Reportable:	**YES** / NO
Circulate to Judges:	YES / NO
Circulate to Magistrates:	YES / NO

IN THE HIGH COURT OF SOUTH AFRICA

NORTHERN CAPE DIVISION, KIMBERLEY

Case No: 1342/2014
Argued: 22/06/2017
Delivered: 13/09/2017

In the matter between:

PATRICK GERT ERASMUS **PLAINTIFF**

And

THE MEC FOR HEALTH: NORTHERN CAPE GOVERNMENT **1ST DEFENDANT**

DR CASPER KRUGER **2ND DEFENDANT**

JUDGMENT

MAMOSEBO J

[1] The dispute in this case emanates from the history given by the plaintiff, Mr Patrick Erasmus, to his General Practitioner, Dr Casper Kruger, initially cited as the second defendant, in respect of the symptoms with which he presented which led to a diagnosis made by employees of the first defendant, the MEC for Health, Northern Cape Province. There are two irreconcilable versions. The outcome of this case will therefore hinge upon which version prevails regard being had to the probabilities. At the commencement of the trial the parties agreed to separate the merits from quantum in terms of Rule 33(4) of the Uniform Rules of Court. The hearing proceeded against the MEC for health only since the dispute between the plaintiff and the second defendant, Doctor Kruger, was settled out of court and Mr Erasmus withdrew the case against him.

[2] The issue that falls for determination is whether the MEC (Kimberley Hospital) was negligent, and if so, whether such negligence can be causally linked to the damages suffered by Mr Erasmus.

[3] The following admissions were made by the MEC for Health:

3.1 The Provincial Department of Health (Kimberley Hospital) entered into a contract with Mr Erasmus to treat the gangrene on his left big toe;

3.2 It undertook to perform the function with the requisite degree of care and skill expected from their profession;

3.3 It foresaw the possibility that Mr Erasmus may suffer damages if it did not perform its functions with the required degree of care and skill;

3.4 That it was under a legal duty to provide Mr Erasmus with medical services expected from personnel in their profession; and

3.5 The personnel that treated Mr Erasmus acted within the course and scope of their duties as employees of the Provincial Department of Health, Kimberley Hospital.

[4] Mr Erasmus raised the following factors in an attempt to show negligence against the Department. That it failed to:
amputate his toe in order to prevent the spreading of gangrene; make proper observations and take timeous steps to prevent the spreading of gangrene; provide adequate medical treatment to him and to start earlier with the amputation intervention to prevent the spreading of gangrene.

[5] Mr Erasmus was 71 years old at the time of his first medical consultation and 76 years at the time of trial. He claims damages suffered as a result of the amputation of his left leg above the knee as a result of a breach of contract or based on delict. The factual background to the claim is as follows.

[6] On 15 August 2012 Mr Erasmus consulted Dr Kruger at his private practice with a septic ingrown toenail on the big toe of his left foot. The doctor treated him with some pain relief medication, an injection and broad spectrum antibiotics and sent him home. He had a follow up visit to the doctor three months later, on 13 November 2012, still presenting with a septic hypertrophic ingrown toenail (thickening of the nail) and the infection had not cleared. The doctor decided to remove the toenail to clear the infection.

[7] Dr Kruger placed an elastic band (tourniquet) at the base of the toe to create a bloodless field, that is, to prevent him from bleeding a lot when removing the toenail. The use of the tourniquet was unnecessary

according to Dr Pienaar as that was not a delicate operation that required its use to achieve a bloodless field. Dr Kruger then applied a ring block by giving Mr Erasmus an anaesthetic for the pain and extracted the toenail and subsequently tightly bandaged the foot. There was lots of puss under the toenail according to the doctor. Mr Erasmus maintains that Dr Kruger did not remove the rubber band from the toe after the procedure, an allegation disputed by the doctor. According to Erasmus the doctor only removed the rubber band after three days, which is on 16 November 2012, when he returned to the doctor's surgery for the toe to be checked and a change in the dressing. Erasmus' left foot remained bandaged for the duration of the 3 days as advised by the doctor.

[8] On 16 November 2012 the doctor noted that the toe was discolouring and turning black. After treatment Erasmus was advised by the doctor to return on 19 November 2013. According to Dr Kruger on the latter day the toe looked worse than on the 16th and he thought it could be gangrene. Erasmus continued to experience excruciating pain. Dr Kruger prescribed more antibiotics, but no adrenalin, and advised him to come the following day with his family.

[9] On 20 November 2012 Dr Kruger diagnosed that the toe was gangrenous and immediately referred Erasmus to Kimberley Hospital, where he was admitted, having made arrangements with Dr Bhyatt, Head of the Surgical Department. A junior doctor saw Erasmus after which he/she consulted Dr Blanco, a Specialist Surgeon in the Surgery Department. Dr Blanco's instructions to the treating doctor (intern) were the following: (i) 48 hours of intravenous antibiotics; (ii) Await demarcation and (iii) for amputation after 48 hours.

[10] The amputation did not take place within 48 hours; instead Erasmus was referred to Universitas Hospital in Bloemfontein where more medical tests were conducted and was detained from 30 November and discharged on 10 December 2012. He was referred back to Kimberley Hospital with a directive that the amputation of the left toe which was only carried out on 20 December 2012.

[11] On 24 December 2012 Dr Swart of the Kimberley Hospital granted Erasmus temporary discharge until 27 December 2012 at 07:00 to spend Christmas with his family at home. Jennifer, his daughter, who testified on his behalf, noticed maggots while cleaning the affected wound, as advised by the medical staff.

[12] After the Christmas break Erasmus returned to Kimberley Hospital where he was again referred to Universitas Hospital. Universitas referred him back to Kimberley Hospital with the advice that a below the knee amputation be performed, but with the possibility of an above knee amputation. Erasmus said: *"toe sê hulle nee, ek moet terug Kimberley Hospitaal toe kom want hulle het klaar die voet opgemors. Die toon is af en die toon lyk slegter as wat hy gewees het. So hulle moet hulle se gemors regmaak."*

[13] Mr Erasmus' son-in-law, Mr Neville Klaasen, testified that he took his father-in-law, who was in possession of a doctor's referral letter, to hospital having been informed by him (Erasmus) that he had to undergo immediate surgery. His father-in-law's left big toe appeared as depicted on the photos "D1" and "D2" at pages 291 and 292. Adv Motloung, appearing for the MEC, objected to the use of the photographs. I considered the fact that Erasmus had confirmed while testifying that it

was his toe that was depicted on the photos taken on the day when he was taken to hospital, 20 November 2012; the Rule 36(10) notice was served on the State Attorney on 10 January 2017 and it was clearly stated therein that absent any objection to the use of the photographs within 10 days of receipt of the notice the photographs will be admitted in evidence by mere production in court. No objection was filed by the State Attorney. I made the ruling for Mr Klaasen to testify on the said photographs and overruled the objection.

[14] Mr Klaasen stated that he had an altercation with one of the treating doctors on 04 February 2013 complaining about the unreasonable delay for the amputation, which motivated him approaching the local newspaper, Diamond Field Advertiser (DFA). The DFA published an article on the matter on 05 February 2013. A day or two following the publication the left leg was amputated and his father was discharged from hospital on 11 February 2013.

[15] From 31 January 2013 until he had his turn in theatre Erasmus was placed on nil per mouth feeding and was on some of these days only allowed breakfast, the stated reason being that he was placed on the waiting queue for theatre. Disconcertingly, on 04 February 2013 the procedure was cancelled because the doctors ran out of theatre time.

[16] Dr Conrad Hendrik Van der Merwe is a specialist diagnostic radiologist in possession of an M Med degree whose credentials were not disputed. He provided a report on the foot x-rays of Erasmus after being placed in possession of a CD containing chest x-rays and two images of the left foot taken on 20 November 2012. He noted that not only had the soft

tissue swollen but there was also a presence of air surrounding the distil phalanx (at the tip of the toe) which was visible in the soft tissue.

[17] According to Dr Van der Merwe air should not have collected in the affected tissues. This condition could have been brought about by two things: Firstly and more probably, wet gangrene because of the vascular insult, that is, reduced blood flow which caused dead tissue with secondary infection by gas forming organisms. Secondly, gas gangrene caused by a gas forming bacteria. Dr Van der Merwe explained: *"dry gangrene on an x-ray normally will show contracted soft tissue around the bone and not swelling with air."* He disputed the reference to "radiological artefacts" as argued by Dr MS Maseme, the MEC's expert witness. According to Dr Van der Merwe there was no defect on the screen which made the x-ray skew. The x-ray responded to the density of the tissue.

[18] During cross-examination the following explanation by Dr Van der Merwe is worth highlighting:

"Counsel: Do you see anything there that indicates that it was [wet] gangrene?

Dr Van der Merwe: Well untreated wet gangrene especially in a patient with vascular, peripheral vascular disease, will spread if not treated quickly. It will definitely spread into the rest of the foot because it is effectively also an infection. So the infection will just – the bacteria will give off enzymes and it will grow and it will spread up the foot. Therefore the gangrenous part will increase in size."

[19] Dr Bastiaan Hendrik Pienaar, a General Surgeon, testified as the expert called on behalf of Erasmus. When he wrote the report he had not met

Erasmus and has no relationship or connection with him. In the process of compiling his report he used hospital records from Kimberley and Universitas hospitals. The compact disc with x-ray images was seen after the report was already compiled. Dr Kruger's notes were also not available when the first report was compiled. Adv Motloung severely and unjustifiably attacked Dr Pienaar's report not only as unhelpful but also as misleading. I do not share his criticism for the reasons that would emanate.

[20] Dr Pienaar explained gangrene as dead tissue. Dry gangrene starts when the tissue becomes pale because there are no red blood cells that enter the blood vessels. The doctor distinguished between dry and wet gangrene in order to arrive at the conclusion that Erasmus suffered from wet gangrene. He opined that the symptoms displayed by Erasmus could not have been dry gangrene because dry gangrene takes weeks and months to develop; it causes very little pain; it does not cause any smell; it is shrivelled or causes the affected part to be shrivelled and **does not spread**. It can auto-amputate.

[21] In as far as wet gangrene is concerned: Dr Pienaar explained that it is infective gangrene or gas gangrene (gas forming bacteria) and moves towards the centre of the body; is caused by a rapid shutdown of the blood supply; the dead tissue continues to communicate with the rest of the body; it spreads; causes pain; causes gas in tissues and causes infection which spreads fast. Some of the organisms are fast spreading while others can spread slowly but be aggressive. Wet gangrene can be identified with swelling or congestion, dead tissue communicating with the rest of the body causing an inflammatory response and pain as well as swelling or redness.

[22] Dr Pienaar explained further that if gas is observed on the x-rays it is axiomatic that there is infection and its source must be removed. In this instance, the doctor holds the view that Erasmus had wet gangrene on his toe and the toe should have been removed as soon as possible. Reference was made to within 24 hours or 48 hours or at the most 72 hours. Had the toe been removed earlier there would not have been a need to amputate leg above the knee or even resort to the "salami amputations", that is, perform more than one amputation on a person.

[23] In this instance, Dr Pienaar emphasised that the toe should have been removed to avoid the above knee amputation because it would have stopped the spread of infection to the rest of the foot and leg. X-rays, in his opinion, are taken to confirm or exclude the presence of gas. He maintains that the swollen toe had to be removed or amputated even before Erasmus could undergo bypass surgery that was recommended by the Universitas because it was the source of the sepsis. There were many factors pointing towards immediate amputation, namely; pain, smelly toe with pus, inflammation, swelling and the presence of gas in the toe. He did not come across any notes or recording in the hospital records that could have been the reason for not performing the amputation immediately. The doctor refutes the conclusion reached by the defendant's side that it was dry gangrene in light of the fact that the toe was not shrivelled but swollen.

[24] Dr Pienaar was pertinently asked to deal with the aspect of vascular status of Erasmus with particular reference to the Doppler tests (pulses on Erasmus' feet). According to the doctor the examination of arteries on a patient's foot is an art that has to be learned. It is possible that an

inexperienced doctor may miss the pulse. The Doppler device used for Erasmus' foot reflected a monophasic flow; however, that would not have diminished Erasmus' chances of healing. When asked to comment on the presence of maggots detected a few days after the amputation in the wound his response was that a wound should be free of maggots; except where the maggots are used as part of therapy. He testified that, nevertheless, there are only two centres in the entire country that use maggot treatment under a controlled environment and with very close supervision and monitoring, namely; the Universities of Pretoria and Stellenbosch. If maggots are found in a wound in a hospital and not in a controlled environment it can only point to gross negligence.

[25] In as far as the bypass surgery is concerned; Dr Pienaar said there must be no focused sepsis in the patient and that amputation of the toe had to precede the bypass surgery. When tests were conducted in Bloemfontein on 30 November 2012 there was a raised white cell count of 10.34 x 10ˆ and a C-reactive protein (CRP Quantitative) 36.0mg/l while the normal range is between 0 and 5, his cardiac marker (NT-ProBNP) was also raised 972 ng/l when the normal upper limit is 300. In his view Erasmus was not fit for bypass surgery, an opinion shared and so recorded by the Bloemfontein specialists: Dr RG Botha and Dr Pearce (see para 28 below).

[26] Flowing from Erasmus' unfitness to undergo bypass surgery Dr Pienaar was also asked to comment on the alleged refusal Universitas to treat Erasmus as shown on the form dated 10 December 2012 which records:

"REFUSAL OF HOSPITAL TREATMENT FORM (RHT)

I, Erasmus P, discharge myself from Universitas/National on my own responsibility. Dr Opperman has explained to me:

1. *The nature of the potential harm or risk that can ensue in taking this action;*
2. *I appreciate and understand the nature of the harm or risk;*
3. *I nevertheless choose to leave the hospital against the wishes of the attending Doctor/Registered nurse;*
4. *I hereby indemnify the Department of Health of the Free State and hold it blameless against all loss or damage or which I or any other person might sustain as a result of discharging myself against advice of Doctor/ Registered nurse;*

   Registration number of the patient UM00613582.

   Signed P Erasmus 10/12/12"

   Erasmus denied that he refused hospital treatment. The form does not record that the content was interpreted and explained to him in a language that he understands. He is Afrikaans speaking.

[27] On the aspect of the keeping of medical records Dr Pienaar emphasised the practice in the medical fraternity that *'if it is not written down, it hasn't been done. If it hasn't been recorded, it hasn't been done.'* There was no entry on the aforementioned RHT form that Erasmus refused bypass surgery. In fact, in his testimony, Erasmus had maintained that the Dr who was supposed to perform the bypass surgery was on leave and would only return in the new year. He therefore requested to return to Kimberley. I accept Mr Erasmus' explanation and reject the contention that he refused hospital treatment as he was always willing to be transferred to Universitas for advanced surgery.

[28] Dr Pienaar also commented that although the hospital records showed that Erasmus was diagnosed with critical limb ischemia as a reason for his referral to Universitas he could not find symptoms of critical limb

ischemia except that Erasmus complained of pain in his left big toe. Interestingly, on the patient referral letter dated 28 January 2013 (plaintiff's Bundle 3 page 111) under clinical information there is a handwritten entry on the left hand side "*#refuse bypass '12 amputation left toe @ Kimberley # now gangrenous left foot (partial) dry*". Under Management/ Treatment received appearing under the same head on the right hand side it is stated: ***Not for bypass according to Dr RG Botha and Dr Pearce.** (Own emphasis)

[29] According to Dr Pienaar and as it appeared in the Kimberley hospital records there is no indication that Dr Blanco personally saw Erasmus on 20 November 2012 because the entry on the records "D W Blanco". "D W" is an abbreviation for 'discussed with'. It may be taken that Dr Blanco gave the instructions telephonically. As explained by Dr Pienaar if Dr Blanco, as the consultant, personally saw or examined Erasmus on that day the registrar or the medical officer making the entry in the hospital records could have said: *'seen by Dr Blanco' followed by what Dr Blanco said or advised.'*

[30] As already stated Dr Blanco had advised that Erasmus receive intravenous antibiotics for 48hours, that the operating doctor should await demarcation and the toe be amputated within 48 hours. This advice by Dr Blanco was given despite the following as seen at page 110 of plaintiff's Bundle 1: the medical records:

30.1 "*Left foot gangrene, positive sign, circled, blackening of first toe, demarcated at base of toe*". According to Dr Pienaar, it did not make sense to await further demarcation because the demarcation was there already.

30.2 *Rest of foot hyperemic slightly swollen.* In Dr Pienaar's view, this is not a sign of dry gangrene but a sign of an inflammatory process and in Erasmus' case due to the infection of the first toe spreading upwards to the rest of the foot.

[31] Of significance, as opined by Dr Pienaar, is that it would have been prudent for Kimberley Hospital to have amputated Erasmus' toe on 20 November 2012 or even up to 23 November 2012 before referring him to Universitas for peripheral arterial diseases and not to wait for an entire month. Dr Kruger should not have used the ring block and the local anaesthetic as it, having volume, might have compressed the arteries that supply blood to the toe. According to him, the primary cause of the gangrene on the left big toe was the application of the rubber band coupled with the fact that it was left on Erasmus' toe for 3 days. The nursing records echo Erasmus' pain throughout his admission which started on the foot, then transferred to the lower leg and eventually to the upper leg. This translates to the infective process spreading slowly upwards. Even if he could have been re-vascularised around 30 November 2012 he would in all probabilities have ended up with a below knee amputation. Despite the fact that the toe was amputated on 20 December 2012 nevertheless by 07 February 2013 Erasmus had above knee amputation. Dr Pienaar disagrees with the assertion that Erasmus had critical limb ischemia. According to Dr Pienaar had that been the case Erasmus would have lost his other leg by now. In fact, according to the peripheral arterial evaluation conducted by the vascular unit on Erasmus at Universitas on 30 November 2012 the segmental pressure of his left leg was better than the right leg.

[32] When asked whether it could not have been Erasmus' vascular status that caused the gangrene Dr Pienaar explained:

"It was not the vascular status of Mr Erasmus that caused that toe to go into gangrene. To my mind there is no indication that the vascular status of Mr Erasmus played a role in the gangrene of the left big toe. This was purely isolated. It was purely demarcated, it was only the left big toe. He suffered immense pain during the three days. The other toes are not affected by gangrene at all. There's no other sign of gangrene. The other foot had no sign of gangrene. And I could not find any indication that he complained of pain in either of his feet or legs prior to this, apart from the toenail that was affected. If this was brought [about] by his vascular status and not by the rubber band I would have expected the same to have happened to his right foot or the remaining parts of his foot. Sorry, it's not there anymore. Let's say the right leg, right foot."

Essentially, Dr Pienaar disagreed with the submission by Dr Maseme that the peripheral vascular disease was the main cause of the loss of limb by Erasmus. Dr Pienaar was quick to also point out that Dr Maseme's report did not deal with the use of the rubber band at all.

[33] Referring to Dr Kruger's notes at page 21 of plaintiff's Bundle 1, Dr Pienaar commented that already on 19 November 2012 when Erasmus visited Dr Kruger's rooms, the doctor wrote: *"query (?) gangrene, gee kans"* ('gee kans' is Afrikaans for allow time). According to Dr Pienaar Dr Kruger should have referred Erasmus to hospital on that day. However, he asked him to return the following day. The note of 20 November 2012 reads: *'follow up. Gangrenous. Reël met Dr Bhyatt vir ? amputasie' (*arrange with Dr Bhyatt for possible amputation). Dr Pienaar was of the view that the management of Erasmus at Kimberley Hospital was negligent hence the above knee amputation.

[34] When Erasmus attended for the first time at Kimberley Hospital on 20 November 2012 at 17h30 the entry in the hospital records show that the left big toe was swollen. According to Dr Pienaar, this does not fit in with dry gangrene. Morphine was prescribed six hourly, it is prescribed for patients suffering from severe pain.

[35] After the amputation of the toe the following was recorded in the hospital record 10/01/13: *"#Post toectomy, wounds, + slough. Mild necrosis."* Dr Pienaar explains "slough" as unhealthy tissue mixed with bacteria which can also be described as solid pus. There was a mixture of dead tissue, dead bacteria and blood. This could mean a contaminated wound. The entry that follows refers to "mild necrosis" which the doctor says can either be necrosis or not: there is no such thing as mild necrosis. Necrosis means dead tissue. On 21 January 2013 following the entry on the hospital record was made: "(l) toectomy, wound necrotic, dry gangrene, 2nd and 3rd toes also seems septic. Plan to discuss with Bloemfontein. Dr du toit at vascular, Bloemfontein. Transfer 25/01/13 for evaluation". According to Dr Pienaar the infection was spreading to the rest of the foot at that stage which could have been stopped by amputation. Dr Pienaar could not find any indication in the hospital records of what the Kimberley Hospital staff did to improve the vascular status of Erasmus neither could he find any evidence in their records that further x-rays of the foot and leg were taken particularly with Erasmus' history of presence of gas on the left toe. In Dr Pienaar's view if blackening of the toe was caused by a vascular problem the demarcation would have been observed as an irregular line and would never be a straight transverse line as depicted on photo D1. That demarcation line came about as a result of the application of the tourniquet.

[36] Dr Blanco (Rene Blanco Venent) was called as a witness by the MEC. There was no Rule 36 (9)(a) or (b) notice filed in advance by the MEC. As a result I denied the defence permission to lead Dr Blanco as an expert but confined him to the advice he provided to the doctor on duty.

[37] The expert witness for the MEC was Dr Qebelo Simon Maseme whose curriculum vitae was admitted by the plaintiff. Dr Maseme is a General Surgeon and used the Kimberley and Universitas hospital records as well as Dr Kruger's notes in his testimony.

[38] Dr Maseme noted in his report that Erasmus was referred to and was seen at the Casualty Department of Kimberley hospital by Dr Marais on 20 November 2012. He was referred by a General Practitioner with a problem of dry gangrene of the left big toe which developed after the removal of the ingrown toenail by Dr Kruger the previous week. However, Dr Kruger's notes did not specify the type of gangrene but only recorded that the left toe was gangrenous. Dr Maseme obtained the information of "dry gangrene" at the left big toe from the first casualty notes by Dr Marais of 20 November 2012. Dr Maseme, however, made no reference in his report and during his testimony to the use of a rubber band (tourniquet) by Dr Kruger during the procedure. It was only during cross-examination that he admitted to not having been aware of the earlier use of the tourniquet. He also recorded that Erasmus' legs were warm from the groin downwards. However, as explained by Dr Pienaar, if the legs were indeed warm, it would go against the diagnosis of critical limb ischemia where the dry gangrene of the left big toe was located.

[39] The following remarks by Dr Maseme testifying in chief in respect of the advice by Dr Blanco to the junior doctor are also relevant:

"Dr Maseme: Firstly, I am not sure whether Doctor Blanco is a medical officer or a consultant, but according to the sequence of the notes it would suggest that he might be a consultant.

Mr Motloung: ok

Dr Maseme: Or a senior member of the Department.

Mr Motloung: yes

Mr Motloung: His suggestion for 48 hours of intravenous, is there anything that you would like to highlight to the Court?

Dr Maseme: Well from the two previous notes.

Mr Motloung: yes

Dr Maseme: The patient has dry gangrene.

Mr Motloung: okay

Dr Maseme: Therefore there was no need, ***I do not know how they, whether he saw the patient or not or this was on history that he got from the junior doctors, I am not too sure****, but on the basis of the previous notes* ***a patient with dry gangrene does not need antibiotics*** *and it has been noted that it had only demarcated. So I am not too sure what the rational for that was.*

Mr Motloung: Okay

Dr Maseme: But maybe he just wanted to give the patient the benefit of the doubt in case there is infection. I cannot answer for him."

According to Dr Maseme, the clinical picture of Erasmus and his general condition were in keeping with dry gangrene. Dr Maseme testified that the gas observed on the tip of the left toe of Erasmus was not relevant as the gas was on a dead toe, hence his remark. Dr Maseme added that he would have been concerned if the air or gas was on the foot and that the presence of gas in the toe does not mean Erasmus had wet gangrene. As

there was no clinical evidence of an infection he would not entertain wet gangrene at all. Further, **he would not even have ordered x-rays of the foot** given the history of Erasmus. Dr Maseme says knowing that Erasmus had had the ingrown toenail removal it must have precipitated his vascular condition. Dr Maseme's explanation for the gangrenous toe is that either Dr Kruger could have used adrenaline, which we know he did not, or he could have used a lot of fluid for that local anaesthetic which increased the tissue pressure around the vessels which were very compromised and led to the occlusion of the vessel and stopped the blood flow to the toe.

[40] Like Dr Pienaar, Dr Maseme was asked to explain the difference between wet and dry gangrene. He distinguished them as follows: dry gangrene occurs when the blood supply to the tissue is cut off, not caused by an infection but normally due to some underlying vascular disease. Wet gangrene can be divided into two types gas forming or non-gas forming. There is further clostridial , which is very aggressive and non-clostridial. According to Dr Maseme if wet gangrene is left untreated it kills whereas dry gangrene does not kill, a person will just lose a limb. In wet gangrene there is infection of the soft tissue. There is an invasion by organisms which cause gangrene. Wet gangrene spreads, as opposed to dry gangrene which is confined to the dead tissue. When wet gangrene spreads, it goes up the tissues causing more tissue damage as it progresses. There will be a patch of necrosis and the limb will be dark. There will not be a definite demarcation. Intravenous antibiotics are prescribed.

[41] Dr Maseme explained that gas found in the distal part of the left toe remained there because the dead toe was disconnected to the rest of the foot, hence there was no communication between the dead toe and the

rest of the foot. The doctor's explanation of the gas on the toe was that it may have been an artefact that was caused by the removal of the toenail and gas occupied the space initially occupied by the nail. Air could also have been introduced by the use of the syringe on the toe. Dr Maseme went on to explain a situation where a dead toe is made wet through cleaning or a humid temperature and it can contract bacteria through putrefaction.

[42] The explanation by Dr Maseme is that Erasmus' procedure by Dr Kruger precipitated the gangrene. More so that he had vascular disease, the gangrene was preceded by claudication, that is pain brought about by increased activity and when just lying in a hospital bed it becomes rest pain. It would later develop into critical limb ischemia where the pain will not go away unless the blood supply in the affected tissues or limbs is improved. In the opinion of Dr Maseme amputation of the dead toe was not urgent but a bypass was necessary to prevent further tissue damage. According to the doctor **since there was no evidence of infection there should not have been a rush to remove the toe**.

[43] I am clearly confronted by two irreconcilable versions. The pronouncement by Nienaber JA in ***Stellenbosch Farmers' Winery Group Ltd and Another v Martell Et Cie and Others*** 2003 (1) SA 11 (SCA) at para 5 is instructive:

"To come to a conclusion on the disputed issues a court makes findings on (a) the credibility of the various factual witnesses; (b) their reliability; and (c) the probabilities. As to (a), the court's finding on the credibility of a particular witness will depend on its impression about the veracity of the witness. That in turn will depend on a variety of subsidiary factors, not necessarily in order of importance, such as (i) the witness' candour

and demeanour in the witness-box, (ii) his bias, latent and blatant, (iii) internal contradictions in his evidence, (iv) external contradictions with what was pleaded or put on his behalf, or with established fact or with his own extracurial statements or actions, (v) the probability or improbability of particular aspects of his version, (vi) the calibre and cogency of his performance compared to that of other witnesses testifying about the same incident or events. As to (b), a witness' reliability will depend, apart from the factors mentioned under (a) (ii), (iv) and (v) above, on (i) the opportunities he had to experience or observe the event in question and (ii) the quality, integrity and independence of his recall thereof. As to (c), this necessitates an analysis and evaluation of the probabilities and improbabilities of each party's version on each of the disputed issues. In the light of its assessment of (a), (b) and (c) the court will then, as a final step, determine whether the party burdened with the onus of proof has succeeded in discharging it. The hard case, which will doubtless be the rare one, occurs when the court's credibility findings compel it in one direction and evaluation of the general probabilities in another. The more convincing the former, the less convincing will be latter. But when all factors are equipoised probabilities prevail."

See also ***Louwrens v Oldwage*** 2006 (2) SA 161 (SCA).

[44] In determining whether I accept the version of the plaintiff or the defendant I weighed up the following:

44.1 It is common cause that Erasmus had pain on the left toe for which he consulted Dr Kruger. While the case against Dr Kruger was settled and was not before me, I take judicial notice of the settlement even though I was not privy to the contents.

44.2 Dr Kruger used the tourniquet (rubber band) to create a bloodless field. While Dr Pienaar expressed the view that the bloodless field

was unnecessary and, in any event, the fact that Dr Kruger omitted to remove the rubber band after the procedure, caused the interruption in the blood flow which caused the gangrene on the left toe. Surprisingly, Dr Maseme having had the hospital records and Dr Kruger's notes, and having consulted with counsel before the trial, **made no reference to the use of the rubber band in his report and in his oral evidence**. It was only during cross-examination when confronted with the effect of the rubber band on a toe that was tightly bandaged that he opened up and expressed an opinion.

44.3 Dr Maseme did not only omit the aspect of the rubber band which in my view was crucial, but also did not notice while perusing the hospital records that **Erasmus was on antibiotics from 13 November 2012 to 06 February 2013**. The doctor's impression was that the antibiotics was stopped and only discovered about the use of antibiotics in court. What is further disturbing is the view by Dr Maseme that Mr Erasmus did not require the toe amputation.

44.4 Logically, although Dr Kruger denied it, he (Dr Kruger) must have noticed the "forgotten" rubber band on the 16 November 2012 when Erasmus returned to him for a follow up with excruciating pain. That is why on his note of 20 November 2012 he made an inscription that the toe was gangrenous because at that stage already it had turned black and there was a clear demarcation.

44.5 If the toe was as depicted on photo D1 and D2 and clearly demarcated why would Dr Blanco, not only the consultant but a General Surgeon, advice a junior doctor to await demarcation if he had personally examined Erasmus? In my view the probabilities point to Dr Blanco having provided telephonic advice and the

receiving doctor made an entry of that advice. I reject the version that Dr Blanco saw Mr Erasmus in person.

44.6 It is not in dispute that Mr Erasmus had a vascular disease. However, I am persuaded by the argument that had his toe been amputated immediately, at least within the 48 hours, the rest of the limb would have been saved.

44.7 I further find that although the vascular disease needed attention, the primary attention ought to have been paid to the amputation of the toe. I am basing my finding on the fact that urgency on treating the vascular disease was over-emphasised by Dr Maseme reiterating that the toe was already dead and there was a need to save loss of further limb due to vascular disease. Almost five or six years later all but the one limb which was amputated are still intact. This confirms the submission by Dr Pienaar and Van der Merwe that the presence of gas in the left toe meant that it had wet gangrene which necessitated immediate amputation.

44.8 I accept that Erasmus suffered from wet gangrene because his foot was smelly, the gangrene moved up his foot and leg, it produced gas, caused rapid shut down of blood supply, there was communication between the dead cells and the healthy part, it spread to other parts of the foot and leg, caused tremendous pain and caused infection. The records clearly show how Erasmus was continuously receiving antibiotics. I disagree and reject the opinion by Dr Maseme that Erasmus suffered from dry gangrene. Firstly, the affected toe had pain whereas dry gangrene causes very little pain, if any; does not cause smell whereas Erasmus' was smelly, the toe was not shrivelled and, as testified to by both Dr Pienaar and Dr Maseme, the dry gangrene does not spread but confined to one space. Erasmus' gangrene spread upwards until his leg had to

be amputated above the knee. While dry gangrene can take weeks or months to develop, Erasmus' toe turned black in 3 days and gangrenous in 6 days.

44.9 It was disconcerting for me to, on more than one occasion, observe that Dr Maseme was partisan to the defendant's case and had to be reminded of his responsibility to the court as an expert witness. ***See Jacobs and Another v Transnet (Ltd) t/a metrorail and Another*** 2015 (1) SA 139 (SCA) at 148B – D where Majiedt JA, writing for the unanimous court, pronounced:

"[15] It is well established that an expert is required to assist the court, not the party for whom he or she testifies. Objectivity is the central prerequisite for his or her opinions. In assessing an expert's credibility an appellate court can test his or her underlying reasoning and is in no worse a position than a trial court in that respect. Diemont JA put it thus in Stock v Stock[1981 (3) SA 1280 (A) at 1296F]:

'An expert . . . must be made to understand that he is there to assist the Court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him. I may add that when it comes to assessing the credibility of such a witness, this Court can test his reasoning and is accordingly to that extent in as good a position as the trial court was.'"

It is on the basis of the afore-mentioned that I find that the version in respect of the medical expert opinion of the Dr Pienaar as corroborated by the plaintiff's other witnesses is not only more probable but also credible and reliable. I reject the version of Dr Maseme in as far as it conflicts or contradicts the plaintiff's version.

[45] It must be borne in mind that the claim against the MEC is compensation for damages suffered as a result of the amputation of his left leg above the knee and based on contract or alternatively, on delict. The MEC has not pleaded contributory negligence.

[46] In order for Erasmus to succeed in his delictual claim it is necessary for him to prove the following elements: that there was an act or omission by the defendant; wrongfulness; negligence; damages and a causal link between negligence and damages.

[47] It is common cause that Dr Kruger referred Erasmus to Kimberley Hospital on 20 November 2012. From that date he was in the care of the defendant. Dr Kruger had already telephonically discussed the matter with Dr Bhyatt, Head of Surgery. It is further common cause that Dr Blanco was contacted for advice on the same evening and he ordered amputation within 48 hours. The defendant failed to amputate Erasmus within the 48 hours and instead amputated him exactly a month later, on 20 December 2012. Unquestionably, it had to take pressure and disgruntlement by a member of the family and publicity by the local newspaper for the Kimberley Hospital to amputate Mr Erasmus. This conduct is unacceptable.

[48] The MEC, represented by the Kimberley Hospital medical staff, were expected to act reasonably and swiftly to safe Erasmus' foot and leg. In the aforementioned, particularly paragraph 44 (above), no reasonableness and swift action can be discerned.

[49] It is common cause that following Erasmus' complaint of a painful toe, he ended up losing his entire left leg above the knee through amputation. He is now confined to a wheelchair for the remainder of his life.

[50] Taking cue from what Holmes JA pronounced in ***Kruger v Coetzee*** 1966 (2) SA 428 (A) at 430E – F:

"For the purposes of liability culpa arises if –

(a) a diligens paterfamilias in the position of the defendant –

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant failed to take such steps.

[51] At the risk of repetition, it is necessary to reiterate that when Mr Erasmus was admitted at the Kimberley Hospital on 20 November 2012, the medical personnel already established that he had a gangrenous left big toe which was already demarcated. They also knew that it was septic because intravenous antibiotics were prescribed by Dr Blanco who also advised that the toe must be amputated within 48 hours. In fact, Dr Kruger had already placed him on antibiotics. It is unquestionable that the Kimberley Hospital did not foresee the possibility of harm in failing to amputate the toe when through reasonable diligence they should have. While aware that the amputation should have occurred within 48 hours they only carried it out a month later, on 20 December 2012. This is not the action of *a diligens paterfamilias*.

[52] Persuasive submission by Adv C Botha, appearing for Mr Plaintiff, was that in assessing the failure to amputate within the 48 hours, I must look at the following relevant factors: Erasmus was 71 years old; he was suffering from vascular disease which curtailed blood circulation to his left leg and foot; upon admission he already had a gangrenous big left toe which was infected; not only his toe but the rest of the left foot was swollen with cellulitis; and there was gas in his left toe. All these factors inclined towards immediate amputation, which the Kimberley Hospital staff failed to do. I have no doubt in my mind that the defendant was negligent in carrying out its duties based on the failure on its part to act reasonably under the circumstances having foreseen the possibility of harm.

[53] What remains is the question of costs. The general principle is that costs follow the outcome. There is no reason why costs in this case should not be borne by the defendant (the MEC) at High Court scale on the merits, as taxed or agreed upon between the parties.

[54] In the result the following order is made:

1. **The first defendant, the MEC: Health, Northern Cape Government, is ordered to pay all damages that the plaintiff, Mr Patrick Erasmus, will be able to prove in due course that was caused to the plaintiff by the defendant's failure to render adequate medical services to the plaintiff during the period of 20 November 2012 to 06 February 2013 that led to the loss of the left leg of the plaintiff above the knee.**

2. The defendant is ordered to pay the plaintiff's costs on the merits on the High Court scale, as taxed or agreed upon between the parties, which costs shall include:

2.1 The qualifying fees of the following experts:

2.1.1 Dr BH Pienaar

2.1.2 Dr CH Van der Merwe

2.2 The reasonable travelling and accommodation costs/fees of Dr Pienaar and Van der Merwe for preparation of reports, attending consultations and the trial.

2.3 The reasonable travelling and accommodation of Dr Pienaar and Dr Van der Merwe for attending the trial;

2.4 It is declared that the witnesses of the plaintiff referred to in paragraph 2.1 above were necessary expert witnesses.

2.5 The reasonable travelling and accommodation costs/fees of the plaintiff's legal representatives to consult with Dr Pienaar and Dr Van der Merwe in Pretoria for purposes of preparation of the expert summaries and the trial.

2.6 The reasonable costs of the plaintiff's technician for providing visual support in court.

3. The defendant will pay the above amounts into the following trust account of the plaintiff's attorneys:

Elliot Maris Wilmans & Hay

Standard Bank Trust Account

Account Number [0...]

Branch Code 050002

MAMOSEBO J

NORTHERN CAPE HIGH COURT

For the plaintiff:	Adv CH Botha
	Elliot Maris Wilmans & Hay Attorneys
For the defendant:	Adv S Motloung
	The Office of the State Attorney