she would have to undergo further surgery but that it would first be necessary to wait and see what the extent of the necrosis would be.
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> On completion of the operation on 7 August the plaintiff was given a broad spectrum antibiotic intravenously as a

prophylaxis against infection. Thereafter she was put on a related oral antibiotic called Cefril. When she was discharged on 13 August she was also given a cream called Biostim which was to be applied topically. This cream is not an antibiotic but has the effect of stimulating the body's own defence mechanisms and in this way combating infection. The course of Cefril was repeated and the plaintiff remained on this antibiotic until 18 August, when the second course was completed.

When the plaintiff's dressings were changed at home on 14 August 1989, both she and a friend, a Mrs Pickering, who assisted her, noticed a discharge from the area immediately below and bordering on the right areola and also from the left areolar complex. They also detected an offensive smell. The following day there was no improvement. On Wednesday, 16 August 1989, the plaintiff went to see the defendant at his rooms in Paarl as previously arranged. He assured her that the discharge was to be expected and was a consequence of the necrosis. He also explained that it was necessary to wait before undergoing surgery for the debridement of the dead tissue. The plaintiff testified that after the 16th the discharge seemed to get worse, as did the odour. She said she also experienced pain and began to feel feverish. Although her next appointment with the defendant was on Wednesday, 23 August, she arranged to come and see him on Monday the 21st as she was not feeling well. On this occasion he prescribed another antibiotic, namely Dalacin C. On the 21st the plaintiff also began receiving laser treatment which was administered to the scars by Miss Susan Wessels, a physiotherapist. On 23 August the plaintiff again saw the defendant. On this occasion he told her that he would be away the following week-end, but that if there was a problem she should get in touch with his colleague, Dr Lückhoff. That week-end the plaintiff continued to suffer pain. She said she felt feverish and emotionally upset. On Sunday night, 27 August 1989, her husband took her to see Dr Lückhoff at the Panorama Medi-Clinic. He arranged for her to be admitted and she remained

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hospitalised until 11 September 1989. On Monday, 28 August, she was seen in hospital by the defendant who took swab specimens from both breasts and sent these off for analysis. Two days later, on Wednesday, 30 August, a debridement of the dead tissue was performed under a general anaesthetic. The plaintiff had lost the entire areolar complex on the left side and an area of skin (including a portion of the areola) below the nipple on the right side. Six days later, namely on 4 September, she underwent a further surgical procedure involving a skin graft to both breasts, the skin for this purpose being taken from high up under the left arm. In the meantime, the analysis of the swabs taken on 28 August revealed the presence of *staphylococcus aureus*. According to the pathologist's reports received on 30 August and 1 September 1989 respectively, *staphylococcus aureus* is resistant to both Cefril and Dalacin C. A different antibiotic, namely Bactrim, was then prescribed.

Upon her discharge from hospital on 11 September 1989, the plaintiff was not yet out of the wars. In May of 1990, she underwent a further operation for the revision of the scars and spent one night in hospital. By this time, however, she had lost confidence in the defendant and the revision was performed by another plastic surgeon. On a subsequent occasion she had the original prosthesis removed and replaced by a smaller, 200 ml prosthesis, spending two nights in hospital for this purpose. Finally, in October 1991 she underwent a further operation in the course of which the left nipple and areola were recreated. On this occasion she spent one night in hospital.

The plaintiff is satisfied with the final result and no further surgery is envisaged. As a result of the necrosis following the original operation, however, she had to undergo a number of additional surgical procedures which involved her in further expense. She also suffered pain and, for a long period, embarrassment and psychological trauma in consequence of the disfigurement of her breasts. Her claim against the defendant is for damages in the sum of R94 952,12.'

The grounds of negligence averred against the defendant in plaintiff's particulars of claim were amended on at least two occasions prior to judgment. One of these amendments occurred (apparently) prior to the commencement of the trial. Notice of the second amendment was given during the afternoon of the ninth day of the trial (ie on 26 November 1991) in the course of further cross-examination of defendant (which had been interrupted in order to interpose the

evidence of other witnesses). The amendment was moved on the morning of the 10th day of the trial (ie 27 November 1991) after the defendant had concluded his evidence and, despite being opposed, was granted later on the day. The evidence in the trial concluded on that day. Subsequent to the amendment, only the evidence of Dr De Goveia was heard and the cross-examination and re-examination of Dr Engelbrecht concluded.

Neither plaintiff's particulars of claim in their amended form (as required by Uniform Rule of Court 28(9)) nor any of the notices of amendment were incorporated in the appeal record, the former only being furnished during the hearing of the appeal.

Paragraphs 7 and 7A of plaintiff's particulars of claim, as amended, read as follows (paras 7*(h)* and 7A having been introduced by the amendment granted on 27 November 1991):

'7. In breach of his aforesaid obligations, defendant wrongfully, unlawfully and negligently:

(a) carried out the surgery in a manner which fell short of the

professional skill reasonably required of a specialist plastic surgeon;

(b) carried out the operation utilising procedures and/or materials which were not of the type which would be utilised by a specialist plastic surgeon, exercising reasonable professional skill;

(c) in removing breast tissue, negligently scarred and damaged the breast when such scarring and damage should not have occurred at all, had proper procedures been used;

(d) in performing the operation, effected an unsightly repositioning of the areolae, which later resulted in the left nipple and areola having to be completely removed and part of the right areola having to be removed, leaving unsightly cavities and wounds;

(e) negligently failed to prevent the breasts, post-operatively, from turning septic and from emitting an offensive discharge through both nipples;

(f) failed to take such steps as were reasonable to ensure that plaintiff did not suffer any harm or damage other than the damage normally following from the operation in question;

(g) failed to ensure that the breasts were symmetrical;

(h) in suturing the incision made during the operation, defendant adopted a suturing technique which made it more difficult and more dangerous to post-operatively release such sutures, should this be required in order to prevent or curtail incipient or actual necrosis.

7A *(a)* Plaintiff further avers that defendant was under a duty to warn plaintiff, prior to operating on plaintiff, of the material risks and complications which might flow from such operation, and of any specific alternative procedures which might be followed in order to minimise, reduce or exclude such risks or complications.

(b) In breach of such duty the defendant failed:

(i) to advise plaintiff that defendant intended to effect a transpositioning of the areolae, which transpositioning would increase the risk of necrosis developing post-operatively; and/or

(ii) to advise plaintiff that it was not essential to effect the aforesaid transpositioning of the areolae, that such transpositioning was done for cosmetic reasons and that it was plaintiff's choice as to whether such transpositioning to be effected or not; and/or

(iii) to advise plaintiff that there was an alternative surgical procedure to the one discussed with plaintiff, namely that of performing the operation in two different stages, the first involving the removal of breast tissue and the second, the insertion of a prosthesis and the effecting of any adjustments which might be required to the nipple; and further failed to advise plaintiff that the latter procedure reduced the risk of necrosis and/or infection setting in post-operatively; and/or

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(iv) failed to advise plaintiff that the operation which defendant envisaged had a complication rate as high as 50%; and/or

(v) failed to advise plaintiff that, necrosis of the tissue being one of the recognised complications arising from such operation, there were virtually no steps which could be taken to avert or curtail such necrosis if it arose post-operatively.

(c) Defendant accordingly breached defendant's duty to disclose to plaintiff the material risks and complications flowing from the operation.

(d) Had defendant not breached defendant's duties in the aforegoing respects and had defendant properly and adequately warned plaintiff of the aforegoing risks, plaintiff would:

(i) not have undergone the operation following the technique in question; and/or

(ii) have undergone some other surgical procedure which reduced or lessened the risks and complications and specifically the risk of necrosis and/or

infection arising post-operatively.

(e) Plaintiff would accordingly not have suffered the *sequelae* and damages referred to in paras 9 and 10 below.'

Many of these grounds of negligence were subsequently abandoned or not persisted in on appeal. The issue of defendant's negligence was limited to the following three grounds, which are culled from the particulars of claim and the further particulars for the purposes of trial:

(a) Defendant's failure to warn plaintiff of the material risks and complications of the operation

In para 7A*(a)* of the amended particulars of claim it is alleged that defendant failed to warn plaintiff, prior to the operation, of the material risks and complications which might flow from the operation and of any specific alternative procedures which might be followed in order to minimise, reduce or exclude such risks or complications. Defendant's breaches in this regard are detailed in para 7A*(b)*(i) to (v) of the particulars of claim quoted above.

It is important to note that in para 7A*(d)* it is alleged that, but for such breach:

(i) plaintiff would 'not have undergone the operation following the technique in question'; and/or

(ii) plaintiff would 'have undergone some other surgical procedure which reduced or lessened the risks and complications and specifically the risk of necrosis and/or infection arising post-operatively';

and in para 7A*(e)* that plaintiff would accordingly not have suffered the *sequelae* and damages detailed in her pleadings.

Although not embodied, strictly speaking, in this ground, it will be convenient in due course to deal at the same time with the allegation in para 2*(a)* 2.2 of plaintiff's particulars for purposes of trial that

'. . . it was specifically agreed between plaintiff and defendant that

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defendant would not remove or reposition the areolae or nipples, and would ensure that plaintiff suffered no loss of sensation in that area as a consequence of the operation, which agreement was breached by defendant . . . (in that he) failed . . . to ensure that the blood supply to the areolae was sufficient to prevent necrosis from setting in'.

(b) Defendant's failure to prevent the onset of or limit the extent of necrosis in plaintiff's breasts

In para 7*(a)* of the particulars of claim as amended it is averred that defendant negligently

'carried out the surgery in a manner which fell short of the professional skill reasonably required of a specialist plastic surgeon'

and in para 2*(a)* 2.2 of the further particulars for trial it is alleged that defendant

> 'failed to ensure that the blood supply to the areolae was sufficient to prevent necrosis from setting in'.

In para 2*(f)*(i) of the particulars for trial (although purporting to furnish particulars in regard to another averment) it is alleged that

> '. . . defendant should, on or about 10 August 1991 have noticed that sloughing of the tissue was beginning to occur. Defendant should have taken steps to prevent or curtail such sloughing and, in particular, should have removed some of the stitches.'

On appeal this ground was finally narrowed to the enquiry as to whether defendant was negligent in not releasing some or all of the stitches used to suture the operative incisions on plaintiff's breasts when he saw portions of her areola complex turning blue.

> *(c) Defendant's failure to adequately or timeously treat the post-operative sepsis which had allegedly developed in plaintiff's breasts*

Although pleaded somewhat more widely in para 7*(e)* of the particulars of claim, as amended, the ambit of this ground was limited as follows in para 2*(f)*(ii) of plaintiff's particulars for trial:

> 'It is furthermore alleged that defendant should, by not later than 16 August 1991, have noticed that the breasts were infected and should have taken proper steps to prevent the spread of such infection, more particularly by:
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> *(aa)* ascertaining what the organism was causing the infection, which would have been done by sending a pus swab for analysis by a pathologist;
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> *(bb)* prescribing appropriate drugs to combat the particular organism;
>
> *(cc)* if such drugs did not have the desired effect, defendant should have at an earlier stage taken further steps to more aggressively combat the infection, including, as a last resort, the removal of the prosthesis.'

The above issues will be dealt with *seriatim*.

Before doing so, however, it should be observed that the general principles applicable to the question of negligence on the part of medical practitioners in performing surgery and in their post-operative care of their patients as summarised by Scott J were not challenged by either party

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on appeal. In this regard the learned Judge said the following (at 509G-510A):

> 'Both in performing surgery and in his post-operative treatment, a surgeon is obliged to exercise no more than reasonable diligence, skill and care. In other words, he is not expected to exercise the highest possible degree of professional skill *(Mitchell v Dixon* 1914 AD 519 at 525). What is expected of him is the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which he belongs. *(Van Wyk v Lewis* 1924 AD 438 at 444; see also *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 221A; *S v Kramer and Another* 1987 (1) SA 887 (W) at 893E-895C; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) at 384I-385E.) It must also be borne in mind that the mere fact that an operation was unsuccessful or was not as

> successful as it might have been or that the treatment administered did not have the desired effect does not, on its own, necessarily justify the inference of lack of diligence, skill or care on the part of the practitioner. (Compare *Van Wyk v Lewis (supra* at 462).) No surgeon can guard against every eventuality, although readily foreseeable. Most, if not all, surgical operations involve to a greater or lesser extent an element of risk, and from time to time mishaps do occur, and no doubt will continue to occur in the future, despite the exercise of proper care and skill by the surgeon. As observed by Lord Denning MR in *Hucks v Cole* (1968) 118 New LJ 469:
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> "With the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not be held negligent simply because something went wrong.'"

It has on occasions been suggested that a 'mere error of judgment' on the part of a medical practitioner does not constitute negligence. In *Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL) the House of Lords *inter alia* considered the correctness of the statement by Denning MR in the Court of Appeal that:

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

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

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

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

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

This appears to me to be the correct position.

> *(a) Defendant's alleged failure to warn plaintiff of the material risks and complications of the operation*

It is of course correct, as pointed out by Scott J (at 517F-G), that

> '*(a)* medical practitioner undoubtedly has a duty in certain circumstances to warn his patient of the risks involved in surgery or other medical treatment'

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but that (at 517G)

> '*(t)*he difficulty is to determine when that duty arises and what the nature and extent of the warning must be'.

In *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 719C/D, 719H Bekker J stated the following:

> 'Generally speaking . . . to establish the defence of *volenti non fit injuria* the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it . . . .

Indeed if it is to be said that a person consented to bodily harm or to run the risk of such harm, then it presupposes, so it seems to me, knowledge of that harm or risk; accordingly mere consent to undergo X-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm.'

In *Esterhuizen's* case the argument was advanced that it would render the position of the medical profession intolerable if it were to be held that they owed a duty to patients of having to inform them, prior to any operation or treatment, of all the consequences, dangers and details of the risks inherent in the operation or treatment. Bekker J dealt with this argument as follows at 721B/C-E:

> 'I do not pretend to lay down any such general rule; but it seems to me, and this is as far as I need go for purposes of a decision in the present case, that a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient - no matter how laudable his motives might be - and should he act without having done so and without having secured the patient's consent, he does so at his own peril.'

Bekker J also quoted with approval the following passage in the judgment of Neser J in *Rompel v Botha* (1953, Transvaal Provincial Division, unreported):

> 'There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases where it is frequently a matter of life and death I do not intend to express any opinion as to whether it is the surgeon's duty to point out to the patient all the possible injuries which might result from the operation, but in a case of this nature, which may have serious results to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent - it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment.'

In *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) at 232 the following approach was adopted by Watermeyer J:

> *(a)* (At 232G.) 'A doctor whose advice is sought about an operation to which certain dangers are attached - and there are dangers attached to most

> operations - is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it.'
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> *(b)* (At 232H.) 'It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do.

> The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'

Scott J adopted the approach enunciated by Watermeyer J in passage *(b)* above.

In the passage *(a)* above, Watermeyer J was alluding to the problems surrounding the so-called 'therapeutic privilege' of the medical professional which Giesen *International Medical Malpractice Law* (1988) (hereinafter cited as 'Giesen *Malpractice Law*') at 375 describes as 'designed to permit health care providers to withhold disclosure which they judge would be counter-therapeutic and, thus, "detrimental to a particular patient"'. (See also Strauss *Doctor Patient and the Law* 3rd ed at 10 and 18-19; Van Oosten *The Doctrine of Informed Consent in Medical Law* (unpublished doctoral thesis, University of South Africa (1989)) at 423-8; Robertson 'Informed Consent to Medical Treatment' (1981) 97 *LQR* 102 at 121-2.) In an *obiter dictum* in *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366, Watermeyer CJ observed that 'it may sometimes be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him'. The dangers inherent in the so-called therapeutic privilege, and in particular the inroads that it might make on patient autonomy, have been commented on by *Van Oosten (op cit* at 414-5); *Robertson (op cit* at 120-2) and *Giesen (op cit* at 376-92). It is not necessary to pursue this issue any further here, because this so-called privilege was not invoked by the defendant or relied upon in argument to justify a non-disclosure which would otherwise have been actionable. It does, however, form part of the wider debate concerning consent to medical treatment and whether emphasis should be placed on the autonomy and right of self-determination of the patient in the light of all the facts or on the right of the medical profession to determine the meaning of reasonable disclosure.

In accepting the test formulated by Watermeyer J in *Richter v Hammann (supra* in passage *(b)*) Scott J commented as follows (at 517I/J-518B):

> 'The "reasonable doctor" test is one which is well-established in our law and is applied in relation to both medical diagnosis and treatment. It affords the necessary flexibility and if properly applied does not, in my view, "leave the determination of a legal duty to the judgment of doctors", as suggested by Lord Scarman in *Sidaway v Governors of Bethlehem Royal Hospital and others* [1985] 2 WLR 480 (HL) ([1985] 1 All ER 643) at 488 (in WLR, and 649*e* in All ER) in relation to the so-called "*Bolam* principle" *(Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 QB).'

I am, with respect, unable to agree.

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The 'reasonable doctor' test, insofar as it relates to the standard of disclosure, has received little attention in our case law and, apart from the above statement of Watermeyer J in *Richter's* case and Watermeyer CJ's *obiter dictum* in *McLoughlin's* case, I know of no firm judicial pronouncement in South Africa to the effect that disclosure is unnecessary because a reasonable doctor faced with the particular problem would not have warned the patient. (See Giesen 'From Paternalism to Self-Determination to Shared Decision-making' in (1988) *Acta Juridica* 107; *Van Oosten (op cit* at 39-53 (in particular, at 50-1)) and *Strauss (op cit* at 8-12 and 18-19).)

I am also unable, with respect, to agree with the conclusion that the 'reasonable doctor' test

does not 'leave the determination of a legal duty to the judgment of doctors'. In *Sidaway's* case, also reported in *Sidaway v Bethlehem Royal Hospital Governors and Others* [1985] 1 All ER 643 (HL), which report will hereinafter be referred to for purposes of citation) at 658-9 Lord Diplock held that:

> '. . . To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in the same way. The *Bolam* test should be applied.'

Lord Diplock was therefore of the view that although the law imposed the duty of care, the standard of care to be enforced was a matter of medical judgment. Giesen *Malpractice Law* at 282 comments as follows:

> 'One has to consider this result carefully. Should the medical profession really be appointed judge in its own cause? Carried to its ultimate logical conclusion, Lord Diplock's opinion would mean that the function of English Courts would be limited to determining whether the defendant physician had acted in accordance with a responsible body of medical opinion, unless the plaintiff was a member of the judiciary (a reference by *Giesen* to the singular observation at 659*a-b* that members of the judiciary have the right to be informed as patients apparently because they are aware of their right of self-determination) or had specifically demanded information which the physician then failed to disclose.
>
> A standard of disclosure which allows the medical profession to be judge in its own cause and physicians in deciding what is best for the patient to override the patient's right to decide for himself is "medical imperialism" at its worst. We cannot but agree with Lord Scarman's criticism of that stance.'

At 284 *Giesen* further comments as follows:

> 'It is further submitted (i) that insofar as *Sidaway could* be interpreted as sanctioning the view that expert medical evidence is conclusive, it must be regarded as misguided and against the overwhelming international trend to the contrary; (ii) that in this case Lord Scarman's dissenting opinion would have to be considered preferable to Lord Diplock's judicial interpretation of the majority decision of the House; (iii) but that in fact, this decision, in the light of the opinions expressed by a majority of the Law Lords (Lords Bridge, Keith, Templeman and Scarman) does *not* sanction the view that expert medical evidence has to be treated as conclusive on the assumption that the standard of disclosure is to be determined exclusively by reference to the current state of responsible and competent professional opinion and practice. The implications of such a view would be disturbing in the extreme. But the Courts do not allow medical opinion

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> with regard to what is best for the patient to override the patient's right to decide for himself whether he will submit to the treatment or not.'

After referring to certain passages from the speech of Lord Templeman in this regard, *Giesen* (at 284) ventures the view that:

> 'The understandable fears of Lord Scarman that the majority decision in Sidaway will result in English law developing out of tune with other important common law jurisdictions may thus prove, in final analysis, to be unfounded.'

At least one commentator, Simon Lee 'A Reversible Decision on Consent to Sterilisation' in (1987) 103 *LQR* at 513 would appear to bear out Lord Scarman's misgivings. In commenting on

the Court of Appeal's decision in Gold v Haringey Health Authority [1987] 2 All ER 888 (CA), *Lee* states the following at 515:

> 'So the Court of Appeal's decision ignores the main thrust of the judgments in *Sidaway*. I observed at the time (101 *LQR* 316) that *Sidaway* should not be treated as informed consent (Lord Scarman) 1, uninformed consent 4. There is plenty of material in the speeches of Lord Bridge, with whom Lord Keith agreed, and Lord Templeman to incline a subsequent Court towards the view favoured by Lord Scarman rather than the other extreme favoured by Lord Diplock. In concentrating on Lord Diplock's judgment to the exclusion of the others, the Court of Appeal has threatened to stop the development of a coherent doctrine of consent.'

In his judgment in the Court *a quo* Scott J held the following (at 518B-E):

> 'Mr *Oosthuizen* invited me to adopt, if not in its entirety, certain aspects of the doctrine of "informed consent". This doctrine originated in certain jurisdictions of the United States of America and has been accepted in modified form by the Supreme Court of Canada *(Reibl v Hughes* (1980) 114 DLR (3d) 1 (Can SC). The doctrine holds that a patient's consent to medical treatment is vitiated if he is given inadequate information concerning the proposed treatment and that, subject to certain exceptions, what it requires to be disclosed to the patient is determined not by reference to the information a reasonable doctor might disclose, but by reference to the significance a "prudent patient" would be likely to attach to the disclosure in deciding whether or not to undergo the treatment *(Canterbury v Spence* (1972) 464 F 2*d* 772). The House of Lords in the *Sidaway* case (Lord Scarman dissenting) declined to adopt the doctrine and instead reaffirmed the "*Bolam*" test. In my view there can be no justification for adopting it in our law.'

I am constrained to disagree, inasmuch as I am of the view that there is not only a justification, but indeed a necessity, for introducing a patient-orientated approach in this connection.

It is important, in my view, to bear in mind that in South African law (which would seem to differ in this regard from English law) consent by a patient to medical treatment is regarded as falling under the defence of *volenti non fit injuria*, which would justify an otherwise wrongful delictual act. (See, *inter alia*, *Stoffberg v Elliott* 1923 CPD 148 at 149-50; *Lymbery v Jefferies* 1925 AD 236 at 240; *Lampert v Hefer NO* 1955 (2) SA 507 (A) at 508; *Esterhuizen's* case *supra* at 718-22; *Richter's* case *supra* at 232 and *Verhoef v Meyer* 1975 (TPD) and 1976 (A) (unreported), discussed in *Strauss (op cit* at 35-6).)

It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the

only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, in addition, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the 'best interests of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would

refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention.

Giesen *Malpractice Law*, after drawing attention (at 289) to the fact that 'an increasing number of both common and civil law jurisdictions' (as diverse as Canada, the United States, France, Germany and Switzerland) have moved away from 'professional standards of disclosure' to more 'patient-based' ones, points out (at 297) that there are two patient-based standards that could be applied:

> '(i) the "objective" or "reasonable" patient standard, posited on the informational requirements of the hypothetical "reasonable" patient in what the physician knows or should know to be the patient's situation, or
>
> (ii) the individual or "subjective" patient standard, whereby the physician must disclose information which he knows, or ought to know, that his particular patient in his particular situation requires'.

Giesen proposes (at 303-5) a 'blending' of the reasonable patient 'minimum' with the individual patient 'additional needs test'.

Giesen (ibid) sees no objection to using the 'reasonable patient' test as the point of departure.

> 'It will normally lead the physician to a correct assessment of the average patient's *minimum* informational needs. His right to self-determination does not require more if in fact the individual patient is a member of that community of reasonable (or "model") patients with average informational needs.'

This approach must, however,

> 'be supplemented by a more subjective patient-based standard, better attuned to the values of each person and his or her inalienable right of self-determination, and better able to manage situations beyond the limitations of the objective test'.

Giesen argues (at 304) that the 'right of the patient to make his own decision about what is to be done with his own body' must be guaranteed

> 'even where the individual patient differs from what the medical profession or anyone else considers to be a "reasonable" patient. The patient has a right to be different. The patient has a right to be wrong.'

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He concludes (at 305) by quoting with approval the following passage from *McPherson v Ellis* 287 SE 892 (NC 1982), a North Carolina Supreme Court decision in which the subjective test was adopted as a supplement to the prevailing objective test:

> 'In determining liability by whether a reasonable person would have submitted to treatment had he known of the risk that the defendant failed to relate, no consideration is given to the peculiar quirks and idiosyncrasies of the individual. His supposedly inviolable right to decide for himself what is to be done with his body is made subject to a standard set by others. The right to base one's consent on proper information is effectively vitiated for those

with fears, apprehensions, religious beliefs, or superstitions outside the mainstream of society.'

Giesen, at 294, comments that:

'Judicial attitudes which stress the primacy of the patient's right to self-determination prevail . . . also in civil law traditions on this (ie the European) side of the Atlantic, at least those with a more developed body of case law . . . . In Civil Law countries, risk-disclosure standards set by the courts prevail to the exclusion of traditional professional standards of disclosure, particularly so in jurisdictions which emphasise the individual's right to freedom from non-consensual invasion of such interests (mostly delict-protected) as bodily integrity.'

Of great interest too are his particular comments (at 295) on German and Swiss law:

'Both legal systems take as their starting point the patient's human right to decide for himself what shall be done to his body, and this principle is in no way reduced or limited by considerations which would allow the medical profession to override the patient's own will with paternalistic views of what is best for him. The duty of disclosure exists to ensure that the patient can make an informed decision, in the words of the Swiss Federal Court, *en connaissance de cause*. This implies that the patient, on the one hand, is aware of the possible consequences of the proposed medical procedure, its risks and possible side-effects and, on the other hand, that he retains his absolute discretion, in the knowledge of his entire situation, to make a decision of his own - even if this decision is one which others (such as the medical profession or a responsible body of medical opinion in the *Maynard* or *Sidaway* sense) would consider to be inappropriate ('verfehlt'), unreasonable ('unvernünftig'), or untenable ('unvertretbar').'

After a detailed review of informed consent in South African, English and West German law, *Van Oosten (op cit)* has the following to say at 414:

'When it comes to a straight choice between patient autonomy and medical paternalism, there can be little doubt that the former is decidedly more in conformity with contemporary notions of and emphasis on human rights and individual freedoms and a modern professionalised and consumer-orientated society than the latter, which stems largely from a bygone era predominantly marked by presently outmoded partriarchal attitudes. The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones that come into play, the cardinal principle of self-determination still demands that the ultimate and

informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor.'

Against this background I turn to consider two leading decisions of the Australian Courts of the standards of disclosure required of a doctor in treating a patient, namely *F v R* (1983) 33 SASR 189, a decision of the Full Court of the Supreme Court of South Australia and *Rogers v Whitaker (1993) 67 ALJR 47, a decision of the High Court of Australia. In both cases the matter was approached on the basis of the doctor's duty of care to the patient, breach of which would constitute negligence on the doctor's part. As already indicated, the matter is approached somewhat differently in South African law, the enquiry being whether the defence of volenti non fit injuria* has been established and in particular whether the patient's consent has been a properly informed consent. On either approach the same, or virtually identical, matters of legal policy are involved, as the following passage from the judgment of King CJ in *F v R* at 191

illustrates:

> 'Determination of the scope of the doctor's duty to disclose involves consideration of two values which are sometimes in conflict, namely the duty of the doctor to act in what he conceives to be the best interests of the patient and the right of the patient to control his own life and to have the information necessary to do so. The decided cases in England have tended to place the emphasis on the former value and in consequence to formulate the test of negligence largely, and sometimes exclusively, in terms of the extent of disclosure required by the practice prevailing in the medical profession . . . . In the United States, and to some extent in Canada, there is a tendency to place greater weight on the patient's right to receive the information which is necessary for an informed decision as to whether to undergo the proffered treatment, that is to say on what is often termed in the United States "the right of self-determination", eg Canterbury v Spence ((1992) 464 F (2d) 772); *Reibl v Hughes* ((1980) 114 DLR (3d) 1).'

After reviewing the various relevant circumstances determining what the careful and responsible doctor would disclose, King CJ stated the following at 193-4:

> 'Finally the question must be: "Has the doctor in the disclosure or lack of disclosure which has occurred, acted reasonably in the exercise of his professional skill and judgment, or, as Bristow J put it in *Chatterton v Gerson* ([1981] 1 All ER 257), in the way a careful and responsible doctor in similar circumstances would have done?" In answering that question much assistance will be derived from evidence as to the practice obtaining in the medical profession. I am unable to accept, however, that such evidence can be decisive in all circumstances: *Goode v Nash* ((1979) 21 SASR 419 (FC)). There is great force in the following passage from the judgment of the Supreme Court of Canada in *Reibl v Hughes* ((1980) 114 DLR (3d) 1 at 13):
>
> "To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there had been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question

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> is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or forgoing certain surgery or other treatment.'"

As King CJ himself emphasised at 194:

> 'The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standards of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community.'

In reviewing the various relevant circumstances pertaining to disclosure alluded to above, King CJ pointed out at 193 that:

> '. . . it is necessary to keep in mind the paramount consideration that a person is entitled to make his own decisions about his life . . .'.

In *Rogers v Whitaker (supra)* Mason CJ and Brennon J, Dawson J, Toohey J and McHugh J in a joint judgment trenchantly criticised the so-called *Bolam* principle and its application in *Sidaway's* case. At 48-9 the following formulation by Lord Scarman in the *Sidaway* case of the

so-called *Bolam* principle was quoted:

> 'The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.'

The Court pointed out (at 49) that although the members of the majority of the Court in *Sidaway* took different views of the *Bolam* principle they nevertheless

> '. . . held that the question whether an omission to warn a patient of inherent risks of proposed treatment constituted a breach of a doctor's duty of care was to be determined by applying the *Bolam* principle'.

The Court (at 50) indicated the following shortcoming in the *Bolam approach as applied in Sidaway*:

> 'One consequence of the application of the *Bolam* principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion. The fact that the various majority opinions in *Sidaway*, for example, suggest that, over and above the opinion of a respectable body of medical practitioners, the questions of a patient should truthfully be answered (subject to the therapeutic privilege) indicates a shortcoming in the *Bolam* approach. The existence of the shortcoming suggests that an acceptable approach in point of principle should recognise and attach significance to the relevance of a patient's question.'

The Court moreover pointed out (at 51) that in Australia,

> '. . . particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts

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have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life"'.

The Court, after referring to the penultimate passage from *F v R* quoted above and the passage from *Reibl v Hughes* which King CJ cited with approval in the second quotation from *F v R* above, held the following at 51:

> 'The approach adopted by King CJ is similar to that subsequently taken by Lord Scarman in *Sidaway* and has been followed in subsequent cases. In our view it is correct.'

The Court then proceeded (at 52) to comment critically on expressions used in American authorities, such as 'the patient's right of self-determination' and 'informed consent'.

The criticism of the former expression was on the basis that, while perhaps suitable 'to cases where the issue is whether a person has agreed to the general surgical procedure or treatment', it was of little assistance in 'the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure'. This criticism strikes me as being

somewhat paradoxical when regard is had to the Court's own endorsement of 'the paramount consideration that a person is entitled to make his own decisions about his life'. In any event, it does not seem to me to be appropriate when applied to the position in South African law, where the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk. In the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its *sequelae* (see *Van Wyk v Lewis* 1924 AD 438 at 451; *Correira v Berwind* 1986 (4) SA 60 (ZH) at 63 and *Verhoef v Meyer (supra* at 32 *et seq* of the unreported Transvaal Provincial Division judgment and 26-9 of the unreported Appellate Division judgment)). As *Van Oosten (op cit* at 14-5) points out:

> 'South African law generally classifies *volenti non fit injuria*, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of the risk of harm, as a ground of justification *(regverdigingsgrond)* that excludes the unlawfulness or wrongfulness element of a crime or delict.'

For consent to operate as a defence the following requirements must, *inter alia*, be satisfied:

(a) the consenting party 'must have had knowledge and been aware of the nature and extent of the harm or risk';

(b) the consenting party 'must have appreciated and understood the nature and extent of the harm or risk';

(c) the consenting party 'must have consented to the harm or assumed the risk';

(d) the consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences'.

(See *Van Oosten (op cit* at 13-25 and the authorities there cited).)

Similarly the criticism in *Rogers v Whitaker* of the expression 'informed consent' was on the basis that

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> '. . . consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass. . . .'

As indicated above, the position in South African law is quite different and the expression 'informed consent' is an appropriate one.

Of particular importance is the conclusion of the Court in *Rogers v Whitaker* at 52 that:

> 'The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.'

This test bears a very close resemblance to the blending of the 'reasonable patient' minimum with the individual patient 'additional needs test' proposed by *Giesen* and discussed above.

In my view we ought, in South Africa, to adopt the above formulation laid down in *Rogers v Whitaker*, suitably adapted to the needs of South African jurisprudence. It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. The majority view in *Sidaway* must be regarded as out of harmony with medical malpractice jurisprudence in other common law countries.

I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

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

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

This obligation is subject to the therapeutic privilege, whatever the ambit of the so-called 'privilege' may today still be.

Expert medical evidence would be relevant to determine what risks inhere in or are the result of particular treatment (surgical or otherwise) and might also have a bearing on their materiality but, in the words of the Supreme Court of Canada in *Reibl v Hughes (supra)*, 'this is not a question that is to be concluded on the basis of expert medical evidence alone'. 'The ultimate question', as King CJ stated in *F v R*, is 'whether (the defendant's conduct) conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community.'

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As King CJ considered in *F v R* at 192 (a passage approved in *Rogers v Whitaker* at 51):

> 'What a careful and responsible doctor would disclose depends upon the circumstances. The relevant circumstances include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient.'

I turn now to consider the plaintiff's complaints of non-disclosure in the present case. They have been dealt with fully earlier in the judgment but may be summarised as follows: It is contended that the following material risks and complications which might flow from such operation and also the following alternative procedures which could be followed in order to minimise, reduce or exclude such risks or complications, were not disclosed to the plaintiff which, if they had

been disclosed, would have resulted in the plaintiff's not undergoing the operation involving the technique in question but undergoing some other surgical procedure which would have reduced or lessened the risks and complications (and specifically the risks of post-operative necrosis or infection):

(1) That defendant intended to effect a transpositioning of the areolae, which would increase the risk of post-operative necrosis. (As previously mentioned, it will be convenient to deal under this heading with plaintiff's further contention that defendant in fact breached an express agreement not to reposition the areolae or nipples and would ensure that plaintiff would suffer no loss of sensation in that area.)

(2) That the transpositioning of the areolae was not essential but done for cosmetic reasons and that it was plaintiff's choice as to whether such transpositioning should be done.

(3) That there was an alternative procedure involving less risk of necrosis or infection, namely a two-stage procedure involving, first, the removal of breast tissue and later the insertion of a prosthesis and the adjustment of the nipple if required.

(4) That the operation envisaged by defendant had a complication rate as high as 50%.

(5) That there were virtually no steps to avert or curtail necrosis of the tissue, a recognised complication of the operation in question, if it arose post-operatively.

Ad (1) above:

This issue involved a conflict of fact both as regards the express agreement as well as defendant's intention to transpose the areolae; the defendant testifying that he told plaintiff that he was going to transpose the areolae (which she agreed to) whereas plaintiff denied this.

Scott J came to the conclusion (at 517D) that the probabilities favoured the conclusion that the defendant explained to the plaintiff that he would reposition the areolae using a trans-positional flap for this purpose, as opposed to the free grafting method. This finding cannot, in my view, be faulted. The defendant's clinical notes indicate that he found plaintiff's breasts to be mildly ptotic. The view expressed by defendant that the mastectomy and implant would of necessity aggravate the position of

plaintiff's areolae was not challenged on medical grounds. It is therefore inherently unlikely that defendant would have told plaintiff that there was no need for her areolae to be moved or, indeed, that the position of her nipples would be the same after the operation as before without their being moved. Scott J rightly drew an adverse inference (at 516H) against the plaintiff for not calling her husband to testify on the disputed issues concerning the consultation on 14 June. He was available to give evidence and could surely have supported plaintiff's version, if defendant had indeed given an undertaking that the areolae would not be moved at all. On 9 August 1989, approximately two days after the operation, plaintiff's husband complained to

defendant that the latter had, contrary to his undertaking, 'removed' the areolae. Defendant replied that he had not removed them but merely 'moved' them. This would have focussed the attention of plaintiff's husband on the consultation less than two months previously. He would surely have remembered the discussion on this topic and, if his recollection accorded with that of the plaintiff, namely that the defendant had undertaken not to move the areolae at all, he would have testified in support of plaintiff's version. It is common cause that the consultation on 14 June 1989 lasted approximately an hour, yet plaintiff was in her evidence able to recall very little of what took place and what was explained to her at the consultation. A great deal can be discussed and explained in an hour. I find it neither surprising, nor suspicious, that a patient contemplating major surgery has little recall of such a consultation. It does, however, necessitate great caution in accepting any evidence by plaintiff that something was not said or explained to her when there is so much of the consultation that she simply cannot remember. Scott J was clearly correct in finding (at 517) that defendant had mentioned to plaintiff the repositioning of the areolae and that she had agreed to it. The learned Judge did not deal explicitly with plaintiff's claim that defendant agreed to ensure that she would not, as a consequence of the operation, suffer any loss of sensation in her areolae or nipples. This was probably due to the fact that this complaint was not strenuously argued before him. It has no merit. Apart from denying that he gave such an undertaking, defendant's evidence is undisputed that the inevitable consequence of a subcutaneous mastectomy is total loss of sensation in these areas. It is in the highest degree unlikely that defendant would have given an undertaking that was impossible of fulfilment.

Before dealing with the complaint of non-disclosure under this, and the other headings, it is necessary properly to contextualise plaintiff's position and the unenviable dilemma she faced. Aged 44, she had a family history, accepted by her and her gynaecologist, of a mother and a grandmother who had died either directly or indirectly as a result of breast cancer. In 1982 plaintiff had undergone surgery for the removal of lumps in both breasts. At the time when plaintiff consulted defendant she was told by her gynaecologist that she had a large number of lumps in her breasts. Plaintiff was having regular X-ray mammograms to monitor her breast condition but her gynaecologist was becoming increasingly concerned because the continuous mammograms themselves posed a danger of inducing malignancy. Plaintiff was therefore in a dilemma. She had a family history of death due to breast cancer. Despite her operation in 1982 she had by June

1989 a large number of lumps in her breasts. It was becoming dangerous to monitor these by X-ray. Her gynaecologist (and not the defendant) suggested to plaintiff that she should have a prophylactic subcutaneous mastectomy and referred her to the defendant to find out the procedures involved and 'the pros and cons of the entire procedure'. It was definitely not an operation contemplated for cosmetic reasons but in order 'to avoid future malignant cancer which might occur bearing in mind the family history'. It seems that plaintiff had three options: (1) To do nothing and to wait until she developed breast cancer and then undergo a radical mastectomy which would definitely entail the loss of her areolae and would otherwise also entail the loss of her breast skin. (2) To have the lumps in her breasts removed from time to time. (3)

To have a subcutaneous mastectomy as soon as reasonably possible. The clear impression gained from plaintiff's evidence is that option 1 was not really a possibility at all; that option 2 was also not seriously considered and that, on the advice of her gynaecologist, option 3 was the only one really open to her. That this is so seems further strengthened, on the probabilities, by the fact that plaintiff was a person who monitored her diet in order to maintain a reasonable figure and that she was fairly figure conscious, as well as clothes conscious. The subcutaneous mastectomy therefore afforded her the opportunity of averting the cancer threat and at the same time affording her the possibility, though by no means the certainty, of a satisfactory cosmetic result. On her own evidence the plaintiff was made aware of the threat that the subcutaneous mastectomy posed to the blood supply to the areolae and skin of her breasts. Plaintiff also stated in her evidence that it was explained to her by the defendant 'that one of the big dangers of loss of blood supply would be if the nipples and areolae was moved'. According to defendant he explained to plaintiff that the operation was not one to be embarked on lightly and that there were many complications involving, *inter alia*, physical complications in respect of her breasts. He says he specifically mentioned to her that the dominant blood supply, which passes through the breast tissue, would be completely removed and that consequently the risk of complications of damage to the skin was very great. He also mentioned to her that complications of infection and bleeding could occur. It was not suggested by the plaintiff, nor seriously contended on her behalf, that as an intelligent lay person she was ignorant of the fact that a compromised blood supply could lead to permanent damage of skin and tissue (including her areolae). In the circumstances Scott J was fully warranted in his finding (at 518I) that the plaintiff was aware of the risks involved in the transposition of her areolae.

Ad (2) above:

There is no merit in the complaint that plaintiff was allowed to labour under the misapprehension that the repositioning of her areolae was prophylactically essential and not merely cosmetic. At no stage did plaintiff indicate that she was unaware of the true position in this regard. It is difficult to see how she could have been. The purpose of the operation was to remove as much of the breast tissue as possible in order to provide a prophylaxis against cancer in the future. This plaintiff was aware of. The repositioning of the nipples could not be thought to further this end.

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Ad (3) above:

In my view Scott J was correct in concluding (at 519F) that the evidence was insufficient to establish that the particular type of subcutaneous mastectomy and prosthesis insertion practised by the defendant involved a materially higher risk than if a two-stage procedure was used. Defendant explained the two-stage procedure to her but says that the plaintiff chose to have it done at one and the same time.

Ad (4) above:

Scott J concluded (at 520C) that defendant's failure to quantify the degree of risk by mentioning

the figure of 50% was not a material non-disclosure. I agree. In the light of the detailed information furnished to plaintiff regarding the risks involved in the operation, alluded to in (1) above, she could have been under no illusion that the risk of skin or areolae loss was not insubstantial. There is in any event nothing on the evidence to suggest that plaintiff subjectively regarded this failure to mention a figure of 50% as material. She did not suggest that, if such figure had been mentioned, it would have affected her operation choice in any way.

Plaintiff's evidence in regard to the materiality of any of the non-disclosures is unconvincing, to say the least. The only evidence she specifically gave in regard to materiality was in connection with the shifting of her areolae. Her answers are vague and uncertain:

> '. . . I certainly would have looked at it very differently as to whether I would have gone ahead with the operation, it is very difficult to ascertain in hindsight. It was a necessary operation.'

And:

> 'I think it is quite likely that I would have gone back to my gynaecologist and rethought everything. Or maybe even sought another opinion.'

And

> '(i)t was a necessary operation from the point of view to prevent family history of cancer. I mean I would still have to have gone ahead with the operation in some form or another, but that might have taken a different form.'

There is no convincing evidence that she would have adopted a different course nor, if she had, that a materially better result would have ensued.

Ad (5) above:

If defendant had properly explained to plaintiff the risks involved in the operation, which Scott J found he had, it would have been clear to plaintiff that the damage was not reversible without reconstructive surgery. Under these circumstances it would have been quite unnecessary for defendant to explain to plaintiff the intermediate pathological process. The risk was the unsatisfactory end result, not the process leading to such result. There is again no evidence that this would have influenced plaintiff's decision.

> *(b) Defendant's failure to prevent the onset of necrosis or to limit its extent in plaintiff's breasts*

As indicated above, this ground was on appeal finally narrowed to an

enquiry as to whether defendant was negligent in not releasing some or all of the stitches used to suture the operative incisions on plaintiff's breasts when he saw portions of her areola complex turning blue.

Scott J dealt with the issue as follows (at 510C/D-512F)

> 'It was common cause between the plastic surgeons who gave evidence on behalf of both the plaintiff and the defendant that a step that possibly can be taken following pedicle (flap) surgery in order to aver the onset of a

threatened necrosis or to limit its extent, is to release the sutures holding the pedicle in place. The defendant did not do so. He testified that, on becoming aware of the threatened necrosis on 9 August 1989, he considered this step but decided against it. The question that arises is whether his decision not to release the sutures holding the pedicle in

place amounted to a failure to exercise reasonable diligence, skill or care.

All the experts were agreed that there is no way of knowing whether releasing the sutures will have any beneficial effect. In this regard, both Dr Cort and Professor Bloch, who testified on behalf of the plaintiff, could say no more than that such a step "might" have helped. The reason for this is that, generally speaking, ischaemia and consequent necrosis may in such circumstances be caused by one or more of several factors. The problem might be the result of a "kink" in the vessels supplying the affected area with blood. In that event, release of the sutures could bring about an improvement in the blood supply. Another possible cause is the presence of thromboses in the blood vessel in question. Should this be the case, release of the sutures would be unlikely to result in any improvement. Yet another possible cause is an inadequate blood supply following removal of the breast tissue. In this event, too, release of the sutures would have no beneficial effect.

Dr Cort favoured the view that it might well have been advisable to release "some or all of the sutures" around the affected area. Nonetheless, he testified that he would not point a finger at the defendant for not having done so, as in each case one is guided by one's own experience and that he, Dr Cort, had not had the benefit of seeing the patient at the time. Professor Bloch readily conceded that the decision whether to release sutures or not, and when to do so, is not an easy one. He felt, however, that, if the condition appeared to be deteriorating and "there was a great deal of tension on the pedicle", the removal of the sutures might well have been indicated. On the other hand, Dr Engelbrecht and Dr Lückhoff expressed serious reservations regarding the efficacy and, indeed, the desirability of releasing sutures as a means of combating or curtailing a threatened necrosis. Both have considerable experience with regard to the operation in question. Dr Lückhoff's attitude was simply that he does not cut sutures in such circumstances. Dr Engelbrecht was a little less dogmatic but nonetheless expressed the view that in such cases releasing sutures was usually a futile step. Dr Lückhoff explained that, generally speaking, the problem manifested itself too late to justify interfering with the sutures. Both he and Dr Engelbrecht pointed out that as the sutures that have to be released are subcutaneous (ie inserted under the skin) the procedure involves cutting into the skin and accordingly further compromising an already compromised blood supply. Furthermore, as both doctors use a single continuous suture to keep the pedicle and the breast in place (as does the defendant), the release of that suture results in the breast, in effect, "springing open". Apart from increasing the risk of infection the procedure exposes the patient to the risk of further scarring as well as other complications. Notwithstanding these drawbacks and his general reluctance to adopt this means of combating a threatened necrosis, Dr Engelbrecht was not prepared to go so far as to say that it was a technique that should never be used. He felt that the step was indicated only if the problem with the blood supply was detected reasonably soon after the operation and if there was some particular factor such as a swelling of the affected breast with tension on the

pedicle that justified cutting the suture and exposing the patient to the risks associated with this procedure.

The defendant's views largely coincide with those of Dr Engelbrecht. He testified that, on becoming aware of the threatened necrosis on 9 August 1989, he came to the conclusion that the problem was probably caused by the presence of thromboses in the blood vessels. This conclusion he appears to have based mainly on his observation that the pedicles were not under tension although the left breast was swollen and also on the fact that the problem had only manifested itself more than 36 hours after surgery. In these circumstances he regarded it as unwise to expose the plaintiff to the risk of the further complications that could result from the release of the sutures and he accordingly decided to treat her conservatively. In other words, he elected to wait and see what the extent of the necrosis would be and thereafter repair the damage by means of skin grafts and reconstructive surgery.

There was also some difference of opinion as to the period following the operation within which it was still

reasonable to release sutures holding the pedicle. It is fortunately unnecessary for me to have to attempt to resolve this question, if, indeed, it is capable of being resolved. It is sufficient to observe that I was referred to reputable medical literature on the subject in which it was suggested that if releasing sutures was to be effective it should be done within eight hours of the operation. Whether this period is correct or not is not really in issue. What is important is that, when it comes to making a decision whether to release sutures or not, the extent of the delay must necessarily be a material consideration.

It must not be overlooked that, even if it were to be shown that the defendant's decision, involving as it did a clinical judgment, turned out to be the incorrect one, it would not necessarily follow that on this account he was negligent. Indeed, a pratitioner is not to be held to be negligent merely because the choice he made or the course he took turned out to be the wrong one. The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the "error" is one which a reasonably competent practitioner might have made, it will not amount to negligence. If it is one which a reasonably competent practitioner would not have made, it will amount to negligence *(Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL) at 281*b)*.

In the present case, as I have said, the problem first manifested itself more than 36 hours after the operation. The defendant, in common with other prominent plastic surgeons and in the light of his own experience, had little confidence in the efficacy of releasing the sutures holding the pedicles. Although the one breast appeared swollen, he considered that there was no undue tension on either pedicle and felt that the cause of the problem was probably the presence of thromboses in the blood vessels feeding the affected areas. He appreciated also that if he were to release the sutures he would expose his patient to the risk of further complications, including scarring and possibly an ugly end result. In these circumstances it is understandable, in my view, that he should decide not to take this step.

In the light of the aforegoing, I can find no reason for concluding that the decision of the defendant not to release the sutures was such that no reasonable plastic surgeon in his position would have adopted the same approach. Indeed, I am far from persuaded that his decision was the incorrect one. The plaintiff testified that she was satisfied with the final result following reconstructive surgery. Had the sutures been released, there is every likelihood that necrosis would not have been averted and the plaintiff would have been left with additional, and perhaps unacceptable, scarring resulting from an unsuccessful attempt to avert the necrosis.'

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The essence of this issue is whether:

(a) defendant was negligent when, on seeing discolouration of the affected tissue 36 hours after the operation, he failed to remove some or all of the stitches around the affected area; and

(b) had defendant removed some or all of the stitches on this occasion it would have prevented or limited the necrosis in any way.

Why the possibility of negligence is limited to a period starting 36 hours after the operation, is because there is no suggestion that there was any prior indication that the blood supply to the affected area was compromised or limited. Nothing was advanced on appeal which demonstrated that Scott J's analysis of or approach to the evidence or his application of the law to the facts was incorrect. In fact, I am of the view that his approach and conclusions on this issue were manifestly correct.

Both Dr Cort's and Prof Bloch's views were expressed in the abstract and were conditional on the full clinical picture which presented itself to the doctor concerned at the time. There is a

margin of clinical appreciation which the doctor treating the patient enjoys, and they were reluctant, correctly so, to criticise defendant's decision at the time.

Professor Bloch would not have expected the surgeon to do anything at the first sign of a 'little bit of blueness of the nipple'. For him the indication on which the surgeon 'could release a couple of sutures and see what happens' (a somewhat vague comment on which to justify a finding of negligence) was if the surgeon was convinced that the condition was getting worse and there was a great deal of tension on the pedicle. There is nothing on the evidence to show that when the nipple started turning blue 36 hours after the operation there was great tension on the pedicle. In fact defendant's evidence, for the rejection of which no good ground exists, is that at this stage the drainage of the wound was normal and all pressure reduced. Both breasts were soft and there was no pressure on either. Reliance was placed by plaintiff's counsel on the following entry made by defendant in a note dated 23 August 1989:

> 'Post-op 2-3rde dag blasies (L) tepel (R) mooi, waar tog goeie perfusie gehad (L) was baie geswel (L) bors, ten spyte van Porto Vac.'

Even if it is correct that the entry 'baie geswel' relates to the plaintiff's left breast, this related to a period at least two days (48 hours) or even three days after the operation.

The indication for releasing the sutures, particularly in the area of the pedicle, is, on plaintiff's case, the impairment to the blood supply caused by a kink in the pedicle. Defendant, who was the only medical witness who had actual first-hand knowledge of plaintiff's condition at the time, testified that for the first 36 hours there was no indication of ischaemia. He was satisfied that his planning of the pedicle was correct, that he had left sufficient subcutaneous tissue under the flap and that his flaps did not cause pressure on the pedicle. His diagnosis of the position was that there had been a thrombosis in the blood vessels of the subdermal plexus and that the inevitable consequence thereof was necrosis of the area. The other experts are really not in a position to challenge this.

It is not disputed that Drs Morris, Stevenson and Watson, authors of Complications of Plastic Surgery, are eminent authorities in their field.

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Their views expressed in this work were referred to in the expert evidence. In this work they express the view that

> '(i)n the early post-operative phase, incipient necrosis in a prejudiced flap may be prevented by removal of tight sutures, release of haematoma or removal of the implant'.

It is likewise not disputed that Drs Regnault and Daniel, authors of *Aesthetic Plastic Surgery*, whose views were canvassed in the expert testimony, are also eminent in this field. Dr Engelbrecht described the senior author Dr Paule Regnault as a person with 'geweldige uitgebreide ondervinding' in the field. According to Dr Engelbrecht: 'Sy (Dr Regnault) is seker van die wêreld se persone wat die meeste borsoperasies gedoen het.' *Regnault and Daniel (op cit)* express the view that:

'The critical point is that, if the cyanosis is recognised within eight hours post-operatively, salvage by decompression is possible.'

It is interesting to note that *Morris et al (supra)* at the conclusion of the chapter in their work referred to in evidence, refer to the work of *Regnault and Daniel* for 'further reading'.

Drs Engelbrecht and Lückhoff, as well as defendant himself, subscribed to the above view of Regnault and Daniel. Only Prof Bloch did not. Although Prof Bloch considered Dr Regnault to be a very prominent plastic surgeon, he considered the above view to be too absolute. His only substantial reason for doing so, however, was that 'we have already replanted limbs that have been off for 33/34 hours and they have still survived'. Professor Bloch did not explain why the analogy between a replanted limb and a subcutaneous mastectomy was an apt one, nor was it canvassed further in evidence. Even so, the high-water mark of Prof Bloch's evidence was that 'even if it is two days later, you *might be able* to save that by reducing the tension or improving the blood supply to that part' (emphasis added).

In the light of this conflict in the expert evidence plaintiff fell far short of proving, on a balance of probability, that defendant was negligent in not taking the steps indicated.

The plaintiff fell even further short of proving, on a balance of probability, that had any or all of the sutures been removed, this would in any way have prevented the onset of or limited the extent of the necrosis. Quite apart from the considerable body of medical evidence and opinion that, after 36 hours, the process was irreversible, the loosening of the sutures could only have helped if the ischaemia was caused by a 'kink' in the vessel supplying the affected area with blood, but not if it was caused by thromboses in the blood vessel. There was no expert evidence which even sought to suggest that, in general, where ischaemia is encountered in a subcutaneous mastectomy, it is more often caused by such a 'kinking' of the supplying blood vessel rather than by thromboses.

The plaintiff has not demonstrated that Scott J erred on this issue. In fact, I am satisfied that he was correct.

(c) Defendant's failure adequately or timeously to treat the post-operative sepsis which had allegedly developed in plaintiff's breast

On 14 August 1989, the day after her discharge from hospital, plaintiff

observed a yellowish exudate from both breasts and smelt an unpleasant odour. Over the next two weeks the discharge increased considerably and the unpleasant odour worsened. She was admitted to hospital again on Sunday, 27 August by Dr Lückhoff. In this two-week period she saw defendant on 16, 21 and 23 August. In this period plaintiff was helped by a friend, Mrs Pickering, to change her dressings and received physiotherapy from a Miss Wessels on 21, 22 and 24 August. On each of these occasions Miss Wessels saw plaintiff's naked breasts. After plaintiff's admission to hospital on 27 August Miss Wessels continued to treat her from 29 August onwards. On these occasions Miss Wessels did not see the plaintiff's breasts and only

treated an abdominal scar on plaintiff's stomach, which is unconnected with this case.

Miss Wessels testified that she observed plaintiff's breast wounds and surgical incisions to be infected on the occasions she treated plaintiff. According to Mrs Pickering and Miss Wessels, the plaintiff on occasions appeared feverish and unwell and her condition deteriorated. Miss Wessels had a telephone conversation with defendant on some occasion between 21 and 24 August to verify with him that she could administer laser therapy to plaintiff's scars. Her evidence in this regard is as follows:

> 'Hy het vir my gesê dat sy het 'n bietjie probleme met infeksie in dele van die wond en dat ek tydens my behandeling daardie gedeeltes moet vermy.'

Defendant denied that plaintiff's wounds ever became infected. He kept plaintiff on an antibiotic only as a prophylactic measure. Dr Lückhoff is an experienced plastic surgeon who has consulting rooms in Paarl next to those of defendant. Though not partners, Dr Lückhoff and defendant look after each other's patients when the one or the other is absent or unable to do so. Dr Lückhoff examined plaintiff briefly in his rooms on 27 August and arranged for her admission to hospital again. He is emphatic in his evidence that on this occasion there was no infection present at all in plaintiff's wounds. In a handwritten note made by defendant and dated 21 August 1989 the following notation appears: 'Mrs D Castel infection bilat nipples.' Thereafter a prescription for 'Dalacin C' appears. There is a further handwritten note by defendant relating to plaintiff and dated 23 August 1989. It appears to be a brief note concerning plaintiff's post-operative progress. It commences with a note 'Post-op 2-3rde dag'. The following appears in the middle of the note:

> 'Geleidelik meer blase tot 10 dae post-op was daar 'n roof (L) tepel met dreinasie v edeem vog - prostese mooi bedek *geen duidelike sistemiese infeksie nie*. *Tog lokale infeksie*? *Steek absessie en Dalacin C*.

(Emphasis added.)

The next inscriptions read as follows:

> '21-8-89 Nog etterig.
>
> 23-8-89 Baie beter.'

The following note appears as the first entry in plaintiff's bedletter at the hospital where she was admitted on 27 August:

'27-8-89 21:00 Nuwe pasiënt toegelaat van dr A de Greef met septiese borste.'

On 28 August at 16:45 swabs were taken from plaintiff's wounds for

microbiological testing. The results of the swab tests showed growths of *staphylococcus aureus*. Dr De Goveia, a specialist medical microbiologist who performed the analysis, was of the opinion that these findings alone did not justify the inference of infection and were not inconsistent with a mere contamination of the wound. The relatively small number of leukocytes

found tended to suggest, in her view, the absence of infection. She emphasised, however, the importance of the clinical assessment of the wounds. Scott J accepted her evidence in the field of her speciality in preference to that of Prof Bloch; rightly in my view. This was not challenged on appeal.

Defendant emphatically and strenuously denied that he had, in any conversation with Miss Wessels, said or suggested to her that any of plaintiff's wounds were infected. He said he could not and would not have done so because plaintiff's wounds were never infected. Although Scott J found it 'likely that he did indeed use the word "infeksie" when speaking to Miss Wessels', the learned Judge did not in his judgment consider what effect such finding had on defendant's credibility or the reliability of his evidence. In regard to defendant's notes dated 21 and 23 August respectively (to which reference has already been made), Scott J accepted (at 514G-H) defendant's explanation and contention that they did not mean that he had diagnosed plaintiff as suffering from an infection. Scott J also rejected (at 515H) the argument that Dr Lückhoff's diagnosis may have been wrong in the light of plaintiff's evidence and that of Mrs Pickering and Miss Wessels, both of whom the learned Judge described as 'lay' witnesses. He accepted Dr Lückhoff's evidence and on the strength thereof held that plaintiff had failed to establish that there had been an infection.

These lastmentioned findings were strenuously attacked on appeal by Mr *Oosthuizen* on plaintiff's behalf and require careful reconsideration.

The issue does not, as I see it, necessarily resolve itself into one of a mutually exclusive choice between the evidence of Miss Wessels and that of Dr Lückhoff; or of a choice between severe infection on 27 August and no prior infection at all.

The learned trial Judge dealt with Miss Wessels as though she were an ordinary lay witness. I am constrained to disagree. She is a qualified physiotherapist, who holds a university BSc degree in physiotherapy involving a four-year course of training. This course involved a practical as well as a theoretical component. Wounds and the physiotherapeutic treatment of wounds form a theoretical as well as a practical component of the course. The ability, expertise and experience of Miss Wessels is such that she lectured in physiotherapy at Stellenbosch University for a period of five years. In fact, the treatment of septic wounds was one of the subjects taught by her on a practical as well as on a theoretical level. There are different forms of treatment, depending on whether the wound is infected or not. Moreover, her experience in treating wounds has been mainly in the field of infected wounds. For the competent practice of her profession it would therefore be necessary for Miss Wessels to be able to distinguish between infected and non-infected wounds. Objectively speaking, her testimony regarding her training, teaching and practical experience (which was never challenged), indicates that Miss Wessels has

specific theoretical and practical training and experience to enable her to distinguish between infected and non-infected wounds. When therefore, against this background, Miss Wessels states in cross-examination that she regards herself as competent to express an opinion on the

physiotherapeutic treatment of open wounds, which involves the ability to distinguish between infected and non-infected wounds, a Court ought, in my view, to treat her as an expert witness in this field, particularly where nothing has been adduced to demonstrate her lack of knowledge, expertise or competence or even to question it. There are naturally degrees of expertise depending, *inter alia*, on the level and length of training and experience. Dr Lückhoff has been practising as a plastic surgeon since 1980. At the time of these incidents he would have been in his tenth year of practice as such. Over the past 12 years he has done 50-60 subcutaneous mastectomies. In not one of these has he seen infection in the wounds. He did not indicate in his evidence whether, over this period, he had observed any other infected wounds. There is accordingly no basis for finding that Miss Wessels' practical experience of infected wounds is less than that of Dr Lückhoff. On the contrary it appears, on the evidence, to be more.

Miss Wessels stated in her evidence that on the first occasion she saw plaintiff, she noticed pus in the areas of necrosis on her breasts, as well as pus oozing in patches from the vertical surgical incision running downwards from the nipple as well as from the horizontal incision. She noticed a brownish exudate and clearly saw streaks of pus in the exudate as well as small streaks of blood. The edges of the open wounds were raised, swollen and red. On the subsequent occasions that she saw plaintiff before her admission to hospital, Miss Wessels noticed that the patches of pus were increasing, also on the horizontal incision. Miss Wessels said that the wounds smelt like infected wounds and that as time passed the smell became worse. Not only did plaintiff complain of feeling unwell and of running a temperature but Miss Wessels noticed this herself. She says that although plaintiff looked generally pale, her face, in the area of her cheekbones was flushed. She looked ill and complained of pain. In her evidence Miss Wessels distinguished between the exudate from the necrosed areas and the pus from the infection. There were clear streaks of pus in the exudate. She was aware that cream was being applied to the wounds. She is quite sure that the wounds she saw were infected wounds. She saw the discharge clearly just after the wounds had been cleaned.

Defendant's experts pointed to the fact that it was possible visually to confuse the exudate from necrosed tissue with pus from an infection. It was never their case that it was impossible visually to distinguish the exudate from the infection, nor even that it was particularly difficult for a trained person to do so.

Miss Wessels appeared to be an intelligent, observant and honest witness. None of these qualities were challenged in cross-examination. It was never suggested to her in cross-examination that she was not qualified to diagnose infection, that her observations were faulty, that she was unable to distinguish between infective pus and necrotic exudate nor that she had mistakenly confused the one with the other when she treated the plaintiff. In addition, Miss Wessels mentioned that plaintiff had other symptoms which, it is common cause, are indicative of infection, namely

that her temperature was raised, that she felt unwell, that she was in pain and that her wounds were red and swollen. In my view Miss Wessels' testimony constitutes cogent evidence that

plaintiff's wounds were infected when Miss Wessels saw her on 21, 22 and 24 August.

In addition to her clinical observations, there is Miss Wessels' evidence of the telephone conversation with defendant which, if accepted, would constitute an implied admission by defendant that the wounds were infected. Miss Wessels is adamant that the defendant referred to infected areas in the wounds and instructed her not to apply laser therapy to the infected areas. There is no basis for rejecting Miss Wessels' evidence as untrue. It is most unlikely that she can be mistaken. The reason she did not treat certain areas of the wounds is because defendant told her not to. Defendant would not have given this negative instruction if there was (or if he believed there was) only necrosed tissue present. She cannot be mistaken about the negative instruction. In addition to the aforegoing there are defendant's own notes dated 21 and 23 August, quoted above. Defendant's attempts to explain away the entries 'infection bilat nipples', '. . . geen duidelike sistemiese infeksie nie. Tog lokale infeksie?' and '21-8-89 nog etterig' were, in my view, quite unconvincing and lacking in candour. He would not have made these entries had he not diagnosed infection. What he was not sure about was whether the infection was systemic or not. The entry '21-8-89 nog etterig' clearly implies that there was 'pus' present on the previous occasion when defendant examined the plaintiff on 16 August. It is significant to note that when Dr Cort (the first of plaintiff's expert witnesses to testify) was cross-examined the following was put to him:

> '. . . what I'm trying to put to you doctor, is that although there may have been a septic - a local septic area, but what was seen there, was not a systemic infection which necessitated an antibiotic . . .'.

This is inconsistent with defendant's evidence that there was never any sign of any infection. It suggests a switch in his defence which is less than honest.

When the aforegoing evidence is viewed cumulatively it compels the conclusion:

(a) that Miss Wessels is speaking the truth when she says that defendant told her not to apply laser therapy to the infected area of plaintiff's wounds;

(b) that defendant himself diagnosed plaintiff as having infected breast wounds on 16, 21 and 23 August 1989.

The remaining question is whether, in the light of the evidence of Drs Lückhoff and De Goveia, plaintiff has proved on a balance of probabilities that she in fact developed post-operative sepsis in her breasts.

It was submitted on plaintiff's behalf that Dr Lückhoff did not, on the evening of 28 August, remove plaintiff's dressings, and that it would therefore be difficult for him to comment on the state of the wounds underneath the dressings. The passage in his evidence to which we were referred in this regard does not, in the context of all Dr Lückhoff's evidence, bear out that contention. When he testified that:

> '. . . When I saw her at that stage she had a dressing on, probably for more than

a day already, and one cannot determine exactly what the underlying situation is because of the discharge and of the dressing situation on the wound.'

He was not conceding that he had not removed the dressing. The point he was, in the context, making was that it was difficult to form an idea of the base of the wound and the formation of granulation tissue when, at the time of examination, the wound had probably not been dressed for more than a day. In his evidence-in-chief he was quite clear that he removed the dressings.

The possibility that Dr Lückhoff made a mistake in not detecting the infection cannot be excluded. There are a number of factors which, taken cumulatively, render this a possibility which is less than remote. It was not his patient; he was called out at 21:00 on a Sunday evening; the examination took place in his consulting rooms and not in a hospital bed; he felt that it was in any event an appropriate stage for her further hospitalisation for the debridement of her wounds; and the defendant would be back on duty the next day to attend to the plaintiff. In addition, Dr Lückhoff regards infection as a very infrequent occurrence in this form of surgery and a complication which he places 'right down at the bottom of the list' of complications. He was therefore not expecting to find infection and certainly not on the look-out for it. The examination was not a lengthy one. He kept no notes of his clinical examination and he testified more than two years after his examination. He saw plaintiff on this one occasion only. It is also quite possible that the infection, when he saw plaintiff, was less severe and noticeable than when Miss Wessels saw the wound last on 24 August. In casting his mind back he might have thought that he only saw necrotic exudate. His recollection of the interview with plaintiff is not very comprehensive and, in one respect at least, clearly incorrect. Plaintiff is quite clear in her evidence that she suffered increasing pain from her wound since discharge from hospital. That she was unwell and suffering (and complaining of) pain is confirmed by Miss Wessels. Plaintiff's evidence on this score is credible and deserves to be believed. She says she complained to Dr Lückhoff of the pain. It is probable that she did so. He says that she did not. It seems that Dr Lückhoff has forgotten the complaint.

I do not understand Dr De Goveia's evidence to exclude an infection, even at the time when the swab was taken during the late afternoon of 28 August. Even on her evidence the clinical picture is most important. While the amount of organisms present does not necessarily correlate with the presence of an infection, and may be caused by colonisation, she cautioned that

> 'one really needs to assess the patient's clinical picture to get a full, to decide whether an infection is present or not'

and

> 'I always ask for full clinical details on the patient, so that we can interpret it in the light of the clinical data.'

While the scanty lucosites would tend to suggest a colonisation, Dr De Goveia warned that

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> 'one cannot be dogmatic about that . . . . As I say, it all depends on the clinical assessment really.'

The fact that plaintiff was not running a temperature on the days following her admission to hospital on 27 August does not exclude the fact that she was when Miss Wessels last saw her. It merely means that the infection was less serious then.

When regard is had: *(a)* to Miss Wessels' evidence; *(b)* to defendant's admission to her; *(c)* to defendant's notes, which cannot be explained on any basis other than a diagnosis by him of infection in plaintiff's wounds; and this is taken in conjunction with plaintiff's description of her physical condition then, in my view, Miss Wessels' evidence is clearly to be preferred to that of Dr Lückoff, to the extent that it can be said that his evidence conflicts in any way with hers.

On the view I take of the facts, plaintiff has proved on a clear balance of probability:

(a) that she developed post-operative sepsis in her breasts which manifested itself no later than 14 August and became systemic and continued to be systemic until at least 24 August;

(b) that defendant became aware of this sepsis on 16 August; and

(c) that the organism, or one of the organisms, causing such sepsis was resistant to the antibiotics which had been prophylactically prescribed by defendant for plaintiff.

The opinion of plaintiff's experts, which was not challenged in evidence or argument, was that in a case such as the present a practitioner should, where he observes or suspects infection to be present, take a pus swab and send this for analysis in order to identify the specific organism causing the infection and to prescribe antibiotic which is effective in eliminating the organism.

On the facts as found, defendant was therefore negligent in not following such a procedure when he suspected infection on 16 August. A swab was only taken 12 days later. Had the swab been taken on 16 August, the appropriate antibiotic would have been prescribed and the infection effectively treated that much sooner.

The final important question is to determine what causal role defendant's negligent failure in this regard played in the *sequelae* suffered by plaintiff and the consequent damage sustained by her.

For the reasons set forth in *(b)* above, the necrosis suffered by plaintiff in her breast had become irreversible not later than 48 hours after the operation, ie by the evening of 9 August, and certainly well before any infection set in or could reasonably be diagnosed. As found, defendant cannot be held liable in law for the *sequelae* of the necrosis. It is clear that the necrosis was at least the predominant and major cause of the restorative and reconstructive surgery and medical treatment, for plaintiff's subsequent periods in hospital and for the pain, discomfort and other trauma suffered by plaintiff in consequence thereof. It is in my view impossible, on the evidence, to establish that defendant's negligence in failing to treat the infection timeously and properly played any role at all in the harm ultimately suffered by plaintiff. It certainly is not sufficiently causally connected therewith in the sense mentioned in *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 208A and 223C-G.

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The best that can be done, under the circumstances, is to compensate plaintiff for the additional period of pain, suffering, illness, discomfort and anxiety she had to endure because of the defendant's failure to treat her infection properly and timeously. This period is fairly represented by the period of delay in taking the swab for microbiological testing. This, as previously indicated, is a period of 12 days. In my view a sum of R7 500 would fairly and adequately compensate plaintiff in this regard.

The appeal must accordingly succeed.

The following order is made:

1. The appeal succeeds with costs.

2. The order of the Court *a quo* is set aside and for it the following substituted:

   (a) defendant is ordered to pay damages to plaintiff in the amount of R7 500, together with interest on the sum of R7 500 at the rate laid down in the Prescribed Rate of Interest Act 55 of 1975, from 17 February 1992 to date of payment, and costs, which costs shall include the qualifying expenses of Dr Cort and Prof Bloch;

   (b) defendant's counterclaim is dismissed with costs.'

Friedman JP and Farlam J concurred.

Appellant's Attorneys: *Rushton, Du Toit, Kraus & Van den Heever.*

Respondent's Attorneys: *Syfret Godlonton-Fuller Moore Inc*.

Endnotes

1 (Popup - Popup)

See *Castell v De Greef* 1993 (3) SA 501 (C) .