**IN THE HIGH COURT OF SOUTH AFRICA**
**(EASTERN CAPE DIVISION, BHISHO)**

**CASE NO. 326/2020**

In the matter between:

**MALUSI KHONONGO** **PLAINTIFF**

and

**MEC FOR HEALTH, EASTERN CAPE** **DEFENDANT**

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**JUDGMENT**

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**Rugunanan J**

[1] A fractured elbow described in medical terms as a severe intra-articulated fracture of the left distal humerus (the injury) fixated in theatre with percutaneous K-wires opined to be substandard treatment leading to malunion, functional impairment and ulnar nerve palsy is at the focus of this litigation. The plaintiff,

an adult male, claims damages arising from the treatment administered to him by medical staff of Frere Hospital, East London (the hospital), after he was involved in a motor vehicle accident on 1 October 2018 in which he sustained the injury to his left elbow.

[2] An overview of the material parts of the plaintiff's case are extrapolated from his particulars of claim as follows:

'3. [T]he plaintiff was admitted at Frere Hospital for surgery and medical care after sustaining a severe fracture of the left distal supracondylar ("the fracture") following a motor vehicle accident that occurred on the same date.

4. On the 3rd of October 2018, surgery was performed on the plaintiff, the fracture was treated and fixed by means of percutaneous K-wire fixation technique involving lateral to medial fixation of the fracture, and plaintiff was discharged on the 5th of October 2018.

5. On a follow-up visit to the hospital on the 22nd of October 2018, plaintiff was examined and it was found at that stage that the fracture had remained physically unchanged and the fixation in fact displaced. The plaintiff was further treated and discharged.

6. On a further review at the hospital on the [27th] of January 2019, the percutaneous K-wires were still in situ however, the bandages around the fracture were found soiled and the elbow had become stuff. Plaintiff was examined by a senior doctor, counselled about this development and outcome and then discharged.'

[3] This pleaded narrative of events is then followed by the legal duty of care which the plaintiff alleges arose by conduct or orally, alternatively tacitly and/or impliedly in terms of which the hospital staff were obliged to provide him with proper surgery, medical care, nursing care, advice, and supervision (the treatment) with reasonable skill, care and diligence.

[4] The particulars of claim thereafter disclose the development of complications to the plaintiff's injury which are alleged as follows:

'10. Following the plaintiff's medical review and discharge on the [27th] of January 2019 as aforesaid, the plaintiff's fracture healed badly leading to the development of a deformed and dysfunctional elbow with excruciating pain.

11. On the 24th of October 2019, x-rays were taken on the plaintiff's left elbow and the results revealed a malunion of the supracondylar fracture (distal humeral metadiaphysis) with shortening and lateral displacement of the distal fracture fragment.

12. The x-rays also revealed the existence of corticated bony fragments in the antral medial compartment with no evidence of any current or immediately sustained fractures or dislocations and with no distinct features of joint effusion.'

[5] Ensuing from the aforegoing are several grounds of negligence. These are pleaded to elucidate the breach of the legal duty of care, the plaintiff alleging notably that the defendants medical and nursing personnel:

'13.1 employed an inappropriate percutaneous K-wire paediatric fixation technique to the fracture which caused poor reduction from the outset, resulting in the fracture healing inappropriately;

…

13.6 … failed to employ the most appropriate, reasonable, adequate and recommended fixation treatment techniques to the plaintiff's elbow injury;

…

13.10 … failed to provide plaintiff with sufficient or effective post-operative care and monitoring to ensure that plaintiff recovers appropriately and timeously.'

[6] As a direct consequence of the substandard treatment, negligence and breach of legal duty, the plaintiff alleges the onset of sequelae entailing, *inter alia*:

'14.1 … a severe malunion of the supracondylar fracture after undergoing surgery and treatment;

14.2 [the development] of a very stiff, deformed, and dysfunctional elbow after the surgery and treatment;

14.3 [the development] of claw fingers, a weak grip, and loss of sensation as a result of damages (sic) to the ulnar nerve due to the deformity of the elbow;

[the development] of lateral displacement and shortening of the distal fracture fragment, after the surgery and treatment causing serious functional impairment of the elbow...'

[7] Save for the instances of negligence which the defendant denies, the allegations aforementioned are to a large extent not disputed, more particularly the defendant admits that the hospital falls under her jurisdiction and admits the duty of care owed to the plaintiff.

[8] At the commencement of the proceedings and by agreement between the parties the trial of the matter proceeded on the issue of the defendant's liability on the merits pursuant to an order under uniform rule 33(4).

[9] According to the parties' rule 37 minutes, it is common cause that the K-wire fixation procedure (the procedure/technique) was employed.

[10] In summary, the plaintiff's case is that the procedure was inappropriate and substandard – its utilisation by the medical and nursing staff employed at the hospital amounted to a negligent breach of the duty of care owed to him causing him to suffer complications and harm for which the defendant is legally responsible.

[11] While admitting that the K-wire procedure was performed on the plaintiff, in disputing liability, the gravamen of the defendant's case is pleaded as follows: '18. … [The] Plaintiff was accorded standard treatment, however what appeared to be his problem was him not following instructions given to him by hospital employees on how to handle his situation at home.'

[12] There are two legs to the defendant's case: *(a)* the K-wire fixation procedure was standard; and *(b)* the plaintiff did not accede to advice/instructions

given to him by hospital staff regarding the post discharge management of his injury.

[13] As to *(b)* it may as well be mentioned that no version was put to the plaintiff and the issue need not be dealt with further in this judgment. The unpleaded proposition put up during cross-examination of the plaintiff that his complications and sequelae were the result of the motor vehicle accident was not persisted with upon objection being taken.

[14] In addition to the pleadings are the joint minutes of the parties' experts, namely orthopaedic surgeons Dr P Mwangalawa and Dr N Mzayiya who gave testimony respectively for the plaintiff and the defendant. The minutes reflect the following agreement (all *sic*):

'1. Mr Malusi Khonongo was a passenger in a vehicle which was involved in an accident.

2. He sustained [a] severe intra-articulated fracture of the left distal humerus (elbow joint).

3. He had closed reduction and fracture fixed with percutaneous K-wire fixation technique stabilised with a back slab for 3 months.

4. The fractured elbow has healed with the deformity (malunion) and stiffness.

5. The elbow function, pain and osteoarthritis will progress further requiring more major surgical intervention like elbow arthroplasty.

6. We both know and agree that the standard treatment for intra-articular fractures is (ORIF) Open Reduction and Internal Fixation.

7. We both agree that Mr Khonongo's fracture did not undergo ORIF.

We disagree on the following:
We differ on the choice on the use of K-wire fixation technique in intra-articular fractures in adults.

Dr Mwangalawa believes that such technique is substandard.

DR Mzayiya is of the view that the preferred treatment did not have impacts on complications Mr Khonongo has.'

## Applicable legal principles for liability

[15] The plaintiff's claim is founded on negligence, that is, upon the absence of that reasonable skill and care which the law requires under the circumstances. In assessing the general level of skill of a practitioner, reference must be made to the branch of the profession to which the practitioner belongs. In *Medi-Clinic Ltd v Vermeulen*[1] the Supreme Court of Appeal appositely quoted the following *dictum* as regards the approach adopted by the English Courts:

'In *Bolam* McNair J, in summarising the true test for establishing negligence on the part of the doctor in medical negligence cases, said (at 122B - C): "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century. That clearly would be wrong." '

[16] It follows that the logical starting point to any enquiry into negligence commences with the standard of conduct of a reasonable person. In *Mitchell v Dixon*[2] the court pointed out that:

[1] 2015 (1) SA 241 (SCA) at paragraph [6].
[2] 1914 AD 519 at 525; *Medi-Clinic v Vermeulen* 2015 (1) SA 241 (SCA) at 243B.

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

[17] In deciding what is reasonable it was held in *Van Wyk v Lewis* that the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the medical practitioner belongs.

[18] A failure to observe a general level of skill and diligence may be negligent if it is found that the failure would not have been occasioned by a reasonably competent practitioner professing to have the standard and type of skill that the defendant held himself out as having.

[19] A medical practitioner would be negligent if they had failed to foresee the possibility of injury to a patient in circumstances where a reasonable person in their particular circumstances would have foreseen the possibility of injury to the patient and would have taken steps to avoid or prevent the injury. The first question to consider is therefore whether there was a failure to comply with the required standard of conduct of a reasonable person (a medical practitioner) in the particular circumstances.[3]

[20] In assessing the issue of reasonableness and negligence, the court often relies on the assistance of experts from the medical profession in navigating through the particular intricacies of the medical field. Although medical opinion

[3] The classic test has been formulated in *Kruger v Coetzee* 1966 (2) SA 428 (A) quoted from the headnote: 'In an action for damages alleged to have been caused by the defendant's negligence, for the purposes of liability *culpa* only arises if a *diligens paterfamilias* in the position of the defendant not only would have foreseen the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss, but would also have taken reasonable steps to have guarded against such occurrence; and the defendant failed to take such steps.
Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case.
Where the defendant has foreseen the possibility and taken certain steps, the *onus* is on the plaintiff to prove that there were further steps which he could and should have taken.'

is of value to the court, the ultimate decision of what is reasonable conduct in the circumstances is reserved for the court. Where expert medical opinions, as they often do, differ, the court will assess the evidence not by applying scientific standards, but by applying the legal standard of balance of probabilities.[4]

[21] In doing so the approach taken in the evaluation of expert testimony is founded on logical reasoning. In *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft fur Schadlingsbekampfung MBH*[5] (*Coopers*) it is authoritatively stated that:

'[A]n expert's opinion represents their reasoned conclusion based on certain facts or data, which are either common cause, or established by their own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of their opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.'

[22] Differently stated, a conclusion arrived at by an expert must be informed by logical reasoning underpinned by admissible facts (see generally *Michael v Linksfield Park Clinic*[6] 2001 (3) SA 1188 (SCA) 1200I-1201B).[7]

**The evidence**

[23] With the parties being in agreement that the standard treatment for intra-articular fractures is open reduction and internal fixation (ORIF), the issues to be

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[4] *MM V Netcare Hospitals (Pty) Ltd and Others* [2017] ZAGPPHC 474 para 81.
[5] 1976 (3) SA 352 (A) at 371F-G.
[6] 2001 (3) SA 1188 SCA 1200I-1202B.
[7] In *PriceWaterhouseCoopers Inc & Others v National Potato Co-operative Ltd & Another* [2015] 2 All SA 403 (SCA) para 98 the Supreme Court of Appeal cited with approval the English case of *National Justice Compana Naviera SA v Prudential Assurance Co Ltd ('The Ikarian Reefer')* [1993] 2 Lloyd's Rep 68 [QB (Com Ct] at 81-82 in which the duties of an expert witness were set out, namely; (1) Expert evidence presented to the court should be and should be seen to be the independent product of the expert uninfluenced as to form or content by the exigencies of litigation…; (2) An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his expertise… An expert witness in the High Court should never assume the role of an advocate; (3) An expert witness should state the facts or assumptions on which his opinion is based. He should not omit to consider material facts which detract from his concluded opinion; (4) An expert witness should make it clear when a particular question falls outside his expertise.

decided by this Court are whether the K-wire procedure was reasonable for an adult such as the plaintiff, and whether such treatment was causally connected to the sequelae he experiences. On these issues the parties relied on the testimony of their respective expert witnesses whose qualifications, credentials and experience were not disputed.

[24] To a large extent the plaintiff testified in support of the factual narrative contained in his particulars of claim which has been quoted earlier in this judgment. He was a satisfactory witness. He testified that his elbow joint was wired and his arm was fixed in a solid plaster cast. He maintained that upon discharge from the hospital on 5 October 2018 no instructions were given to him by the medical staff for the management of his elbow. His discharge was followed by three follow-up visits. It is common cause that these took place on 22 October 2018, 10 December 2018, and 27 January 2019. There is nothing significant in his evidence regarding the treatment given to him on each occasion, save that physiotherapy was recommended on the third visit – to which treatment he submitted.

[25] The medical records indicate that plaintiff was counselled about the outcome of his injury (the content of such counselling is not documented). In this regard he stated that he was informed that his arm was stiff and although it would not function as it previously did, he was at no risk of an amputation. He maintained that at no stage during any of his follow-up visits was he informed by attending medical/nursing staff that he was not taking proper care of his arm, post-operatively. Overall, he confirmed that on each of the follow-up visits his arm was x-rayed and the plaster cast removed and replaced with bandaging. As for his situation at present, he complained that his arm is functionally impaired. He is unable to drive with ease nor is he able to use a spade when he does home gardening.

[26] Cross-examination of the plaintiff was directed at the issue of causation. In other respects, not mentioned herein, it was unremarkable. It was put to the plaintiff that the attending doctors at the hospital informed him that his injury could not be conventionally treated. Precisely what was meant by conventional treatment was not put to the plaintiff, and the imputation was met with a denial. It was further put to him that a nursing attendant informed him that his arm would never be normal due to the severity of the injury. The plaintiff admitted that he was informed that his arm would never be normal but denied that it was due to the severity of the injury. He maintained rather that his expert witness informed him that the treatment given to him at the hospital was 'wrong' and that his arm ought to have been restored to normal function.

[27] I now deal with the expert evidence. To begin with, in a report dated 7 August 2023 the contents of which he confirmed, Dr Mwangalawa described the plaintiff's injury as an 'unstable displaced comminuted intra-articular fracture of the left distal humerus'. By definition, this type of fracture is characterised by the presence of three or more bone splinters. He testified that the principle in the orthopaedic management of an unstable fracture is to achieve alignment of the bony fragments as they were before the injury occurred. The targeted objective is to reduce the fracture to near normal as possible. The standard procedure for achieving this in adults is through open reduction surgery with the use of plates and screws. The fixatives serve to maintain anatomical alignment and prevent displacement of bony fragments.

[28] Percutaneous K-wiring, on the other hand, is a technique that does not involve open reduction surgery with the use of plates and screws. The technique entails the use of wires, with varying diameters – the largest of which is 2mm – to hold together bony fragments. The procedure is unsuitable for 'big bones' in adults – it is weak; it does not achieve stability and does not prevent displacement

of fragments. It may however be suitable for smaller bones such as those in the fingers or toes. The procedure has a negative outcome due to the fact that the wiring will not withstand muscular tension and will fail.

[29] Testifying on the plaintiff's hospital records, Dr Mwangalawa noted that the plaintiff was initially scheduled to undergo open reduction and internal fixation surgery. In point, the records indicate that the plaintiff consented to undergoing this procedure. However it did not happen and the percutaneous reduction technique entailing the use of K-wires was resorted to. For the plaintiff, this treatment was inappropriate – it did not conduce to stable rigid fixation to achieve near anatomical joint alignment. The outcome was poor – the plaintiff's elbow is deformed and stiff, the fracture has healed badly and the plaintiff has ulnar nerve palsy. In that regard, Dr Mwangalawa notes in his report that the K-wires were 'inserted blindly from a safe side to a dangerous area leading to ulnar nerve damage'. In all, Dr Mwangalawa maintains that the attending medical personnel ought to have known what the upshot would be for the choice of treatment rendered to the plaintiff.

[30] As for the plaintiff's follow-up visits, Dr Mwangalawa opined that on 22 October 2018 the plaintiff's injury was noted in the hospital records as 'swollen unchanged displacement'. This meant that the treatment initially given did not achieve reduction. A reasonable intervention at that stage would have entailed the removal of the percutaneous wire fixatives and recourse to open reduction and internal fixation surgery. As for the plaintiff's second visit on 10 December 2018, the hospital records indicate inter alia 'poor callus' formation (suggestive of non-union of the bony fragments); 'remove slab and mobilise elbow'; and 'keep K-wires in situ'. Dr Mwangalawa was of the view that the removal of the slab rendered the plaintiff's elbow joint movable and susceptible to complications. Even at this point in time, the percutaneous fixatives could have

been removed with open reduction and internal fixation being resorted to as a corrective procedure for remedying the non-union of bony fragments in the joint complex. On 27 January 2019 the plaintiff presented with soiled bandages, and the range of motion of his elbow was diminished. The hospital records disclose that the plaintiff was counselled about the poor outcome of his injury. On this occasion the dressings were removed and so too were the K-wire fixatives. According to Dr Mwangalawa, there was opportunity for resorting to an osteotomy and the insertion of plates and screws to stabilise the joint. In his opinion, the hospital records indicate that post operatively the medical and/or nursing staff knew that there was still displacement of the plaintiff's fracture and that they failed to take him back to theatre.

[31] The evidence of the defendant's expert, Dr Mzayiya, moves from the premise that the plaintiff sustained a high energy injury, hence the presence of multiple fragments would render the use of the K-wire technique appropriate since it would be difficult to determine where each fragment belongs. Put otherwise Dr Mzayiya appeared to suggest that anatomical alignment cannot be achieved in what he described as a 'bag of bones' scenario. When confronted by this during cross-examination Dr Mwangalawa indicated that such a statement is inconceivable from an orthopaedic surgeon. I agree.

[32] Dr Mzayiya accepted that the plaintiff was initially scheduled to undergo open reduction and internal fixation surgery but was of the view that the decision at ground level amongst the attending medical personnel might have changed. This line of thinking is speculative considering that no evidence was led from a factual witness.

[33] In cross-examination Dr Mzayiya conceded *inter alia* that the percutaneous K-wire fixation technique was inappropriate and inadequate for the purpose of

achieving stabilisation of the plaintiff's injury. The concession came about after the witness embarked upon a series of circuitous and evasive responses to fairly straightforward questions. When asked if poor callus formation meant that the bone was not healing after 8 weeks on plaintiff's follow-up visit of 10 December 2018, he stated that one could not comment at 8 weeks. When asked if he maintained that the K-wire fixation procedure was the best option for the plaintiff, he elected to list other treatments that were of no relevance to the plaintiff's injuries. He eventually conceded that he was speculating in that regard.

[34] In assessing the experts' evidence specifically on the issue of negligence, I am of the view that the evidence of Dr Mwangalawa is to be preferred since it bears the hallmark of logical reasoning and musters the threshold requirement/s set out in *Coopers*.

[35] In the joint minutes, the experts are in agreement that the standard treatment for the kind of injury sustained by the plaintiff is open reduction and internal fixation. It is trite that parties are bound by the facts agreed upon in a joint minute between their expert witnesses (see *Glen Marc Bee v Road Accident Fund*[8] and *Thomas v BD Sarens (Pty) Ltd*[9]). Dr Mwangalawa's evidence logically proceeds from the principle of the orthopaedic management of a fracture such as that sustained by the plaintiff – which principle recognises open reduction and internal fixation surgery as the standard for achieving union and stability.

[36] The deviation from employing the recommended standard of treatment (and the unexplained departure therefrom owing to the absence of a factual witness), in circumstances where the defendant's medical and nursing personnel

[8] 2018 (4) SA 366 (SCA) paras 64-66.
[9] [2012] ZAGPJHC 161 para 9.

reasonably ought to have foreseen the consequences of the deviation and ought to have taken steps to guard against such consequences, constitutes negligence.

[37] The final important question is to determine what causal role did the negligence play in the complications besetting the plaintiff and the consequent damage suffered by him.

[38] On the causation issue, the question to be asked is what would have happened if the negligent conduct or omission of the treating staff is mentally eliminated and hypothetically replaced with lawful conduct. If the plaintiff established that in such event his condition would on a preponderance of probabilities not have happened, he would be entitled to recover his damages because causation will be regarded as having been established as a fact.[10]

[39] In *Minister of Safety and Security v Van Duivenboden*[11] the Supreme Court of Appeal aptly summed up the position in the following terms:

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

[40] In testifying as he did, Dr Mzayiya expressed the view that despite open reduction and internal fixation being the treatment of choice it still carries the risk of complications such as stiffness. He proffered no comment on the occurrence of the risk of ulna nerve palsy which materialised as it did for the plaintiff – and indeed he was not asked to do so. Dr Mwangalawa's thesis of the K-wires being inserted blindly into a dangerous area of the fracture site stands uncontradicted.

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[10] International Shipping Company (Pty) Ltd v Bentley 1990 (1) SA 680 (A) 700F-701G.
[11] *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 26.

[41] A reading of the particulars of claim suggests that the plaintiff's pleaded case is that his complications are the direct consequence of the negligent substandard treatment occasioned by the use of percutaneous K-wires which occasioned nerve damage and the onset of clawed fingers. A mental elimination of the treatment rendered to the plaintiff and its substitution with the agreed orthopaedic standard sensibly leads to the conclusion that the plaintiff's condition and its impediments would not have materialised.

[42] I am therefore satisfied that causation is established.

[43] At the conclusion of the hearing the plaintiff contended for a costs award to include the employment of two counsel. In my view the matter was not of such complexity as to necessitate the employment of second counsel.

[44] In the circumstances I make the following order:

1. The separated issue of liability on the merits is determined in favour of the plaintiff and the defendant is held liable to pay 100% (one-hundred percent) of the plaintiff's agreed or proven damages suffered by him consequent to the medical treatment administered to the plaintiff upon his admission to Frere Hospital on 01 October 2018.

2. The issue of the plaintiff's quantification of damages is postponed *sine die*.

3. The defendant is ordered to pay the plaintiff's costs of suit on a party and party scale in respect of the determination of the separated issue of liability on the merits as follows:

    3.1 Costs up to and including 01 September 2023.

3.2 The costs of consultations, travelling and subsistence of the plaintiff's expert witness and legal representatives for the purpose of consultation and trial.

3.3 The costs in 3.1 and 3.2 shall be limited to the employment of one counsel.

3.4 The costs of reports, supplementary reports, qualifying expenses, and joint minutes in respect of the plaintiff's expert witness Dr Mwangalawa who testified on the issue of liability on the merits.

4. The costs shall include interest at the prescribed legal rate from a date 14 (fourteen) days after allocator to date of payment.

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**M S RUGUNANAN**
**JUDGE OF THE HIGH COURT**

Appearances:

For the Plaintiff: *L van Vuuren* and *Z Zito*, Instructed by Msitshana Incorporated, East London, Tel: 043-722 0603 (Ref: *Msitshana/Mawande*).

For the Defendant: *Z Nabela*, Instructed by The State Attorney, East London, Tel: 043-706 5100 (Ref: 464/20-P16 (*Ngcama*)).

Dates heard: 29, 31August 2023, 01 September 2023.

Date delivered: 23 November 2023.