Republic of South Africa

IN THE HIGH COURT OF SOUTH AFRICA

(WESTERN CAPE HIGH COURT, CAPE TOWN)

Case no: 9924/2008

In the matter between:

RONALD MABOY SOMKE Plaintiff

and

M K OSTROFSKY Defendant

Court: Judge J I Cloete

Heard: 4, 5, 6, 7, 13 February 2013 and 30 May 2013

Delivered: 4 June 2013

JUDGMENT

CLOETE J:

[1] The plaintiff claims damages arising out of allegedly negligent treatment administered to him by the defendant, a maxilla-facial and oral surgeon, during June 2005. The plaintiff initially claimed the amount of R280 000 comprised of

past medical and hospital expenses of R40 000; future medical and hospital expenses in the amount of R20 000; past loss of earnings of R20 000; and general damages for pain, suffering, discomfort, disability, permanent loss of amenities of life and disfigurement of R200 000. By notice dated 16 January 2013 the plaintiff withdrew the claims for past medical and hospital expenses; future medical and hospital expenses; and past loss of earnings. The only issues for determination are thus: (a) the merits; and (b) if the plaintiff succeeds on the merits, his claim for general damages.

[2] On 12 July 2004 the defendant performed surgery on the plaintiff for the intermaxillary fixation of fractures of the left mandible due to an injury that the plaintiff had suffered during an assault and attempted hijacking. Because of malunion of the fractures, the plaintiff underwent further surgery on 9 September 2004 in the form of an open reduction and internal fixation of the left mandible. On 27 June 2005 the plaintiff underwent a third surgical procedure, namely a bilateral surgical split osteotomy. The claim only relates to the osteotomy procedure carried out on 27 June 2005.

[3] It is alleged by the plaintiff that during February 2005 the defendant advised him to undergo a bilateral surgical split osteotomy in order to obtain better occlusion and function. The plaintiff accepted the defendant's advice and the operation was carried out on 27 June 2005.

[4] It is further alleged that subsequent to the operation the plaintiff suffered an infection in the upper of the two plates in his mouth; the plaintiff's bite opened progressively in the front and on the sides; and the plaintiff experienced numbness and a loss of sensation along the left side of his lower lip. The infection was first detected in the mandible on 9 September 2005 and had settled by 22 November 2005. The post-operative relapse indicated by progressive opening of the bite became evident and progressed gradually after the release of the inter-maxillary fixation on 11 July 2005. The anterior open bite was clinically detected on 29 July 2005, and treated successfully by means of dental extractions. Clinical evaluation of the right alveolar nerve revealed neuropraxia (i.e. temporary loss of nerve function resulting in tingling, numbing and weakness, usually caused by compression of the nerve although there is no structural damage involved, resulting in complete recovery). Clinical evaluation of the left inferior alveolar nerve revealed a complete neurotmesis (i.e. complete severance), although there was subsequent recovery with normal sensation. In addition the left nerve displayed causalgia (i.e. pain due to nerve damage) indicated by a 20mm area of hyperalgesia (i.e. increased sensitivity) in the chin area.

[5] The grounds of negligence alleged by the plaintiff are that the defendant in circumstances in which a reasonable specialist maxilla-facial and oral surgeon would have done so: (a) failed to consider orthodontic correction in order to obviate the need for surgical intervention; (b) decided to utilize an intra-oral procedure and failed to consider and/or utilize an extra-oral procedure, i.e. a

bilateral extra-oral ramus osteotomy (reverse-L); (c) failed to employ pre-surgical orthodontics in order to provide immediate post-operative stabilization of the dental occlusion; (d) failed to remove all plates and screws from the plaintiff's mouth and jaw pre-operatively before embarking on the procedure; (e) decided to extract the plaintiff's lower teeth when such extraction was unwarranted in the circumstances; (f) failed to assess and diagnose the post-operative complications properly, timeously or appropriately and failed to take proper and/or timeous steps to treat such complications; and (g) failed to inform and advise the plaintiff of (i) the risks attendant on the procedure recommended by him and (ii) the alternatives to the procedure recommended by him, including orthodontic treatment and extra-oral surgical intervention.

[6] All of the grounds of negligence are denied by the defendant.

THE APPLICABLE LEGAL STANDARD REQUIRED OF A MEDICAL PRACTITIONER

[7] Both in performing surgery and in his post-operative treatment a surgeon is obliged to exercise no more than reasonable diligence, skill and care. In other words, he is not expected to exercise the highest possible degree of professional skill. What is expected of him is the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which he belongs: per Scott J in *Castell v De Greef* 1993 (3) SA 501 (CPD) at 509F-H and the authorities cited therein.

[8] Further:-

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

[Castell (*supra*) at 509H-510A]

[9] In order to establish negligence it must be shown that a reasonable practitioner in the particular circumstances would have foreseen the likelihood of harm and would have taken steps to guard against its occurrence, but that the practitioner concerned failed to take such steps: see *Kruger v Coetzee* 1966 (2) SA 428 (AD) at 430E-F.

[10] The negligent conduct on the part of a medical practitioner must have caused or contributed to the ultimate condition from which the patient suffers. In *Blythe v van den Heever* 1980 (1) SA 191 (AD), the Court dealt with a claim where the plaintiff had sustained fractures of his right radius and ulna. After a medical practitioner had operated to reduce the fractures, sepsis set in together with an ischemic condition. As a result the plaintiff suffered pain and suffering and even

after other operative procedures had nevertheless been left with a "*claw-like*" right arm. The Court of Appeal found that the medical practitioner had been negligent in his post-operative treatment of the plaintiff in that he had failed to diagnose and take the necessary prompt action for the ischemia, as a reasonably skilled and careful medical practitioner would have done, and that had he done so the fractures would probably have healed satisfactorily and full use of the arm regained; his negligence had caused or contributed to the permanent disability.

[11] The court set out the questions that need to be addressed as follows: (at 220H-221C);

> *'Applying the basic principles relating to delictual negligence which is causally linked to the damage suffered to the situation in the present case, it seems to me that this enquiry resolves itself into the following questions:*
>
> *(i) Whether the reasonably skilled and careful medical practitioner in the position of the respondent would have realised that a serious ischemic condition was developing or threatening to develop in appellant's forearm; and, if so, when he would reasonably have come to realise this.*
>
> *(ii) Whether there was remedial action which could reasonably have been taken.*
>
> *(iii) Whether the same notional practitioner would have known of this remedial action and would have realised that it had to be taken.*
>
> *(iv) Whether the remedial action, if taken when the need for it ought reasonably to have been realised, would have prevented the damage suffered by appellant.*

(v) Whether respondent himself failed to take such remedial action....'

THE APPROACH OF OUR COURTS TO EXPERT EVIDENCE

[12] The approach of our courts to the evaluation of expert evidence was restated in the case of *Michael and Another v Linksfield Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) at pages 1200 and 1201, paragraphs [34] to [40]:

> *'[34] In the course of the evidence counsel often asked the experts whether they thought this or that conduct was reasonable or unreasonable, or even negligent. The learned Judge was not misled by this into abdicating his decision-making duty. Nor, we are sure, did counsel intend that that should happen. However, it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the Court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the Court's reaching its own conclusion on the issues raised…*
>
> *[36] …. (W)hat is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning…*
>
> *[40] ….(I)t must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House*

of Lords in the Scottish case of Dingley v The Chief Constable, Strathclyde Police 200 SC (HL) 77 and the warning given at 89D - E that

> *"One cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved - instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence". …."*

[emphasis supplied]

[13] In the matter of *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at paragraph [27] the Court stated:

> *'What was required of the trial Judge was to determine to what extent the opinions advanced by the experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in the light of the probabilities.'*

(See also *Fulton v Road Accident Fund* Case No 2007/31280 SGHC (1 February 2012) at paragraphs [22] – [23].)

[14] As regards the duties of expert witnesses, it was stated in *National Justice Cia Naciera SA v The Prudential Assurance Co Ltd, The Ikranian Reefer* [1993] 2 Lloyds Report 68:

'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.

3. An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.

4. An expert witness should make it clear when a particular question or issue falls outside his expertise."

THE ISSUE OF INFORMED CONSENT

[15] A practitioner generally has no right to treat a patient unless the latter consents to such treatment. A patient has a common law and constitutional right to bodily integrity. A practitioner who treats or performs an operation on a patient without consent may be liable in a civil action for any damages arising therefrom: see Joubert The Law of South Africa (17) at p27 and the authorities cited at footnotes 2 to 4 and 8.

[16] A patient will be held to have consented where he *inter alia* (a) has knowledge of the nature and extent of the harm or risk involved; (b) appreciates and understands the nature of the harm or risk; (c) has consented to the harm or assumed the risk; and (d) the consent is comprehensive, that is to say it extends

to the entire transaction, inclusive of its consequences: *Castell v De Greef* (full bench) 1994 (4) SA 408 (C) at 425H-J. Whether or not there was consent in a particular instance is a question of fact. The patient can consent expressly to treatment (meaning the consent may be either orally or in writing), or the person may consent tacitly (meaning by conduct). Consent generally takes the form of a request made by a patient for a specific treatment or operation. As a general rule, where a patient enters a hospital or undergoes surgery, a written consent is required: see Lawsa (*supra*) at p28.

[17] For the purposes of a claim based upon lack of informed consent, it is incumbent upon the plaintiff to prove that, had he been informed of the particular risk in question, he would have refused to consent to the operation; i.e. that there was a causal connection between the failure of the defendant to obtain the plaintiff's informed consent to the operation and the injury resulting from the materialisation of the risk of which the plaintiff was not informed. In *Broude v Mackintosh and Others* 1998 (3) SA 60 (SCA) the appellant appealed against the finding by the trial court of absolution from the instance. One of the grounds upon which the appellant relied was the alleged failure of the respondent to inform him of the risk of damage to the facial nerve and the availability of an alternative operation. Marais JA held as follows at 68F-69E:

> "*The omission to inform appellant of the risk of leakage of cerebrospinal fluid was of no significance. The leakage was not proved to be causally related to the onset of the facial palsy and appellant did not claim that if the risk of leakage had been mentioned to him, he would have refused to consent to the operation. Appellant's*

evidence as to the alleged failure of first respondent to inform him of the risk to the facial nerve and of the availability of the alternative operation (labyrinthectomy) was rejected by the trial Judge. He pointed out that appellant had signed a document in which he consented specifically to a translabyrinthine vestibular neurectomy and in which he acknowledged that the nature and possible effects of the operation had been explained to him.... He added that appellant had never said that, if he had been informed of the risk to the facial nerve and of the alternative operation, he would not have consented to the operation which was performed. The highest that appellant had put it was that he might not have consented. ... He also considered it to be improbable that first respondent would have failed to inform appellant of these matters. One might add that it is also somewhat improbable that appellant would have been disinterested in such matters given the fact that he was a medical practitioner with some knowledge of the anatomy of the area in which the operation would be performed. No good reason exists to differ from the trial Judge's view that this cause of action was not made out. The same applies to the alternative cause of action based upon an alleged negligent failure to inform appellant of these matters."

THE LAY EVIDENCE

[18] The plaintiff himself testified as did Dr Marlene Kotze, a dentist based at 2 Military Hospital, Wynberg. The only lay witness to testify for the defendant was his personal assistant, Ms Curtis.

[19] The plaintiff's evidence was that he is employed by the South African Navy. In July 2004 he sustained a broken jaw during an assault by a group of persons who attempted to hijack his vehicle. He was taken to 2 Military Hospital. He was referred to the defendant who treated his fractured jaw by wiring it together.

[20] The jaw did not mend properly and a second operation was performed on 9 September 2004. Plates were put in so that the jaw could heal. His jaw was wired closed again. After the second operation, the plaintiff felt some numbness on his lower lip.

[21] Subsequently, and during one of his follow-up appointments, the defendant informed the plaintiff that his lower jaw was *'prominent'* causing the teeth in the upper jaw to protrude over the teeth in the lower jaw. The defendant suggested that he could correct the problem and the plaintiff agreed to this suggestion.

[22] An operation was then performed on 27 June 2005. After the operation wires and elastics were placed in his mouth. He attended on the defendant for follow-up appointments. At one of these appointments the defendant removed some of the elastics and realized that the plaintiff had an open bite on the left side. The defendant ground some of the teeth down and in the end referred the plaintiff to Dr Kotze to correct the open bite. Initially the open bite was not big but it grew bigger as time went by.

[23] The plaintiff was seen by Dr Kotze at 2 Military Hospital. She did not want to grind down the teeth to correct the problem, and referred him back to the defendant. He returned to the defendant who advised him that the problem would resolve itself with the passage of time. He did not know what to do, and decided to return to Dr Kotze for advice. The plaintiff again consulted Dr Kotze who referred him to Dr Rushdi Hendricks, a specialist in maxilla-facial oral surgery, for a second

opinion. Dr Hendricks examined him and found infection. He consulted Dr Hendricks two or three times thereafter before the latter carried out surgery to his mouth and jaw.

[24] The surgery performed by Dr Hendricks related to the removal of the plates and screws. Dr Hendricks also extracted some teeth at the back of his mouth to try to reduce the open bite. The surgery was effective as the open bite was improved. At a later date Dr Hendricks carried out a further operation to *'shape'* the plaintiff's jaw.

[25] On the day of the first operation by Dr Hendricks, the defendant saw the plaintiff in hospital and asked him what he was doing there, given that he was the defendant's patient. The plaintiff advised him that the hospital had arranged for another doctor to see to him. Before his initial consultation with Dr Hendricks, the plaintiff had telephoned the defendant's rooms to arrange another consultation but was told that the defendant was in London on vacation. Thereafter and on the advice of colleagues and members of the community, he laid a complaint against the defendant with the Health Professions Council of South Africa, but the defendant was subsequently exonerated of any professional misconduct.

[26] The plaintiff's evidence was further that as a result of the third operation carried out by the defendant, he experienced an open bite, numbness in the lower lip, loss of weight, pain and infection. He first testified that he had started to feel numbness in his lower lip after the second operation carried out by the defendant.

His evidence was then that he was not sure whether it was numb after the first operation but accepted that he must have felt numbness of the left lower lip after the first operation because this had been recorded by the defendant in his notes. At present his only complaint is that there is still a little numbness in the same area, but it is better now than it was. The numbness does not affect the plaintiff's speech and only bothers him when eating hot or cold foodstuffs. He also testified that he had no complaints about the first or second operations carried out by the defendant. He was not asked whether he had suffered a knock or other injury to his jaw after the third operation.

[27] As regards his consent to the third operation, the plaintiff's evidence was that he did not recall signing any formal document before that operation was carried out, nor did he remember discussions with the defendant about possible complications of the third operation.

[28] The evidence of Dr Marlene Kotze, the principal dentist at the Oral Health Department of the 2 Military Hospital, may be summarised as follows.

[29] On 12 July 2004 the plaintiff was assessed at the Emergency Unit by Dr Groenewald after he suffered an assault during an attempted hijacking. At the time Dr Kotze was the acting Head of Department. The plaintiff was referred to the defendant as maxilla-facial treatment was necessary. A Dr Serfontein had assisted the defendant in theatre.

[30] Dr Kotze had assisted the defendant in theatre during the second operation on 9 September 2004 when the inter-maxillary fixation was carried out. She saw the plaintiff again on 10 September 2004 and he was given instructions to schedule appointments for the defendant for follow-up treatment. Subsequently, Dr Kotze received a telefax from the defendant dated 8 February 2005 in which the defendant advised her *inter alia* that:

> '*We now have a problem with asymmetry of the occlusion with a severe traumatic bite involving the lower left anterior teeth which has led to a fair amount of mobility of the teeth in this area.*
>
> *The treatment which needs to be carried out in order to obtain a better occlusion and function and in order to avoid further trauma to the anterior teeth would be for a mandibular saggital split osteotomy to be carried out on both sides. …'*

[31] The saggital split operation was carried out on 27 June 2005. The defendant was assisted by a Dr Cawood. No notes were made during the operation and Dr Kotze has no personal knowledge of what occurred.

[32] On 29 July 2005 Dr Kotze saw the plaintiff who had been referred to her by the defendant for minor selective grinding of the surface of certain teeth to eliminate some premature contacts. Dr Kotze found the plaintiff to have an open bite. The open bite was more or less 8mm in extent. She telephoned the defendant and informed him that she could not do any selective grinding as the plaintiff had an open bite. The defendant requested Dr Kotze to send the plaintiff back to him for a consultation.

[33] On 5 August 2005 Dr Kotze received a telefax from the defendant in which he reported, *inter alia,* that:

> *'I have taken all the arch bars off the above patient and I am quite happy that if one places his mandible in centric relation that there is no anterior open bite. He sometimes habitually places his jaw forward and I think that this is to avoid the premature contacts which are present in the new bite.*'

[34] On 9 September 2005 Dr Kotze saw the plaintiff again. The open bite was still present with definite premature contacts which prevented the plaintiff from closing his mouth. At the consultation Dr Kotze took photographs of the plaintiff's mouth when he closed his mouth on his own and when she placed his jaw in centric relation; i.e. to obtain as full a contact as possible. In centric relation the bite was still open. The plaintiff was very despondent, as he could not chew properly, given that he only had contact on the right hand side of his mouth. Ordinary occlusal equilibration was not possible due to the extent of the open bite. Dr Kotze was not comfortable performing major occlusal equilibration, and suggested that a second opinion be obtained. X-rays were also taken which showed that there were fractures involved, rather than premature contacts only.

[35] Dr Kotze referred the plaintiff to Dr Hendricks and in her referral letter, dated 9 September 2005, she stated that:

> *'*[The plaintiff] *was referred back to me to do occlusal adjustments to remove premature contact areas. I however think the problem is much bigger and that the* [plaintiff] *will have to go back to theatre.*'

[36] Dr Kotze's evidence was further that it is the norm that the military does not pay for pre-operative orthodontics to be carried out on adult patients. In two cases in which Dr Kotze was involved special motivations had been sent to military headquarters for orthodontic treatment for adult patients. Both were denied. Dr Kotze has never been successful in obtaining such approval.

[37] Finally, Dr Kotze accepted that during his examination of the plaintiff the defendant may not have observed the anterior open bite, since, when placed in centric relation, the open bite was significantly reduced.

[38] Ms Colleen Curtis, the defendant's personal assistant, testified *inter alia* as follows. Her duties entailed maintaining the defendant's diary on a daily basis, interacting with patients, ensuring that accounts were paid, attending to the defendant's theatre listing and making sure that all bookings were correct.

[39] The plaintiff attended an appointment with the defendant on 12 August 2005 when the inter-maxillary fixation was removed by the defendant. The defendant recommended that the plaintiff return for further occlusal equilibration.

[40] The plaintiff was unable to attend a post-operative appointment scheduled for ten days later on 22 August 2005 as he was going to be away on a course in Saldanha Bay. The plaintiff left the defendant's rooms on the understanding that he would check his schedule and that after consulting with Dr Kotze for the

occlusal equilibration he would contact Ms Curtis to arrange a further appointment with the defendant.

[41] During September 2005 the plaintiff telephoned the defendant's rooms whilst the latter was overseas. This must have been about two days after the defendant left for overseas on 2 September 2005. The plaintiff informed Ms Curtis that he needed an urgent appointment with the defendant. She advised him that the defendant was overseas and that he would be accommodated as soon as the defendant returned some eight days later. None of the dates offered to the plaintiff fitted in with his commitments. Ms Curtis suggested that the plaintiff obtain leave of absence and requested him to let her know when he would be able to attend an appointment. The plaintiff agreed. Ms Curtis did not hear from the plaintiff again, and neither did the defendant prior to this litigation.

THE EXPERT EVIDENCE

[42] The expert evidence was that of Dr Hendricks, who testified for the plaintiff, and Professor Morkel, who testified for the defendant, both of whom are maxilla-facial and oral surgeons. At the outset it is necessary to comment on how these witnesses gave their evidence. I was impressed by the level of expertise and degree of impartiality displayed by Professor Morkel throughout his testimony. Unfortunately the same cannot be said of Dr Hendricks, who exhibited an alarming degree of personal antagonism towards the defendant.

[43] By way of example: (a) in his evidence in chief he accused the defendant of *'ridiculing'* parts of an earlier report that Dr Hendricks had furnished *'when he attempted to dishonour me in front of the Health Professions Council'*; (b) when this was taken up with him in cross-examination Dr Hendricks confirmed his view in strong terms and referred me to a memorandum written by the defendant to the Health Professions Council *'whereby he misled the Council with incorrect facts so that they could make a finding in his favour'*; (c) he also accused the defendant of luring away one of his patients, allowing complications to develop in the defendant's treatment of that patient, and thereafter attempting to discredit Dr Hendricks before the Health Professions Council; and (d) he claimed that the defendant had previously left a health facility at which Dr Hendricks had been a registrar under *'a cloud of suspicion relating to his activities'* at that establishment. It must also be borne in mind that it was Dr Hendricks who had subsequently treated the plaintiff after he was referred to him by Dr Kotze.

[44] Although Dr Hendricks attempted to nonetheless portray himself as impartial I was left with the disturbing impression that he had a large axe to grind with the defendant, and he did not hesitate, when the opportunity presented itself, to take both personal and professional swipes at the defendant during the course of his testimony.

[45] Shortly before the matter was argued I was provided by the plaintiff's attorneys with a copy of a letter addressed to the plaintiff by them confirming a discussion

relating to outstanding fees due to counsel who appeared on the plaintiff's behalf. The relevant portion of that letter is as follows:

> *'We refer to the meeting at our offices dated the 15 May 2013 wherein we advised you of the circumstances regarding your case against Dr Ostrofsky and wherein you advised us that Dr Rushdi Hendricks was to have assisted you with the payment of counsels fees.*
>
> *Counsel has called on us for payment of her fees and unfortunately on contacting Dr Rushdi Hendricks to discuss the payment he seems to have capitulated on his earlier decision to assist you.*
>
> *As we have been unable to secure proper financial instructions from Dr Rushdi Hendricks regarding counsel's fees in this matter and since we now as attorneys of record are responsible to pay counsel.* [sic]
>
> *We have made several attempts to make contact with you since then, in order to take further instructions, and you do not seem to answer your telephone or respond to the numerous messages left for you to make contact with us.*
>
> *In the circumstances we have no alternative but to withdraw as your attorneys of record and advise you that the matter is set down for closing argument on 30 May 2013 at the High Court, Western Cape High Court. The Sheriff of the Court has been instructed to deliver the Notice of Withdrawal to you today.*
>
> *The Court usually commences at 10h00 and we suggest that you obtain the services of other attorneys to represent you or you may attend court personally.'*

[46] Dr Hendricks was also somewhat bombastic in his attitude and was prone to lengthy and unstructured answers to simple questions, apparently in an attempt

to demonstrate his superior knowledge and expertise to that of the defendant, and to some extent, Professor Morkel.

[47] As was stated by Davis J in *Schneider NO and Others v AA and Another* 2010 (5) SA 203 (WCC) at 211J-212B:

> *'In short, an expert comes to court to give the court the benefit of his or her expertise. Agreed, an expert is called by a particular party, presumably because the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with as objective and unbiased an opinion, based on his or her expertise, as possible. An expert is not a hired gun who dispenses his or her expertise for the purposes of a particular case. An expert does not assume the role of an advocate, nor give evidence which goes beyond the logic which is dictated by the scientific knowledge which that expert claims to possess.'*

[48] It is therefore my view that I must, of necessity, treat the evidence of Dr Hendricks with the utmost caution. I am however assisted in making findings in light of the crucial concessions which Dr Hendricks ultimately made as well as the testimony of Professor Morkel who, as submitted by Mr Corbett who appeared on behalf of the defendant, gave his testimony in a measured, structured and objective fashion; and who led me to conclude that his opinions were founded on logical reason when viewed against the probabilities.

[49] Professor Morkel testified that as Head of the Department of Maxilla-Facial Surgery at Tygerberg Hospital, he encounters a number of trauma patients and complications such as that of the plaintiff's. He had examined the plaintiff, the

records of the treatment received by the plaintiff, the x-rays which were available and the models of the plaintiff's teeth prior to surgery.

[50] He highlighted the importance of bearing in mind that prior to the carrying out of the bilateral saggital split osteotomy the plaintiff had suffered two fractures of the jaw, namely to the body and the condyle of the jaw.

[51] It is against this background that the expert evidence will be considered by reference to each individual ground of negligence alleged by the plaintiff.

FAILURE TO CONSIDER ORTHODONTIC CORRECTION

[52] Professor Morkel testified that until the 1960s orthognathic surgery was performed without any pre-surgical orthodontic treatment. (Orthognathic surgery is the surgical correction of severe malocclusion to improve facial appearance).

[53] More recently, as a general rule, orthodontic treatment is administered before surgery. However, this practice has been criticized on the basis that it is a very time consuming stage of treatment.

[54] Currently orthodontic treatment can take up to two years, is extremely expensive and waiting lists for orthodontic cases at public hospitals are lengthy and limited to severe cases such as cleft pallets or patients with other deformities.

[55] In many cases where the bite has shifted and the bony fractures have united in the incorrect position due to trauma, orthognathic surgery is carried out without pre-orthodontic treatment given the practical and logistical challenges attendant upon orthodontic treatment.

[56] If a patient's teeth are completely out of position orthodontics would be carried out and it would take up to two years to attempt to secure a stable occlusion prior to surgery.

[57] The maxilla-facial surgeon concerned will use his clinical judgment with reference to the models of the patient's teeth to see if there are sufficient contacts between the teeth and adequate occlusion before making a decision as to whether or not pre-surgical orthodontics are necessary. Where, however, the malocclusion is due to trauma it is usually treated as an orthognathic case without orthodontic treatment.

[58] After examining the pre-surgical models of the plaintiff's teeth, Professor Morkel found that there were seven points of contact between the upper and lower teeth, whereas only three points of contact are required for a sufficiently stable occlusion to dispense with pre-surgical orthodontic treatment.

[59] The plaintiff also presented with relative contra-indications for pre-surgical orthodontic treatment given that he had loose and peridontically compromised teeth as well as crown and bridgework.

[60] In Professor Morkel's opinion the defendant did not act improperly in failing to refer the plaintiff for orthodontic treatment prior to surgery:

> '*I do not think that it was an incorrect treatment option. A surgeon will have to take multi-factorial matters in consideration and if this case presented in the academics we will most probably also have treated it with our logistical conditions as a surgical case without orthodontics.*'

[61] In cross-examination, and although loathe to accept that pre-surgical orthodontic treatment was not indicated, Dr Hendricks testified that he could not fault the defendant for carrying out the saggital split osteotomy; and that orthognathic surgery had indeed been necessary to correct the asymmetry of the plaintiff's jaw, irrespective of whether orthodontics had been employed or not.

FAILURE TO UTILIZE AN EXTRA-ORAL PROCEDURE

[62] In Professor Morkel's experience the older approach adopted by maxilla-facial and oral surgeons was to utilize the extra-oral procedure. However, and at least since before 2005, the procedure of choice is the intra-oral procedure carried out by the defendant. This was conceded by Dr Hendricks.

FAILURE TO REMOVE THE PLATES AND SCREWS.

[63] Professor Morkel testified that as a general principle plates and screws surgically inserted after trauma should not be removed prior to surgery of this nature.

[64] In his opinion there was no clinical, radiological or intra-operative evidence of infection in the area of the screws and plates prior to the surgery being carried out by the defendant.

[65] Professor Morkel testified that having viewed the x-ray taken directly after the surgery there was also no evidence of infection associated with the plates or screws.

[66] Dr Hendricks conceded that plates and screws are not routinely removed. They are only removed when there are specific indications such as infection associated with the plates or they are in the way of the surgery to be carried out, which was not the case here. He also conceded that there was no radiological evidence of infection prior to surgery, but claimed that radiological evidence alone was not a sufficient indicator of the absence of infection. It was put to him that there had been no clinical signs of infection either, which he was unable to dispute given that he had not examined the plaintiff prior to the surgery having been carried out by the defendant.

[67] Dr Hendricks conceded that during his first examination of the plaintiff on 9 September 2005 (i.e. two months after the defendant had carried out the surgery) he did not observe any infection associated with the plates. He only observed the infection during his second clinical examination a further three weeks later on 29 September 2005. In his opinion, the infection probably developed a good while after the carrying out of the saggital split procedure: *'in*

my opinion that infection may have come in a lot later; more towards the time that [the plaintiff] *came to see me … I cannot comment on when the infection actually started'.* He then also conceded that *'no, I'm not* [blaming the defendant]. *It could well have been undetectable…'.* and that, in the circumstances, it could not have been expected of the defendant to have noted and treated the infection.

[68] In addition the infection was not severe when first noted by Dr Hendricks on 29 September 2005 and it was only dealt with during the surgery carried out five weeks later on 7 November 2005:

> *'And it couldn't have been that serious because you only operated on him on the 7th of November which was more than a month, probably after six weeks after you observed it. --- I would agree with that. That's not an issue.'*

EXTRACTION OF TEETH

[69] It became common cause during the trial that no teeth had been extracted by the defendant after all and this ground of negligence alleged by the plaintiff requires no further comment.

FAILURE TO ASSESS AND DIAGNOSE THE POST-OPERATIVE COMPLICATIONS PROPERLY

[70] Professor Morkel testified that having viewed the x-ray taken directly after surgery on 27 June 2005 there was good alignment of the lower jaw. The subsequent x-ray taken when the plaintiff saw Dr Kotze on 9 September 2005 demonstrated

that the lower jaw had moved and the osteotomy site had become displaced with the result that the mandible had what is known as a "*bucket handle*" deformity. The surgical fracture site had become dramatically displaced resulting in the anterior open bite.

[71] Professor Morkel testified that according to the defendant's notes, the plaintiff was fine after surgery and the x-rays showed that there was good alignment of the fracture sites. In his evidence the plaintiff also testified that he was fine directly after surgery but that over time his bite had changed.

[72] Dr Kotze had conceded that it was possible that when the defendant examined the plaintiff the open bite was not apparent to him; in particular if the jaw had been placed in centric relation. When Dr Kotze saw the plaintiff on 29 July 2005, i.e. 32 days after surgery, she observed the anterior open bite.

[73] In Professor Morkel's opinion, there must have been an event which disrupted the fracture site after the osteotomy was carried out, such as a knock to the chin. Because the patient would have experienced numbness post-operatively he might well have been unaware of the event given that major force is not required to cause a disruption of this nature. Professor Morkel has personally experienced such cases during the course of his professional career. His evidence was as follows:

> *'Mr Somke said that he was fine directly after surgery and then his bite changed. So he was fine. Dr Ostrofsky felt that he was fine after surgery if we look at his*

notes and if we look at those X-rays there were alignment of the fracture sites. Then if we move to Dr Kotze's evidence, and that's on day 32, post surgery she saw an anterior open bite of 8mm and that coincides to the clinical photographs that Dr Hendricks showed. So we have to have a look at – we only have an X-ray at two and a half months where it shows that clinically coincides we would now assume with the same clinical picture that Dr Kotze saw. So now we have to move back and try and theorise what happened. So there must have been some event that caused disruption of these fixation sites. The fixation sites as we've explained before are osteotomies and one must see them as controlled fractures of the jaw that were not fixed. We don't routinely use as I said before in our unit and myself we don't use bicortical screws. People that use bicortical screws feel that there is even more stability with bicortical screws than with plates and that plates sometimes allow you a little bit of movement. So looking at those X-rays and the amount that's these fracture sites displaced was astounding. So I – one has to speculate that something happened that displaced that fracture. Now Dr Ostrofsky he has never seen something like that. Dr Hendricks said he has seen that once in a surgical case and in my experience and the academics, I've been fortunate to see it a few times. The thing that masks such an event is the fact that the patient is numb. So the patient feels as if they've had a local or a dental injection in their lower jaw. So all the lower teeth, the bone and the lips all feel numb. So they can hardly feel or have any sensation inside their mouth and outside their mouth.'

[74] After displacement of the fracture site muscle action in the area would further displace the fragments and that is what results in the "*bucket handle*" effect since the lower muscles tend to pull the jaw downwards. Further, when the operation site becomes displaced, this is a recipe for infection.

[75] In Professor Morkel's opinion the use of a bite splint by the defendant did not play a role in the development of the post-operative complication. In any event, the defendant could not be faulted for having used a splint.

[76] In the view of Professor Morkel, regarding the difference between the defendant and Dr Kotze's observations, the open bite could be due to the fact that there was movement in the fracture site and that the plaintiff presented with different clinical pictures when he was first examined by the defendant and later by Dr Kotze.

[77] Professor Morkel's evidence was also that relapse after a saggital split osteotomy can occur for a number of reasons such as condylar sag, condylar compression, infection or unstable occlusion. Although the risk of relapse is minimal (roughly 3%) and subsequent disruption of the fracture site even less (roughly 1%) the fact of the matter is that these are nonetheless recognised complications. Dr Hendricks too conceded that relapse and displacement of the fracture site is a recognized complication after a saggital split osteotomy.

[78] Dr Hendricks also conceded that damage to the nerves, in particular the left inferior alveolar nerve, would have been caused by the relapse or displacement of the osteotomy and not by the procedure itself; and that nerve damage is also a recognized complication of a saggital split osteotomy.

THE FAILURE TO INFORM AND ADVISE PLAINTIFF OF THE RISKS

[79] The plaintiff's evidence in chief was that the only information provided to him by the defendant before the surgery was that he would be admitted to the intensive care unit and that *'wires and elastics'* would be placed in his mouth. He denied that any other discussions between the defendant and himself had taken place.

During cross-examination the plaintiff conceded that he was made aware by the defendant of the purpose and nature of the surgery; but testified that he could not recall whether he had signed a document concerning the surgery before it was carried out. A document was then presented to the plaintiff, bearing the heading *'SA Military Health Service Informed Consent'*. It is dated 20 May 2005; reflects the surgical procedure to be carried out; and bears the plaintiff's signature adjacent to the end of the following words:

> *'I, the undersigned, hereby consent to the performance of, and understand the nature, risk and possible consequences of the procedure(s), anaesthesis and treatment in the ICU, high care and/or wards. The doctors who perform the procedure(s) may increase the reasonable scope thereof to carry out additional or alternative measures (including general anaesthesia) if considered necessary.'*

[80] The document also records that the *'means used'* to explain the surgical procedure to the plaintiff was *'personally'*; and that the plaintiff had personally furnished his consent thereto. It also bears the defendant's signature next to the words *'I have explained the nature, risks and possible consequences of the medical / surgical procedure(s), as well as the risks of anaesthesia, to the above-signed patient / person legally competent to give consent'* as well as the names and signatures of two witnesses, namely Ms Curtis and a Ms Cindy Giffard.

[81] The plaintiff did not dispute the veracity of this document; nor did he take issue with what was recorded therein. He was also referred to the defendant's note of 26 May 2005 which set out certain points of discussion between himself and the defendant. These points were not disputed by the plaintiff, save that he claimed

that he did not remember any discussion about possible complications which was one of the points reflected.

[82] Significantly however there was no evidence that the plaintiff would not have undergone the procedure if he had been informed of the risk of the complications that subsequently developed. On the contrary, his evidence was that prior to the surgery he had full confidence in the defendant who on the plaintiff's own version had treated him successfully in the past. There is also no evidence that the plaintiff had not been fully informed by the defendant prior to undergoing the two previous operations. Against this background the probabilities are overwhelming that the plaintiff was indeed properly informed by the defendant before the surgery was carried out. In addition the possibility exists that the plaintiff confused the pre-operative discussions held with the defendant and those with Dr Hendricks, since the latter conceded during cross-examination that he himself had not obtained a written consent from the plaintiff prior to the surgical treatment administered by him. There is thus no basis upon which I can conclude that the defendant failed to inform the plaintiff of the risks attendant upon the surgery.

EVALUATION OF THE REMAINING GROUNDS OF NEGLIGENCE ALLEGED

[83] Even on the evidence of Dr Hendricks the plaintiff has failed to make out a case relating to the alleged failure to utilize an extra-oral procedure and the extraction of lower teeth. Insofar as the failure to remove the plates and screw is concerned, Dr Hendricks conceded that there was no evidence of infection associated with

the plates at the time the saggital split osteotomy was carried out; that the defendant could not be faulted for failing to detect the infection; and that the infection most probably developed quite some time later. In the circumstances, nothing more need be said on this issue.

[84] As to the allegation that the defendant was negligent in failing to refer the plaintiff for orthodontic treatment prior to carrying out the osteotomy procedure, the plaintiff has also failed to make out a case for the following reasons. First, although it is the norm that orthodontic treatment is administered prior to orthognathic surgery, this depends on each individual case, and the evidence of Dr Kotze shows that military personnel rarely if ever receive authorisation for orthodontic treatment to be carried out. Second, it was the evidence of Professor Morkel, who examined the models made of the plaintiff's teeth prior to surgery, that there were seven points of contact between the upper and lower teeth (three points of contact being sufficient) which was indicative of sufficiently stable occlusion for orthognathic surgery. Third, the plaintiff presented with relative contra-indications for orthodontic treatment; in that he had loose and periodontically compromised teeth, and he also had crown and bridgework. Fourth, in the trauma cases with which Professor Morkel has regularly been involved orthognathic surgery is routinely carried out without pre-surgical orthodontic treatment, which is both logical and understandable bearing in mind the relative urgency of the treatment required. Fifth, and in any event, even if the defendant was remiss in failing to refer the plaintiff for pre-surgical orthodontic

treatment, there was no evidence to suggest that the outcome of the osteotomy would have been any different and that the relapse would have been prevented.

[85] The plaintiff has also failed to make out a case based on the defendant's alleged failure to assess and diagnose the post-operative complications adequately for the following reasons. First, Professor Morkel testified that post- surgical x-rays showed that there was good alignment of the lower jaw. Second, Dr Hendricks conceded that the defendant could not be faulted on how the osteotomy procedure was carried out. Third, it was common cause that the relapse and/or disruption of the fracture site of the osteotomy occurred progressively over a period of time; and the fact that the plaintiff was placed in elastic traction would have camouflaged the developing open bite. Fourth, the plaintiff was examined by Dr Kotze 32 days after surgery on 29 July 2005. The open bite was significantly reduced when the jaw was placed in centric relation; and Dr Kotze conceded that when the defendant examined the plaintiff he could have failed to observe the open bite and reached a different clinical finding in that regard. Fifth, Professor Morkel's evidence was that it is quite possible that because of the mobility in the fracture site the plaintiff could have presented a different clinical picture when examined by Dr Kotze, on the one hand, and by the defendant on the other. Sixth, it must also be borne in mind that it was the plaintiff himself who failed to attend scheduled post-operative appointments with the defendant after 12 August 2005, thereafter demanding an urgent appointment on 4 September 2005 when the defendant was overseas; and that all of the appointments offered

to the plaintiff immediately after the defendant's scheduled return eight days later were not suitable to the plaintiff.

[86] Applying the principles set out in *Blythe* (*supra*), there is simply insufficient evidence as to: (a) when the defendant should reasonably have observed the open bite; (b) what remedial action could have been taken at that stage; (c) whether such remedial action, if taken when the defendant ought reasonably to have observed the open bite, would have prevented the relapse of the osteotomy suffered by the plaintiff; and (d) in any event, how the defendant was expected to have taken any remedial action when the plaintiff made himself unavailable for consultation.

[87] On the contrary, all the indications are that by the time the open bite had developed, the relapse had already occurred. The relapse, in itself, was a complication of the procedure and is not indicative on its own of any negligence on the part of the defendant.

CONCLUSION

[88] The plaintiff has thus failed to make out a case on any of the grounds alleged and it follows that his claim must fail. There is no reason why, in these circumstances, costs should not follow the result.

[89] **I accordingly make the following order:**

1. **The plaintiff's claim is dismissed with costs.**

2. **The plaintiff shall pay the defendant's costs on the scale as between party and party as taxed or agreed, such costs to include the qualifying expenses of the defendant's expert witness, Professor J Morkel.**

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J I CLOETE