IN THE HIGH COURT OF SOUTH AFRICA

(EASTERN CAPE DIVISION – PORT ELIZABETH)

CASE NO: 1717/2011

DATEHEARD:13,14,15/11/2013

DATE DELIVERED: 04/02/2014

In the matter between

NICOLENE MICHELLE HELMEY	**PLAINTIFF**
And	
MEC, DEPARTMENT OF HEALTH EASTERN CAPE	**1ST DEFENDANT**
THE MEDICAL SUPERINTENDENT LIVINGSTONE HOSPITAL, PORT ELIZABETH	**2ND DEFENDANT**

JUDGMENT

ROBERSON J:-

[1] On Saturday 23 May 2009 the plaintiff fell while holding a cup. The cup broke and caused certain injuries to the plaintiff's left hand. She was treated the same day at Livingstone Hospital, Port Elizabeth, which is an institution established, funded and managed by the Eastern Cape Provincial Administration. In this action she sues in

contract, alternatively in delict. She alleged that it was a term of an agreement concluded with the defendants that they or their employees would provide the requisite and necessary treatment with the professional skill, care and diligence as can be expected of a hospital and its medical personnel, alternatively that they were under a duty of care to provide such treatment. In breach of their obligation, alternatively duty of care, they failed to provide the necessary treatment, and as a result of such breach she suffered certain adverse consequences.

[2] In her particulars of claim the plaintiff described the injuries suffered at the time she fell as a serious laceration of the palm of her left hand, the severing of certain tendons, and nerve damage. The focus of her claim was on the tendon damage. She pleaded as follows:

> "11 In breach of the agreement, alternatively the legal duty set out above, the First and/or Second Defendant and/or their employees, acting within the course and scope of their employment and/or under his/its authority were negligent in that he/she/they:
>
> 11.1 Failed to appoint medical practitioners and/or medical personnel with sufficient qualifications and/or experience so as to ensure that the medical practitioners and/or medical personnel attending to the Plaintiff for treatment of the injuries described in paragraph 4 above would provide adequate and/or appropriate treatment to the Plaintiff;
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> 11.2 Failed to, adequately or at all, examine the Plaintiff and/or explore the laceration sustained by the Plaintiff, and in particular whether the Plaintiff had sustained any tendon and/or nerve damage as a result thereof when, in the circumstances, they could and should have foreseen that certain tendons in the Plaintiff's hand may have been severed.
>
> 11.3 Failed to immediately or within a reasonable period of time refer the Plaintiff to an operating theatre and, under regional or general anaesthesia and tourniquet control examine and/or explore the laceration sustained by the Plaintiff in order to properly assess the full nature and extent of tendon and/or nerve damage to the Plaintiff's hand;

> 11.4 Failed to immediately or within a reasonable period of time perform a tendon repair on the Plaintiff's hand when, in the circumstances, it could and should have been done;
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> 11.5 Failed to adequately or at all monitor the condition of the Plaintiff so as to ensure that the Plaintiff recovered from the laceration and severed tendons in her hand, prevent the wound from becoming septic and prevent the loss of sensation, movement and function of her ring and little fingers, when, in the circumstances, they could and should have done so;
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> 11.6 Failed to adhere to the reasonable standards of medical practice applicable to a Hospital and its Doctors and nursing personnel."

[3] The plaintiff alleged that as a consequence of the negligent treatment she has suffered a loss of sensation in her little and ring fingers, loss of movement and function of her little and ring fingers, and frequent and severe pain in her upper and lower left arm, extending to her neck.

[4] The defendants admitted that the plaintiff sustained a laceration to her left hand which caused some of the tendons in her little finger to be severed, and that she received treatment at Livingstone Hospital in the form of sutures to her left hand. They admitted the contractual obligation and the duty of care as alleged, but qualified such admissions by adding that the plaintiff would be treated with such skill, care and diligence as can reasonably be expected of a provincial hospital and its personnel. The defendants denied the alleged breach and the consequences.

[5] By agreement, I ordered in terms of Rule 33 (4) that the issues of liability and quantum be separated and the trial proceeded on the issue of liability.

[6] The plaintiff testified that when she was cut by the cup she suffered a burning pain and the wound bled profusely. She put a pressure bandage on the wound, which she demonstrated in court as being across almost the breadth of her palm a little below the fingers. She realised she should immediately go to hospital and was taken to the casualty department at Livingstone Hospital. She showed her injured hand to the sister at casualty who immediately referred her to the doctor. The doctor and a sister were at the time treating a patient's head wound and the plaintiff waited her turn. When the doctor finished he asked her what the problem was. She showed him her hand. He leaned over her and looked at her hand, but did not take hold of it or examine it, nor did he ask her to move her hand. He instructed the sister, Sister Swiegelaar, to stitch the hand.

[7] Sister Swiegelaar tried to clean the wound and when she bent the plaintiff's fingers back the plaintiff felt severe pain. Sister Swiegelaar cleaned the wound, which was gaping, and the plaintiff saw white pieces in the wound which she thought were bits of the cup. Sister Swiegelaar felt the white pieces and said they were tendons which had been cut, that she could not stitch the wound, and that the doctor had to stitch it. At this time the doctor was attending to another patient. Sister Swiegelaar drew the doctor's attention to the plaintiff's hand and told him that the plaintiff could not straighten her fingers. The doctor again leaned over her and looked at her hand. He did not take hold of the hand or ask her to open it. He told the sister that the pain prevented the plaintiff from opening her hand and that the tendons were not cut, and that the sister must stitch the hand. Sister Swiegelaar said she was not going to stitch the hand and

that the doctor must do so. Sister Swiegelaar explained to the plaintiff that the doctor should first stitch internally, then externally. Another sister looked at the hand and said that the tendons were definitely cut and that the doctor must stitch the hand.

[8] Sister Swiegelaar then administered local anaesthetic to the plaintiff's hand and told her to wait for the doctor. After Sister Swiegelaar repeatedly tried to get him to stitch the plaintiff's hand a young boy came in with a head injury. The doctor attended to him and as he was about to leave Sister Swiegelaar prevented him and told him that the plaintiff was still waiting. The doctor asked Sister Swiegelaar if she had stitched the hand and Sister Swiegelaar replied that she did not want to take the risk and that the doctor should do it. The doctor tried to clean the wound, at which it began to bleed again. He stitched the Plaintiff's hand while her fingers were bent (she demonstrated at a 45 degree angle), bandaged it, and told her she should get her card and medication from Sister Swiegelaar. Sister Swiegelaar gave her a card and tablets for pain. When she was told that according to the records she had been given antibiotics and an antibiotic injection, she said Sister Swiegelaar had said the tablets and the injection were for the pain. On the card it said that she should go to the Chatty clinic on 29 May 2009 for the removal of the stitches.

[9] The plaintiff went home and was in severe pain for the whole weekend. She went to work on the Monday but left early because of the pain. The pain was so severe that on 27 May 2009 she consulted a private doctor, Dr. Mayet, who removed the bandage and saw that the wound was gaping and swollen. He told her the wound was

septic and prescribed pain tablets and an antibiotic. When she was referred to Dr. Mayet's comment in his report, "movements of limb ok", she said that Dr. Mayet had not examined her hand and had only removed the bandage and looked at the wound. She went to the clinic on 29 May 2009. The wound was swollen and raw, and the sister told her that she could not remove the stitches, and that she should come every second day for treatment. The plaintiff did so and every second day the bandage was changed. This process endured for about two weeks and then the stitches which remained were removed.

[10] She next consulted another private doctor, Dr. Jakoob, who arranged for an appointment for her at Livingstone in October for tendon repair. Dr. Yakoob told her to try to get an earlier appointment and she returned to Livingstone in August 2009. She underwent a procedure which she was told was an attempted tendon repair.

[11] Sister Colleen Swiegelaar testified that on 23 May 2009 she was on duty in the casualty department at Livingstone Hospital. She did not remember the plaintiff but testified about protocol in the case of hand injuries. Cuts to the hand were attended to by a doctor who would examine the hand and if the patient was able to flex and extend the hand it was assumed that the tendon was intact and the doctor would stitch the wound. It was against protocol for sisters to stitch hand wounds. Whether or not a tendon was visible in the wound made no difference to the protocol. If a patient's hand did not function the wound would not be stitched and the patient would be referred to the orthopaedic section for an expert opinion and a decision on treatment.

[12] The plaintiff's expert witness was Dr. Basil MacKenzie, an orthopaedic surgeon whose qualifications and expertise were not in dispute. He examined the plaintiff on 25 May 2010 and prepared a medico-legal report. He recounted the history of the accident and treatment which the plaintiff had given him and which was in line with her evidence. He referred to the clinical record of the plaintiff's visit to Livingstone Hospital on 23 May 2009. This document did not contain the date or the plaintiff's name. It reflected that the patient was a 40 year old lady with an 8cm laceration of her left palm which was stitched with nylon. It also reflected that certain medication had been administered. Dr. MacKenzie referred to a note dated 30 June 2009 compiled by Dr. Yakoob which reflected that the plaintiff was unable to extend her ring and little fingers and that there was loss of sensation and early muscle wasting. The note further reflected that Dr. Yakoob suspected flexor tendon damage and referred the plaintiff to Livingstone Hospital.

[13] According to a physiotherapy note dated 30 July 2009, an occupational therapist noted loss of sensation in the plaintiff's little finger and it was then suggested that surgery be performed to explore and possibly suture the lacerated tendons. Dr. MacKenzie referred to the surgeon's note of a procedure known as tenolysis performed on the plaintiff on 14 August 2009. This report reflected that tenolysis was carried out on the flexor tendons of the plaintiff's little finger. The previous laceration scar was excised and the excision extended proximally and distally. The flexor digitorum profundus (FDP) which is the deeper of the two flexors, was adherent to the tendon

sheath and the flexor digitorum sublimis (FDS) was attached only to the lateral aspect of the little finger. Dr. MacKenzie agreed that the surgeon was trying to convey in that note that the FDS tendon was not totally severed.

[14] During the operation the FDP tendon was released from surrounding fibrotic tissue and the wound was closed. Dr. MacKenzie agreed that one could not deduce from the surgeon's note that the FDP tendon had been severed but said it was important to know in what position the hand was when it was cut. He agreed that the surgeon did not say that he found the proximal ends of the FDP tendon but did not know if the surgeon actually looked for them. He said that the surgeon might not have stated the obvious, because if there was no flexor tendon function the tendons must either be severed or severely damaged. He was of the view that the surgeon could not have exposed the entire tendon because that would have destroyed what was left of the fibrous sheath. He said that the report could be interpreted in various ways. He agreed it was difficult to ascertain exactly what had happened but his strong feeling was that the plaintiff suffered a severance of the FDP tendon and partial severance of the FDS tendon, as a result of the laceration to her palm. He explained that in a tenolysis procedure, which is a freeing up of a tendon from scar tissue and adhesions, one is dealing with distorted anatomy and nothing looks normal. There is a big mass of scar tissue, which in the plaintiff's case was made worse by the sepsis. It appeared from the operation note that no formal suture of the tendons of the little finger was practicable and would have been ambitious.

[15] Dr. MacKenzie was of the opinion that the plaintiff still suffers from a severed tendon and that this condition occurred on 23 May 2009. When Dr. MacKenzie examined the plaintiff, she had a progressively lesser range of motion from the index finger through to the little finger. The restricted movement in her little finger was a result of the damage and arthro-fibrosis. The FDP and FDS tendons to her index and middle fingers were functioning adequately. The FDS tendon to her ring finger was functional but the FDP tendon was not fully functional. He could not detect any FDP or FDS function in her little finger. The plaintiff's left hand was generally colder than her right hand and there was a purple discolouration especially of the tips of her ring and little fingers. Her little finger also lacked pseudo motor function. The plaintiff complained that her little finger lacked sensation and there was disturbed sensation of the ring finger. Dr. MacKenzie said that loss of sensation indicated nerve damage which meant that there had been a total severance of the tendon and that could only have happened when the plaintiff fell with the cup.

[16] Dr. MacKenzie went on to state that the plaintiff's little finger was anaesthetic and the ring finger hypoaesthetic. The little finger lacked tactile sensation and was stiff and functionless, and there was no likelihood of improvement. He was of the view that another doctor's suggestion of amputation of the little finger had merit. He examined the plaintiff on the day of the trial and found a little bit of sensation on the side of the ring finger. He detected FDP and FDS tendon function in the ring finger but none in the little finger. This meant that there is a severed or damaged tendon in the plaintiff's little

finger. The plaintiff's ability to flex her little finger 90 degrees at the metacarpophalangeal joint was attributable to muscle function.

[17] Dr. MacKenzie said that an 8cm wound is quite big and the vital structures in the hand are fairly superficial and therefore vulnerable. There is the skin, the palmar aponeurosis, subcutaneous tissue, and then the tendons and nerves. With regard to the plaintiff's evidence that something white was seen in the wound, Dr. MacKenzie said that a tendon presents as something white. If a hand is bleeding, it is difficult to assess accurately precisely what has happened and if a busy doctor in a big regional hospital is not totally certain of himself, he is able to refer the patient to someone more familiar with hand anatomy and the implications of hand injuries. If there is the slightest hint of tendon damage it should be investigated. The plaintiff's complaint of pain which was aggravated by an attempt to extend the fingers, would have indicated to him that the wound was probably deeper than the skin. A reasonable doctor who knows he can send the patient nearby for a more expert opinion, will do so. If there is no nearby orthopaedic department, the doctor should make use of other facilities, for example a regular orthopaedic outpatient clinic, preferably within no more than five or six days, and within a maximum of ten days.

[18] Given the plaintiff's symptoms and the treatment she received, Dr. MacKenzie was of the view that the gravity of the situation had not been fully appreciated. He did not believe that the treatment was, in the circumstances, performed with reasonable skill, care and diligence. He said that the extent of the plaintiff's injury could have been

determined fairly simply by doing a few standard tests to determine whether there was sensation and which specific tendons were damaged. He was of the opinion that if the doctor who treated the plaintiff had initially assessed the injury and referred the plaintiff to orthopaedic personnel the resulting situation would have been more favourable and she would probably have been able to use her little finger. The orthopaedic unit of the Port Elizabeth Hospital Complex is at Livingstone Hospital.

[19] In his report, under the heading "Opinion and Prognosis", Dr. MacKenzie stated, *inter alia*:

> "With the advantage of hindsight, it would seem reasonable to argue that, on the occasion of her first visit to Livingstone Hospital, the nature and extent of the injury of Mrs. Helmey's left hand was not fully appreciated.
>
> Ideally, if there is a suspicion that tendon and nerve damage has occurred as a result of a palmar laceration, the patient should be taken to the operating theatre where under regional or general anaesthesia and tourniquet control the wound should be explored and the full nature and extent of tendon and/or nerve damage assessed. This can seldom be done properly under local infiltration or without creating a bloodless field through the application of a tourniquet. ……."

[20] Dr. MacKenzie said that if the plaintiff had been referred to the orthopaedic section, there would have been a proper examination to determine which tendons were severed, whether or not there was sensation, and which nerves were affected. If it was a regional hospital, the plaintiff would have been referred to the operating theatre where under anaesthetic a tourniquet would have been applied to create a bloodless field and an unequivocal diagnosis made. The FDS tendon could have been sacrificed and the FDP tendon could have been sutured as a primary procedure. The likelihood of sepsis

would also have been significantly reduced. He said that sepsis in hand lacerations is common, especially if initial precautions are not taken. In the plaintiff's case, suturing the skin and giving antibiotics is not the ideal way to treat hand lacerations. Dr. MacKenzie agreed that the ensuing sepsis was a severe set back but a different scenario would have occurred had the protocol been followed. In his view, if a tendon is left unsutured, it will form adhesions and the main effect of the sepsis in the case of the plaintiff was to make a bad situation worse. He could not dispute that if no sepsis had occurred and the plaintiff had gone to the clinic and been referred for tertiary care, she would have received the necessary treatment. However he reiterated that the consequences suffered by the plaintiff could have been avoided if sufficient care had been taken at the outset to establish a definite diagnosis.

[21] Dr. MacKenzie prepared an addendum to his report by way of a letter to the plaintiff's attorneys, in which he stated as follows:

> "As you mentioned, in my report I referred "obliquely" to what in my opinion constitutes appropriate management of a patient with a laceration of the hand where there is a suspicion of associated tendon and/or nerve damage.
>
> Based on Mrs. Helmey's account of what transpired, the treatment measures I described were not adhered to. Accordingly, it is my opinion that reasonable standards of medical practice probably where not adhered to in this case.
>
> The delay of more than ten days in treating the injury, i.e. the "tenolysis", never was likely to afford Mrs. Helmey an outcome of treatment equal to what could have been achieved had she been managed appropriately within the first ten days following her injury."

[22] Dr. MacKenzie was referred to the defendants' expert report of Dr. Sobamowo Oluwadayo, who was the doctor who treated the plaintiff on 23 May 2009 and completed the brief note referred to in paragraph [12] above. His expert report elaborated on his initial note and added that the plaintiff was clinically stable, that movement of the hand and fingers was intact, and that sensation and circulation were intact. The report further stated that she was discharged for follow up at the local clinic for dressing and removal of sutures.

[23] Dr. MacKenzie pointed out that movement, circulation and sensation were not mentioned in the initial note, and anyone who appreciates the seriousness of hand injuries would note in the first report that sensation and tendon function had been tested and found intact. He said that the reference to movement did not state the extent to which the plaintiff could flex her little finger, which would be reconcilable with the finding at the time of the tenolysis. The fact that one part of the FDS tendon was still attached meant that the finger could have worked to a certain extent. However the report said nothing about the FDP tendon, which is the more important one. In order to determine whether the FDP tendon is functional, certain tests have to be done. Flexion of the metacarpophalangeal joints is done with hand muscles and does not require the long flexor. The fact that the plaintiff could move her fingers did not exclude a flexor tendon injury and a blanket statement that a person can move her fingers does not exclude a diagnosis of flexor tendon injury. With reference to Dr. Mayet's comment "movements of limb ok" Dr. MacKenzie said that Dr. Mayet did not specify the fingers and that the plaintiff would have been able to move at least four of her fingers anyway.

[24] Dr. MacKenzie was referred to articles by experts on treatment of severed tendons and the opinions expressed that tendon repair should be carried out at a later stage. He said that he was not advocating primary tendon repair across the board but in the present case “they missed the boat” on the day of the injury, and that was when the damage was done. He referred to an article in which it was stressed that the initial management of the hand is probably more crucial than the entire treatment programme. In the plaintiff’s case, the only forward planning was the referral to a clinic for the removal of the stitches. He did not think it was fair merely to give the plaintiff antibiotics and send her away.

[25] Dr. MacKenzie agreed during cross-examination that the casualty department at Livingstone Hospital is busy and overcrowded at weekends, and that a higher standard of care could be obtained at a private hospital. However in his view a doctor with a basic MBChB who has done his housemanship and has worked as a casualty officer, and who is presented with an 8cm laceration of the hand, would think there was more to the injury than meets the eye, and would refer the patient to an orthopaedic surgeon or a dedicated hand surgery unit.

[26] Dr. Oluwadayo testified. He qualified as a doctor in Nigeria in 2005 and has worked as a senior medical officer in various sections of the Port Elizabeth Hospital Complex, including the trauma unit at Livingstone Hospital since 2008. Over weekends two medical officers work a twelve hour shift and will see at least fifty patients.

[27] With regard to patients with hand lacerations, he said that one must keep in mind that there may be a tendon injury and before the injury is repaired, the doctor must first test for movement of the hand or finger, circulation and sensation. If all three aspects are intact, the repair can be carried out. If there is loss of movement, circulation or sensation, the patient would immediately be referred to the orthopaedic section. He did not think it was necessary to send every patient to the orthopaedic unit to check for an injury which can be checked at the casualty unit. A sister will not attend to a hand although some of them are trained in stitching and can stitch for example a wound on the head or elsewhere on the body. However a hand is a vital organ and must be attended to by a doctor.

[28] Dr. Oluwadayo had no independent recollection of attending to the plaintiff and had to rely on his initial note. He could not remember how busy the unit was that day. He testified that the plaintiff came in with an injury to her left little finger. He examined her and checked for movement, sensation and circulation, which were all intact. He specifically said that there was movement of the fingers, which meant that there was no tendon laceration. The test for movement is performed by asking the patient to flex and extend their hand. If he had found a cut tendon he would have referred the plaintiff to the orthopaedic unit. He did not agree that a person will still be able to move their hand if there is a cut tendon, but said that if there is a partial cut one can move a finger.

[29] He cleaned the plaintiff's wound and while doing so did not observe any tendons or anything else which was cause for alarm. He then stitched the hand. He disagreed that he had instructed the sister to stitch the hand and said that the sister was not allowed to do so. The plaintiff was given an antibiotic injection and discharged with oral antibiotics and analgesics, and told to go to the out-patient clinic in seven days for removal of the stitches. Dr. Oluwadayo was referred to a document dated 23 May 2009 on which he had written the medication given to the plaintiff, namely an antibiotic and an analgesic.

[30] He acknowledged that the failure to note the date and time on the initial clinical note was an oversight. He did not note the plaintiff's blood pressure or temperature but said that would have been recorded by the nurse on a separate document. His note was the doctor's note.

[31] He prepared his expert report by checking his initial note. He noted in his expert report that the plaintiff was clinically stable. He did not include that observation in his initial note but said that if there had been any instability he would have noted it and that one does not need to record everything that is observed. In his expert report he stated that movement of the hand and fingers was intact and that sensation and circulation were intact. The omission of these observations in his initial note did not mean that he had not performed the tests. He agreed that they were very important tests. His failure to record these tests was not an oversight because there was no injury to the tendon. In his expert report he stated that the plaintiff had been referred for follow up to the local

clinic for removal of the stitches. He said that in an emergency setting it is not necessary to include everything in the initial note and it is not necessary to include in the initial note that the patient is to go to the clinic for removal of stitches. He would have referred the plaintiff for follow up at the clinic and have advised her how to manage her hand.

[32] Professor Gert Vlok was the second expert who testified on behalf of the defendants. He is an orthopaedic surgeon and his extensive qualifications and expertise were not in dispute.

[33] With regard to the difference between private and public hospitals, he was of the view that sometimes a person does not get the best treatment in a tertiary institution and that the best level of care in his experience is at the secondary level, where there are specialists and good medical officers. He did not altogether agree with Dr. MacKenzie's evidence that there was a significant difference between Greenacres Hospital and Livingstone Hospital and said that secondary hospitals deliver on average a good service.

[34] Professor Vlok examined the plaintiff in 2012 and found that the FDP tendon was not functioning. He was of the opinion from the information available to him, that there had only been a partial severance of the FDS tendon and that the rest of the condition was fibrosis. His analysis of the tenolysis operation note was that there was a partial severance of the FDS tendon. He examined the plaintiff the day before he testified and

found that she could move the whole finger. This meant that the FDS tendon, although partially severed, was still functioning. He did not think that amputation was necessary. He agreed that Dr. MacKenzie was right when he said there would be movement even if the tendon is severed, but not the movement which the plaintiff has. He was of the view that the FDP tendon had not been severed and that it was not functioning because of fibrosis. If the plaintiff had felt pain when her hand was opened, this meant that both flexor tendons were functioning, even though the FDS tendon was partially severed. With regard to the fibrosis which was present when the tenolysis was performed, Professor Vlok said it was caused by the initial injury which healed with scar tissue, and next by the sepsis, which creates fibrosis. The originating factor was the original trauma. If there had been no sepsis, the plaintiff would have gone to the clinic and the stitches would have been removed. If the finger was stiff she would have needed treatment of the flexor tendon for mobility, but its normal function would not be restored. In his view, the sepsis played a major role. It delayed mobilisation, and he thought it played a role in the plaintiff's current problem which he termed reflex sympathetic dystrophy.

[35] Professor Vlok was satisfied with the treatment the plaintiff received in the casualty unit of a secondary hospital. He relied for this opinion on the documentation he had seen, his examination of the plaintiff, the evidence he had heard in court, and his experience of a secondary hospital casualty unit on a Saturday. With regard to what had been done by Dr. Oluwadayo, he mentioned that Dr. Oluwadayo had thought that it was not necessary to refer the plaintiff to a specialist clinic because there were certain

things about which he was satisfied, presumably referring to the tests he said he had carried out. Professor Vlok accepted that the tests were done as described by Dr. Oluwadayo. He did not think that anything was wrong with the treatment given to the plaintiff. He said that Dr. Oluwadayo was a qualified and reputable doctor who had not employed the wrong test and had treated the plaintiff to the best of his ability. Having regard to the position of the plaintiff's hand and the pain at the time, as well as the evidence of Dr. Oluwadayo, Professor Vlok did not think that there was a suspicion that the tendons were damaged, and said that Dr. Oluwadayo was confident that the tendons were intact. Dr. Oluwadayo said it was a simple wound and was sure that there was no tendon laceration. He also said that there was movement of the plaintiff's fingers. If her little finger had been lying straight that would have indicated that the flexor tendons were severed. In an ideal situation each patient would have to be taken to theatre and that would not be practical. Even if Dr. Oluwadayo had properly performed the tests he said he did, he would not have been alerted to the partially severed FDS tendon. Professor Vlok said if Dr. Oluwadayo had thought that the tendons were severed he would have referred the plaintiff to the orthopaedic unit.

[36] When asked about something white being visible in the wound, Professor Vlok explained that white subcutaneous fat pinnacles are often seen in an open wound. He said that it is very difficult to see a tendon in a cut of the hand. With regard to sensation, he said that Dr. Oluwadayo said that sensation was intact, and that the first mention of loss of sensation was by Dr. Yakoob, a month later. When it was put to him that it was possible there was a loss of sensation as a result of the injury on 23 May

2009, he said he could not argue with the proposition and that if there was loss of sensation six weeks later it probably was as a result of the injury. He could not say if the infection played a role.

[37] Professor Vlok was referred to Dr. Mayet's note that "movement of the limb was ok" and said that it was a very broad statement. He was of the view that Dr. Mayet's treatment with antibiotics was correct. At this stage it would not have been proper to open the wound and explore for tendon damage because sepsis was the priority.

[38] Professor Vlok said that if it was accepted that the tendon was severed, or there was a suspicion that it was severed when the plaintiff arrived at the casualty unit, he would have stitched the wound and referred her to the hand unit within a maximum of seven days, where the wound would have been explored in theatre. If there was a severed tendon, it would be wrong not to refer the patient. If he had a suspicion that there was more to the wound he would have explored it. He said that when he was a younger orthopaedic surgeon working in casualty, before he stitched a wound it would be cleaned and explored and debrided and tests would be done. However he said one must remember that in the plaintiff's case it was a Saturday afternoon (presumably meaning in a busy casualty unit).

[39] Professor Vlok was asked what the outcome would have been if the plaintiff had been referred to a specialised unit on 23 May 2009 or shortly thereafter and evaluated there. He said that a partially severed FDS tendon does not require stitching. The

wound would have been stitched, a note made that there was a partially severed tendon, and the plaintiff would have had physiotherapy and occupational therapy for mobility. The only difference referral would have made was that physiotherapy and occupational therapy would have commenced earlier. He thought that the infection would still have occurred because it occurred from the start. There is a 10% risk of infection of non-surgical hand wounds.

[40] It is necessary first to resolve the factual dispute concerning Dr. Oluwadayo's treatment of the plaintiff on 23 May 2009. I can find no reason to find fault with the evidence of the plaintiff. Her evidence was consistent with a busy casualty unit at the weekend. She remembered specific details of the other patients who were treated while she waited to be stitched. I cannot see why she would have fabricated her evidence about Dr. Oluwadayo's request to Sister Swiegelaar to stitch the wound. As a layperson she would not know what the correct medical protocol was and her account accords with both Sister Swiegelaar's and Dr. Oluwadayo's description of protocol in that Sister Swiegelaar was not prepared to stitch the wound. She said that Dr. Oluwadayo had cleaned the wound before stitching it. If she had wanted to fabricate lack of care on his part she could have omitted this evidence. Moreover, her evidence accords with Dr. Oluwadayo's initial note, which does not mention tests done for movement, sensation and circulation. It was Dr. Oluwadayo's and Sister Swiegelaar's evidence that in the case of a hand wound tests are to be done for possible tendon damage, and that if there is suspected tendon damage the patient will be referred to the orthopaedic unit. It would therefore be crucial to note that tendon damage was excluded. In my view the

brevity of the note and the absence of the plaintiff's name and the date on the note, is consistent with the plaintiff's description of how she was treated. The plaintiff also had reason to remember the events of that day, whereas Dr. Oluwadayo, understandably, had no independent recollection and had to rely on his note and reconstruct what would have happened. I therefore conclude on the probabilities that Dr. Oludawayo did not perform the tests he said he did. I would add that I take no account of the plaintiff's evidence that the sisters said there was tendon damage. This was hearsay and not confirmed by Sister Swiegelaar.

[41] In *Castell v De Greef* 1993 (3) SA 501 (C) at 512A-B Scott J said the following with regard to medical negligence:

> '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] All ER 267 (HL) at 281b).'

[42] I think I can accept from the expert evidence that the exercise of reasonable skill and care in the event of a hand wound such as that sustained by the plaintiff, includes the assessment for tendon damage. I did not understand Dr. MacKenzie or Professor Vlok to differ on this point. Professor Vlok's opinion was largely based on an acceptance that Dr. Oluwadayo had performed tests for tendon damage and was satisfied that there was no damage. Having found that Dr. Oluwadayo did not perform such tests, Professor Vlok's opinion that the standard of care was satisfactory largely falls away.

[43] In my view, the attempt by the defendants to suggest that some lesser standard of care can be expected at a provincial hospital, is not supported by the evidence. While I accept that the casualty unit at Livingstone Hospital is busy over weekends, in the present case there was no evidence of a lack of staff or equipment. Sister Swiegelaar and Dr. Oluwadayo both had the knowledge that tests for tendon damage were required and did not suggest that there was no time to perform such tests at weekends. The orthopaedic unit was housed at Livingstone Hospital. As Dr. MacKenzie said, a doctor with a basic MBChB who has done his housemanship and has casualty experience, would think that there was more to the injury than met the eye. Professor Vlok, when referring to his younger days, said that before stitching he would have explored and debrided the wound but attempted to qualify such care by referring to a busy casualty unit. However I am satisfied that the conditions at the time were no excuse for not assessing the wound for tendon damage and I am of the view that the treatment of the plaintiff by Dr. Oluwadayo on 23 May 2009 fell below the reasonable standard of skill and care required. A reasonably competent practitioner would not have failed to test for tendon damage and proceeded merely to stitch the wound without any further treatment plan other than the removal of stitches.

[44] Dr. MacKenzie and Professor Vlok were substantially in agreement concerning the plaintiff's present symptoms, although Professor Vlok did not think that amputation is necessary. They differed on the extent of tendon damage, Dr. MacKenzie maintaining that the FDP tendon was severed and the FDS tendon partially severed, whereas Professor Vlok was of the view that the FDP tendon was not severed and the

FDS tendon partially severed. In their plea, the defendants admitted that **some** of the tendons in the plaintiff's little finger were severed. Professor Vlok's evidence says otherwise. Dr. MacKenzie and Professor Vlok supported their different conclusions with reference to various factors, including an analysis of the note of the tenolysis procedure. Dr. MacKenzie attributed the current lack of function of the FDP tendon to its severance, whereas Professor Vlok attributed it to fibrosis. I am of the view that the reasons they gave for reaching their respective opinions were equally cogent and am unable to accept one opinion in preference to the other. Mr. Mouton, who appeared for the plaintiff, did not submit that Professor Vlok's evidence should be rejected.

[45] The point is that the plaintiff has been left with the physical defects described, subsequent to her treatment at Livingstone Hospital on 23 May 2009. Whichever of the tendons was damaged, no tests or examinations were done to exclude tendon damage. The chain of events, including sepsis and fibrosis, was set in motion on 23 May 2009. I do not think that the sepsis can be regarded as an intervening event which caused the plaintiff's present condition. As Dr. MacKenzie said, if her wound had been properly evaluated in the orthopaedic section under the conditions described, the risk of infection would have been significantly reduced. Even if the injury had not been treated there and then in the orthopaedic unit, there would have been a follow up within the appropriate time period. Instead the plaintiff was sent away with no plan for future tendon treatment. By the time the sepsis cleared up and the symptoms of tendon damage were discovered, it was too late. I do not think that Professor Vlok's evidence that the tendon damage would not have been detected even if Dr. Oluwadayo had

performed the tests he said he did, assists the defendant. Dr. Oluwadayo did not describe in detail which tests he performed and he knew that there can still be movement with a partially severed tendon. Professor Vlok himself said, albeit referring to his younger days, that before stitching he would have explored and debrided the wound. This was not done when it could have been done.

[46] It is correct, as was submitted on behalf of the defendants, that the doctrine *res ipsa loquitur* rarely applies in medical negligence cases. (See *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) at para [16].) However in the present case it is common cause that at least a partially damaged tendon was there from the start and was not detected because Dr. Oluwadayo failed to treat the plaintiff with the required standard of care. I do not think that Dr. MacKenzie's use of the words "with the benefit of hindsight" changes that position.

[47] I am therefore satisfied that the plaintiff proved the breach of the defendant's obligation or duty of care as alleged, and that such breach caused the condition and sequelae from which she now suffers.

[48] The plaintiff asked for the costs of two counsel in the event of a finding in her favour. Considering the expert evidence and the divergent opinions, I am of the view that the matter was sufficiently complex to warrant such an order.

[49] I make the following order:

[49.1] It is declared that the defendants are liable for 100% of such damages the plaintiff may prove.

[49.2] The defendants are to pay the costs of the trial to date, as well as interest thereon at 15,5% per annum from date of allocatur to date of payment, such costs to include the costs of two counsel.

[49.3] The above liability for damages and costs is joint and several, the one paying the other to be absolved.

[49.4] The issue of quantum is postponed sine die.

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J M ROBERSON
JUDGE OF THE HIGH COURT

Appearances:

For the Plaintiff: Adv P Mouton, and AdvN Barnard, instructed by G P van Ryn, Minaar & Co Inc, Uitenhage

For the Defendants: Adv B Pretorius, instructed by the State Attorney, Port Elizabeth