THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

REPORTABLE

CASE NO: 181/2004

In the matter between

DR HENK DOUW LOUWRENS **APPELLANT**

and

JAMES PETER OLDWAGE **RESPONDENT**

CORAM:	**MPATI DP, STREICHER, MTHIYANE, LEWIS et PONNAN JJA**
HEARD:	**18 MAY 2005**
DELIVERED:	**21 SEPTEMBER 2005**

Summary: Medical negligence – Vascular surgeon diagnosed a patient as having serious arterial disease in the right leg – diagnosis disputed – History of symptoms with which patient presented disputed. Proper approach for resolving factual disputes discussed.
Informed consent – whether given by patient.
Risks and post-surgical complications (steal/claudication) – whether caused by surgical intervention.
Duty to warn patient where risks are negligible discussed. Credibility findings by court *a quo* – appellate court's approach thereto. Proper approach to expert medical evidence discussed.

JUDGMENT

MTHIYANE JA:

Introduction

[1] The dispute in this appeal concerns the history given by a patient (the respondent and to whom I shall refer as the plaintiff) to a vascular surgeon (the

appellant, referred to as the defendant), in respect of the symptoms with which he presented, leading to a diagnosis subsequently made by the appellant. There are two conflicting versions in this regard and the outcome of the appeal depends on which of the two versions is to be believed, having regard to the probabilities. The plaintiff sued the defendant in the Cape High Court for damages for alleged medical negligence. At the commencement of the trial Yekiso J ordered a separation of the issues in terms of rule 33(4), and subsequently dealt only with the question of negligence. The learned judge decided that issue in favour of the plaintiff and granted the defendant leave to appeal to this court.

[2] These are the facts. On Monday 5 June 2000, the plaintiff was suffering from intense pain in his right leg. He consulted his general practitioner, Dr George Simons, who examined him and then referred him to the defendant. The defendant saw him on Tuesday 6 June 2000 and upon examining him he suspected, as he put it, that the pain was caused by a lack of, or poor, blood flow to the lower leg. On Wednesday 7 June, he did an angiogram on the plaintiff, which revealed that various arteries in the right upper leg were occluded (blocked). From this he concluded that the plaintiff had severe ischaemia, which required urgent surgical intervention (in the form of a bypass operation). On Thursday 8 June, he performed an iliac bi-femoral bypass operation on the plaintiff.

[3] On Wednesday 14 June 2000, the plaintiff, who says that he was still not pain free after the vascular surgery, consulted a neurosurgeon, Dr Kieck. Dr Kieck discovered that the plaintiff had disc degeneration at the L4/5 vertebrae which had resulted in a prolapsed disc in that area. There is a dispute as to whether this condition had occurred before or after the plaintiff's visits to Dr Simons and the defendant. The back problem also required surgery, in the form of a laminectomy. On Wednesday 21 June 2000 Dr Kieck did the back operation, which the plaintiff says brought him instant relief. However, shortly after the back neuro-surgery, he began to exhibit (and, according to him, continues to exhibit) symptoms of claudication (blockage of the arteries with resultant cramping) in the left leg. He alleges that the current claudication was caused by the defendant's surgical intervention.

[4] The central factual issue at the trial was whether, when the plaintiff saw Dr Simons and the defendant, he presented with lower back pain, which radiated from the back of his leg upwards into his buttock as a result of a recent fall and a 'snap' in his back, as alleged by him, or pain in the right lower leg (in particular the right foot), as alleged by the defendant (supported by Dr Simons) primarily arising from his vascular problem. The judge *a quo* found that the pain with which the plaintiff presented was of neuralgic origin and not of

vascular origin. In essence thus, the judge found that the defendant had made an incorrect diagnosis.

Issues on appeal

[5] On appeal the principal issue is whether the defendant misdiagnosed the plaintiff's problem as being primarily of vascular rather than of neuralgic origin which, on the plaintiff's case, was more urgent. Three other related issues were also raised: first, whether in examining the plaintiff and in allegedly missing the symptoms indicative of neuralgic/back pain, the treatment of which should have taken priority, the defendant acted as a reasonable vascular surgeon would have done when faced with the symptoms with which the plaintiff presented (of course if we find that on the probabilities the defendant did not miss a neuralgic problem this issue will fall away); secondly, whether the plaintiff gave informed consent to the surgical procedure performed by the defendant, in the absence of which consent such intervention would have amounted to an assault; thirdly, whether the plaintiff's current claudication in the left leg was caused by the defendant's surgical intervention. I discuss these issues in turn.

Did the defendant make an incorrect diagnosis?

[6] The case for an incorrect diagnosis is based primarily on the plaintiff's evidence and on that of Professor D R De Villiers, a vascular surgeon, who had already retired by the time of the trial. Professor De Villiers told the court that

the pain which the plaintiff described as having experienced when he had consulted the defendant signified a neurological rather than a vascular problem, and that he should then have been referred to a neuro-surgeon. He did not think that the plaintiff had critical ischaemia, which he described as a progression from intermittent claudication - ‘a lameness, a weakness, a pain, a cramp that usually starts in the calf muscle and may extend upwards’- not downwards - and which comes only with exercise. According to Professor De Villiers, intermittent claudication is not incapacitating and does not interfere with a person’s everyday life. Claudication is only incapacitating and requires surgical intervention when it progresses to critical ischaemia. The symptom that signifies critical ischaemia is referred to as ‘restpain’, and is not intermittent, but constant, extremely severe and maximal. It is constant because it involves the nerves and is limited to the farthest part of the foot, which is the last body part that the blood supply reaches. Restpain indicates a fairly advanced stage of arterial disease. The worst form of critical ischaemia manifests itself in gangrene, at which stage the vessels become completely blocked and the tissues die. Then, nothing can come through and the leg becomes absolutely black and dies. The only ‘cure’ would be amputation. Although Professor De Villiers was satisfied from what he was told that the plaintiff had not reached the advanced stage of critical ischaemia, he conceded that, if the plaintiff exhibited restpain at the time he consulted with Dr Simons and the defendant, then surgical intervention was justified.

[7] I turn to the plaintiff's evidence. He told the court that, when he saw Dr Simons on 5 June 2000, he complained of intense pain in the back of his right thigh, which shot up into his buttock. He also mentioned severe pain in the back and remarked: 'my back is buggered'. Notwithstanding this remark, Dr Simons 'fiddled' with his feet, which he considered to have nothing to do with the pain in the back.

[8] Dr Simons disputed the plaintiff's version. He testified that the plaintiff had mentioned pain in the lateral part of the right lower leg, which shot up to his buttock. The plaintiff told him that he had had this pain for some five days and made no mention of pain in the back. The plaintiff also told him of a back operation, a laminectomy, which he had had, way back in 1972. Thinking that the pain in the leg might be a recurrence of the old injury, Dr Simons decided to do a straight leg-raising test on both legs. The test achieved a 70˚ raise, as a result of which he was satisfied that the plaintiff exhibited no neurological deficit. In fact, in his report Dr Simons noted the absence of entrapment of the nerve. Professor De Villiers conceded that the test carried out by Dr Simons was indeed the normal test used to determine the presence or absence of neurological deficit. Dr Simons also noted that the plaintiff's right foot was a little different to the left. He felt pulses in the left foot but none in the right foot. He also felt pulses behind the left knee and up in the groin but found that they

were completely absent on the right side. Having in addition established that the plaintiff was a heavy smoker, smoking about 30 to 40 cigarettes per day, he was satisfied that the plaintiff had definite ischaemia or lack of blood supply to the right leg. He advised the plaintiff that there was an urgent need for correction and that he wished to refer him urgently to a vascular surgeon, as he was extremely concerned with what appeared to be a very greatly diminished blood supply to the right leg. He feared that the plaintiff was in danger of losing his leg and felt that a decision had to be made urgently.

[9**]** As regards the defendant's version, he had - not surprisingly - no independent recollection of what was said during his consultation with the plaintiff on 6 and 7 June 2000. Since then he had seen many other patients. He could therefore only meet the plaintiff's version by referring to how he routinely consulted with his patients and by referring as an *aide memoire* to his records, which he had initially kept electronically on computer, and which were replaced by a letter he sent to Dr Simons on 26 June 2000. The letter records that the plaintiff presented with a five day history of pain in the right leg and restpain of the foot. The pain is described as most marked over the peroneal compartment of the right lower leg. It also records that, on examination, the right foot was clearly ischaemic with blue discolouration and decreased temperature and that no pulse was felt in the right leg whereas pulses were present in the left leg. Elaborating on his report, the defendant testified that the

plaintiff had complained of pain in the right leg which he said was most pronounced in the outer part of the lower leg, just above the ankle. He noticed that the plaintiff limped into the examination room and that his foot had a dusky, light bluish colour and was cool to the touch. It was clear to him that the plaintiff had severe pain seeing that, as he walked, he attempted to place as little weight as possible on the right foot.

[10] The defendant suggested that an angiogram be done to define the severity and extent of the disease, on the basis of which he could then recommend corrective treatment. The angiogram revealed a much more severe situation than the defendant had anticipated. Not only were the main vessels which supplied blood to the right leg blocked, but the other vessels which normally provide alternate routes were also blocked. The external right iliac artery - the vessel that normally takes the blood down the leg - was completely blocked off. Although there were also blockages on the left hand side, the plaintiff's body had compensated adequately for that deficit. There was sufficient blood getting to the left foot via collateral arteries, which acted as effective substitutes for the arteries that were disabled by the blockage. The angiogram confirmed the defendant's earlier clinical suspicion of a very poor blood flow to the right leg. In the light of this he diagnosed the plaintiff as having severe ischaemia. He considered that the leg was under threat and that the next stage, if the vascular problem was left uncorrected, would be the setting in of gangrene, with the

consequent risk of amputation of the lower leg. The defendant testified that if a leg did not receive blood it was starved of nutrients which are essential for it to function. In the absence of nutrients, the leg would be jeopardised, which was the prospect facing the plaintiff. The defendant considered that, if there were a minor injury to the leg, infection could set in and speed up this process. He was of the view that the plaintiff faced the real prospect of losing his leg and that something had to be done urgently.

[11] The defendant stated that he attempted to explain the situation to the plaintiff in as understandable a manner as possible. He advised the plaintiff that his vascular problem could be corrected by doing an aorta-bi-femoral bypass, which entailed bypassing both iliac systems (affected by blockages) and re-routing the blood along substitute tubing to the lower part of the leg which was not getting adequate supply of blood. This suggested surgical procedure turned out to be beyond the plaintiff's financial means, however, as the hospital and clinic fees alone amounted to between R80 000 and R90 000. Notwithstanding that the defendant was prepared to lower his fees, the aorta bi-femoral bypass surgical procedure was excluded as a viable financial option, as the hospital and the clinic were not prepared to lower their charges.

[12] The defendant then suggested a cheaper, simpler and less risky surgical procedure, an iliac bi-femoral bypass, the cost of which was in the region of

R40 000. The plaintiff agreed to this procedure and the operation was done on 8 June 2000.

[13] In deciding which of the two opposing versions is to be accepted, it is necessary to have regard first to what transpired at the consultation the plaintiff had with Dr Simons and later with the defendant, in respect of the history given to them by the plaintiff and their clinical findings, assessed in the light of the probabilities. The plaintiff's version as to the pain with which he presented and which he described to Dr Simons and, later, to the defendant (namely the complaint concerning back pain) is totally divergent from and incompatible with the defendant's version of ischaemic vascular disease of the right lower leg and foot, with which he says the plaintiff presented and described to him. All the plaintiff's experts were agreed that if, at the time, the plaintiff had back pain only and no pain in the lower leg and foot, the plaintiff's problem was of neuralgic origin.

[14] It seems to me that the issue for determination is whether the plaintiff, when he consulted the defendant, suffered from a neuralgic or a vascular problem, and this is entirely dependent upon which factual version is to be accepted. If there was a dual pathology, then we must determine whether the procedure followed by the defendant was correct. The dispute thus involves a choice between the version of the plaintiff, on the one hand, and that of the

defendant on the other, supported by Dr Simons. Yekiso J accepted the plaintiff's version in preference to that of Dr Simons and the defendant. Counsel for the plaintiff urged us to follow suit and submitted, somewhat boldly it must be said, that the judgment of the court *a quo* includes findings of credibility with which the appellate court will not normally interfere. We were not referred to any specific passage in the judgment recording such credibility findings. I could not find any. Indeed, it is not apparent from the record why the version of Dr Simons and the defendant was rejected. On a proper approach, the choice or preference of one version over the other ought to be preceded by an evaluation and assessment of the credibility of the relevant witnesses, their reliability and the probabilities. (See *Stellenbosch Farmers' Winery Group Ltd & another v Martell Et Cie & others*[1]). Unfortunately it is not apparent from the record that this approach was adopted by the judge *a quo*. I do not think this is a case where, sitting as a court of appeal, we should defer to the trial court's findings of credibility because of the peculiar advantages it had of seeing and hearing the witnesses. Even if such findings were in fact made by the trial court, I do not think that we are precluded from dealing with findings of fact which do *not* in essence depend on personal impressions made by a witness in giving evidence, but are rather based predominantly upon inferences from the facts and

[1]2003 (1) SA 11 (SCA).

upon the probabilities. In *Union Spinning Mills (Pty) Ltd v Paltex Dye House (Pty) Ltd & another*[2] this court, per Zulman JA, said:

'Although Courts of appeal are slow to disturb findings of credibility they generally have greater liberty to do so where a finding of fact does not essentially depend on the personal impression made by a witness's demeanour but predominantly upon inferences from other facts and upon probabilities. In such a case a Court of appeal with the benefit of an overall conspectus of the full record may often be in a better position to draw inferences, particularly in regard to secondary facts.'

[15] It follows therefore that the factual evidence presented to the court *a quo* merits reconsideration and re-evaluation. It seems to me that, if the plaintiff's version regarding the history he gave to Dr Simons and the defendant is to be believed, the two doctors not only clinically missed his back problem, but deliberately chose to ignore it, notwithstanding that he had specifically mentioned it to them. This is in my view highly improbable. Furthermore, it is difficult to see why the two doctors, consulting the plaintiff individually and separately on different dates, would both focus on the right leg, in respect of which there was (on the plaintiff's version) no complaint. There is yet another important feature. Is it merely a coincidence that the leg depicted on the angiogram happened to be the leg that was in fact occluded? The picture revealed in the angiogram appears to support the diagnosis, made by both Dr Simons and the defendant, of a severe vascular problem in the right leg and

[2]2002 (4) SA 408 (SCA) para 24. See also *R v Dhlumayo & another* 1948 (2) 677 (A) at 698 and *S v Robinson & others* 1968 (1) SA 666 (A) at 675G-H.

contradicts the plaintiff's assertion that he had no pain in the right foot or that there was nothing wrong with his right lower leg. The evidence that the plaintiff, when he saw Dr Simons and the defendant, complained of pain in the right lower leg (in particular the right foot) and not of pain in the back, and the defendant's clinical findings in this regard are supported by all objectively verifiable facts and circumstances. Those include the earlier presentation to Dr Simons who, in broad terms, made similar findings to those of the defendant; the angiogram which depicted a vascular condition with very little blood flow to the right lower leg; the defendant's letter to Dr Simons dictated some 3 weeks after the operation and from contemporaneous notes clearly confirming the defendant's version of events; and the clinical note made by Dr Kieck that the plaintiff had told him about pain in his right calf prior to his visit to the defendant.

[16] As indicated above, Professor De Villiers conceded that if, at the time, the plaintiff exhibited restpain, surgical intervention was justified. In this regard the court had only the evidence of the plaintiff to be weighed against that of the defendant. The defendant noted restpain in the letter he sent to Dr Simons. Dr Simons did not specifically mention the presence of restpain, a fact which might to some extent be taken to support the contention that vascular surgical intervention was not urgent. Dr Simons did, however, testify that on examination he found the plaintiff's right foot to be 'a little different to the left';

he felt no pulses in the right foot, which to him suggested severe arterial disease. Dr Kieck did not note restpain but made a note that the plaintiff had told him about pain in his right calf prior to his visit to the defendant. The bits and pieces of evidence that support the contention that there was no restpain at the time of the visits to Dr Simons and to the defendant pale into insignificance when one has regard to the evidence of the two doctors and the other supporting evidence. I think it is fair to accept that a general practitioner such as Dr Simons would not have wished or been able to do a more in-depth investigation than a specialist. That is why he referred the plaintiff to the defendant for further evaluation. His failure expressly to mention restpain in his notes does not mean that he missed it.

[17] The evidence of the plaintiff is riddled with other difficulties. It is contradicted by the angiogram which demonstrated that he had a serious vascular problem notwithstanding his protestation that there was nothing wrong with his right lower leg. The plaintiff was also contradicted by his estranged wife, Ms Marlene Oldwage, who told the court during cross-examination that, when the defendant visited Dr Simons, the pain in his back resulting from a fall in the Cederberg had long disappeared. She said at that stage he complained of pain in the leg. There are also discrepancies between, on the one hand, the plaintiff’s evidence relating to exercise, and that of his wife and his brother, Mr George Henry Oldwage, on the other. The evidence of the plaintiff’s wife and of

his brother in this regard also does not tie up in several respects. The plaintiff testified that, before the vascular operation, he used to do a lot of exercise in the form of walking, swimming and cycling. The plaintiff's evidence was that he and his wife used to cycle after supper but his wife said they cycled before supper. Her evidence was that they used bikes belonging to the plaintiff, whereas his brother said that the bikes which the plaintiff and his wife used belonged to him. The plaintiff's brother said that he had bought a bike for his girlfriend and two for his children, and that the latter were the bikes that he lent to the plaintiff and his wife. At some stage the contradictions become comical: the plaintiff's wife said under oath that she and the plaintiff had brought two bikes with them to the Cederberg and said: 'O, ons het `n Mercedes gehad, en agter die Mercedes was die ding waar ons die fietse gesit het'. To a further question in cross-examination, she replied that the plaintiff cycled on his own bike. At first glance these contradictions seem to be minor. But when the plaintiff's account of his exercising regime is contrasted with the expert medical evidence of Professor Immelman, Dr Stein and the defendant, all supported by the angiogram, to the effect that the state of the plaintiff's arterial disease was such that he could not do exercise to the extent to which he claims he did, the contradictions assume importance. Those small lies cumulatively make one question the truth of the plaintiff's evidence. In particular, the claim by the plaintiff's brother that the plaintiff cycled some 50 kilometres up the mountain pass is totally discredited by the medical evidence. It seems to me that the

evidence of the plaintiff and his witnesses to the effect that he engaged in such exercise before the defendant's surgical intervention must be rejected as contrived and unworthy of credence.

[18] I also do not agree that the symptoms with which the plaintiff presented were neurological and related to his back, rather than vascular. First, the plaintiff did not inform Dr Simons and the defendant that he had slipped and injured his back in the Cederberg. I find the evidence of the doctors more reliable and persuasive than that of the plaintiff. It cannot be said that the defendant lied to the court in the version which he presented. Against this is the evidence of the plaintiff which is very unreliable. Furthermore, the probabilities militate against the contention that Dr Simons and the defendant missed and/or ignored the back pain which the plaintiff says he mentioned to them.

[19] There is yet another feature that supports the version of Dr Simons and the defendant and contradicts that of the plaintiff. The plaintiff says he was not pain-free after the surgical procedure performed by the defendant. In this regard he is contradicted by the hospital notes prepared by the nurses during his post-operation confinement, from which it appears that he did not complain of any pain. His explanation when confronted with this in cross-examination, to the effect that he did not complain because he wanted to be discharged, is not at all convincing. Also, the plaintiff said that when Dr Simons visited him at home

after the vascular operation, he told the doctor that he was suffering from exactly the same pain that he had before the operation. This was disputed by Dr Simons who said that the plaintiff mentioned pain in the back. Indeed, when he went to see Dr Kieck, the neurologist, he was diagnosed as having a back problem for which he underwent surgery on 21 June 2000, after he had told Dr Kieck of the incident in which he hurt his back and of the back pain that shot down to the right leg. In my view, this supports the version of Dr Simons, that when he visited the plaintiff at home, the latter complained of pain in the back and casts serious doubt on the plaintiff's version in this regard. Furthermore, at the first consultation, as I have already indicated, Dr Simons did a leg raise, achieving a 70˚ elevation of both legs, from which he concluded that there was no nerve entrapment. Dr Kieck was only able to achieve a leg raise of 30˚ in the right leg. It is therefore clear that the symptoms with which the plaintiff presented to Dr Simons and to the defendant were different to those with which he presented to Dr Kieck. In my view, there is no basis for concluding that the pain which the plaintiff had when he went to see Dr Simons and the defendant arose from a neurological problem. Accordingly, on all the evidence, the defendant's surgical intervention was justified and there is no basis for a finding of misdiagnosis. In *Mitchell v Dixon*[3] Innes ACJ said:

'A practitioner can only be held liable in this respect, if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply absence of

[3]1914 AD 519 at 526.

reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession.'

In the present matter it cannot be said that the defendant was negligent or did not exercise the necessary care and skill required of him in making the diagnosis. I am saying this mindful of the fact that the defendant was a specialist and that what is expected of him is the following:

'A specialist is required to employ a higher degree of care and skill concerning matters within the field of his speciality than a general practitioner. The objective "reasonable physician test" is subjectified to the particular branch of medicine to which the specialist belongs. This means that it is expected from a specialist in the treatment of his patients to act as a reasonable specialist would have done under similar circumstances.'[4]

On all the evidence that is exactly what the defendant did. He examined the plaintiff's problem in depth, subjected him to an angiogram and did what he and other specialists, Professor Immelman and Dr Stein, considered to be an appropriate operation to treat the plaintiff's condition. In my view there is no basis for a finding of incorrect diagnosis.

Did the defendant perform an incorrect surgical procedure?

[20] Allied to the above question is the issue whether the defendant acted as a reasonable vascular surgeon would have done when faced with the symptoms with which the plaintiff presented, referred to in para 5 above. According to the plaintiff's expert witness, Professor De Villiers, the defendant should have done an aorta bi-femoral bypass. The problem was that the plaintiff could not afford

[4] N J B Claasen & T Verschoor *Medical Negligence in South Africa* (1992) p 15.

that procedure and, for that reason, the defendant suggested the iliac bi-femoral bypass, a simpler, cheaper and less risky - but by no means inferior - surgical procedure. As regards the plaintiff's lack of sufficient funds, Professor De Villiers suggested that the procedure could have been done at a public hospital. There was however overwhelming evidence from Professor Immelman that this was not possible. He testified that the plaintiff might not have met the means test. Besides, there was a long waiting list and the plaintiff would not have been permitted to jump the queue. If the defendant's evidence of the plaintiff's serious arterial disease is anything to go by, his leg might well have had to be amputated by the time his turn came. It seems to me that on the acceptable evidence the defendant acted reasonably in his treatment of the plaintiff. In any event the plaintiff would have been aware of the existence of public hospitals but chose to consult a private practitioner who could perform an operation which was appropriate and which cured the deficient blood supply to the plaintiff's lower right leg. In the circumstances even if the plaintiff could have had the more expensive operation done at a public hospital there was no duty on the defendant to refer him to such a hospital. What is reasonable in the circumstances was explained by Innes CJ in *Van Wyk v Lewis*[5] where he said:

'…[in] deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.'

[5]1924 AD 438 at 444.

On the acceptable evidence there can be no question that the methods used by the defendant to diagnose the plaintiff's problem were those used in his profession and the surgical procedure he performed was the correct one. The plaintiff could not dispute this but was driven to contend, relying on the evidence of Professor De Villiers, that there had been a dual pathology and that treatment of the vascular problem diagnosed by the defendant was not urgent. On the evidence of Dr Simons and the defendant the dual pathology had not been presented to them. According to them the plaintiff exhibited a serious vascular disease and the angiogram confirmed this. No mention was made of pain in the back. I accept their evidence. The views and the conclusion reached by Professor De Villiers suggesting the presence of dual pathology, at the time the plaintiff was seen by Dr Simons and the defendant, must therefore be rejected. It is true that in his letter to Dr Simons dated 26 June 2000 the defendant does allude to the possibility of dual pathology but in my view that seems to be based on the fact that *subsequently* the plaintiff was found by Dr Kieck to have a neurological problem. It is by no means an admission that at the time he was seen by himself and Dr Simons the plaintiff had both a vascular problem and a neurological problem.

Was there informed consent?

[21] In argument it was submitted that the plaintiff did not consent to the surgical procedure performed by the defendant (the iliac bi-femoral bypass).

Counsel argued that the plaintiff did not know what procedure was performed. He drew attention to the consent form signed by the plaintiff in which the operation was described as a 'fem-fem bypass' whereas an iliac bi-femoral bypass was performed. There is no merit in the argument. According to the defendant that is the general terminology used for the cross-over bypass whether it be an iliac bi-femoral or a femoro-femoral bypass. Professor De Villiers testified that the difference was of semantic interest only and that although the medical literature referred to the femoro-femoral bypass everybody did the iliac-femoral bypass. The defendant explained in detail to the plaintiff the surgical procedure he planned to do and which was eventually done. In the circumstances I am satisfied that the plaintiff gave informed consent to the operation. In any event Professor De Villiers conceded that the iliac bi-femoral bypass or the cross-over bypass was superior to the femoro-femoral bypass, because of its advantages in facilitating a natural flow of blood to the extremities.

Was the plaintiff warned of the risks involved and was his current claudication caused by the defendant's surgical intervention?

[22**]** It was argued that the defendant had failed to warn the plaintiff of the risks at stake. In *Castell v De Greef*[6] Ackermann J said:

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

[6]1994 (4) SA 408 (C) at 425H-I.

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

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

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

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

Relying on *Castell v De Greef* it was argued that the defendant should have explained the likelihood of claudication occurring as a result of the iliac bi-femoral bypass, the so-called 'small operation'. Professor De Villiers said that the claudication which the plaintiff experienced on the left leg is undoubtedly due to what is termed a 'steal syndrome', as evidenced by the fact that the first time the plaintiff walked after his back operation, he had claudication of the left leg. He said that the problem in the left leg relates directly to the vascular operation. For this view Professor De Villiers relied on what he called Veteran Administration Studies (VA studies). The results of the study were published in 1976. It was then the largest study in the world of patients who had undergone these extra-anatomical bypasses. The study was conducted on ex-war veterans from the Second World War and the wars in Korea and Vietnam at the Veteran Administration Hospitals which were built across America. Professor De Villiers said four per cent of these patients demonstrated clinical manifestations of 'steal' and that the defendant should have anticipated a four per cent possibility of 'steal'. In simple lay terms what Professor De Villiers suggested

was happening was that blood which was meant to flow down the left leg was now being diverted to the right leg. He argued that the claudication was directly related to the smaller operation, that is the iliac bi-femoral bypass. He said that if a bigger operation, that is the aorta bi-femoral bypass had been done, the graft would have been taken down to the knee level on the left and the plaintiff would not be having a problem. Of course the evidence was that the latter operation could not have been done because the plaintiff could not afford it.

[23] Professor Immelman who gave evidence on behalf of the plaintiff said that there was only a two per cent chance of steal occurring where the smaller operation (the iliac bi-femoral bypass) was done. He said that the comparison made by Professor De Villiers and the conclusion reached by him were simply not valid. To compare the situation as it was in the year 2000 with a study that was done in 1976 at a hospital which simply did not have many of the tests available to a vascular surgeon today was unrealistic. So, for example, in the cases referred to in the study, angiograms were not performed to ascertain if there was stenosis (narrowing of the vessels), whereas the defendant *had* done the angiogram in the present matter. Professor Immelman also pointed out that the war veteran hospitals where these studies were done were not well-equipped. He said the VA studies are not highly regarded as scientific studies.

[24] Professor Immelman further pointed out that what makes modern vascular procedure difficult to compare with the VA studies is that the veterans were a generally unhealthy lot. They smoke; they drink; they are obese and they tend to have very extensive diseases. He had seen them when he visited some of these hospitals when he was in the United States. He did not consider it fair to compare that group of patients with an average patient in South Africa in the year 2000. He pointed out that, since that study in 1976, technology and investigations have improved enormously and the 'steal' percentage in cross-over by-passes, if it was four per cent in 1976, must now surely be a lot lower than that. As indicated he put the risk of 'steal' as being no higher than two per cent.

[25] The reasons advanced by Professor Immelman appear to me to be so compelling that I have no hesitation in accepting them. If there was only a two per cent chance of 'steal' occurring then the risk to the plaintiff was so negligible that it was not unreasonable for the defendant not to mention it. In *Richter and another v Estate Hammann*[7] a neuro-surgeon was found not to have been negligent in failing to warn the patient where on the evidence there was only a remote possibility of complications arising. The court said that the doctor's actions had to be tested by the standard of the reasonable doctor faced with the particular problem. In this regard Watermeyer J said the following:

[7]1976 (3) SA 226 (C) at 232G-H.

'A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interest to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'

In my view of the evidence, the likelihood of steal occurring, with the resultant claudication, was so negligible that no duty arose on the defendant to mention it and his omission to do so did not constitute negligence. In any event there is no evidence that the plaintiff's current claudication is due to 'steal' or that, if it is the result of 'steal', it is due to the cross over bypass performed on the plaintiff. The evidence was that there are many causes of 'steal'. Poor heart functioning is one of them. Professor Immelman said that if 'steal' does occur, it can be rectified by a minor operation. For the above reasons it was not in my view shown that there was an absence of informed consent or that the claudication was due to the defendant's surgical intervention.

Expert evidence and how it was dealt with at the trial.

[26] It is perhaps appropriate at this stage to touch on how the expert evidence was dealt with by the judge *a quo* in coming to his conclusion. Each side called experts eminently qualified in their respective fields. Professor De Villiers, a retired vascular surgeon, Dr Harries-Jones, a consultant radiologist and Dr Parker, a neurosurgeon, gave evidence for the plaintiff. Dr Stein, a vascular surgeon, Professor Immelman, a vascular surgeon and the Head of the Vascular Unit at Groote Schuur Hospital, testified on behalf of the defendant. Their evidence was helpful and illuminated many obscure and complicated aspects and contributed enormously to the understanding of the issues for decision in this case.

[27] Confronted with the battery of experts on either side, presenting competing and contrasting evidence, the learned judge preferred the evidence of the plaintiff's experts to that of the defendant without advancing any basis for so doing. All that he said was that the opinions of Professor De Villiers and Dr Parker are based on logical reasoning but he failed to give any demonstration of this. The learned judge did not give equal credit to Drs de Kock and Stein and Professor Immelman whose views he harshly dismissed as being incapable of logical analysis and support. I do not share these views. The conclusion reached was clearly wrong. It is an approach which this court has recently decried in *Michael and another v Linksfield Park Clinic (Pty) Ltd*,[8] where it was said:

[8]2001 (3) SA 1188 (SCA) para 39.

'…it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed".'

The uncritical acceptance of the evidence of Professor De Villiers and the plaintiff's other expert evidence and the rejection of the evidence of the defendant's expert witnesses falls short of the requisite standard and the approach laid down by this court in *Michael v Linksfield Park Clinic*. 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. I have already indicated why I found the evidence adduced on behalf of the defendant to be more acceptable than that of the plaintiff's witnesses and why the conclusion of the trial court cannot stand.

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

1. The appeal is upheld with costs, including the costs consequent upon the employment of two counsel.
2. The order of the court *a quo* is set aside and replaced with the following:

   'The plaintiff's action is dismissed with costs, including the costs consequent upon the employment of two counsel.'

KK MTHIYANE
JUDGE OF APPEAL

CONCUR:

MPATI DP
STREICHER JA
LEWIS JA
PONNAN JA