THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Reportable
Case No: 504/13

In the matter between:

MEDI-CLINIC LIMITED **APPELLANT**

And

GEORGE VERMEULEN **RESPONDENT**

Neutral citation: *Medi-Clinic v Vermeulen* (504/13) [2014] ZASCA 150 (26 September 2014)

Coram: Ponnan, Wallis, Pillay and Zondi JJA and Dambuza AJA

Heard: 22 August 2014

Delivered: 26 September 2014

Summary: Medical negligence ─ hospital and its nursing staff ─ whether bedsore and sciatic nerve injuries sustained by patient avoidable ─ two schools of thought on proper treatment of patient ─ correct test

of liability.

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ORDER

On appeal from: North Gauteng High Court, Pretoria (Mothle J sitting as court of first instance):

1 The appeal is upheld with costs including the costs of two counsel.

2 The cross-appeal is dismissed with costs.

3 The order of the court below is set aside and replaced with the following:

'The plaintiff's claim is dismissed with costs including the costs of two counsel.'

JUDGMENT

Zondi JA (Ponnan, Wallis, Pillay JJA and Dambuza AJA concurring):

[1] No one can be unmoved by the disaster which has befallen Mr Vermeulen, the respondent in this appeal. Mr Vermeulen was hospitalised on 17 May 2007 at Medi-Clinic Nelspruit Hospital, which is operated by the appellant (the defendant). He contracted cerebral malaria while on holiday in Mozambique during April 2007. As he was gravely ill on admission, he was treated in the Intensive Care Unit (ICU) where he remained from 17 May 2007 until 24 July 2007. Thereafter he was transferred to a general ward for further treatment until his discharge on 21 October 2007. Shortly after he was admitted and while he was still in the ICU he developed a pressure sore to the sacral area and heels of his feet. As a result of the sacral bedsore he suffered bilateral sciatic nerve injuries with severe impediment of his mobility. Mr Vermeulen became paralysed and is now wheelchair-bound.

[2] Mr Vermeulen sued the defendant for damages in the North Gauteng High Court, Pretoria contending that the injuries he sustained were caused by the

negligence of the defendant's nursing staff. He alleged that the nursing staff failed to take sufficient preventative measures to avoid the onset of the sacral bedsore. He said they ought to have prevented a bedsore from developing by regularly turning him so as to remove continuous pressure from his sacrum. The defendant denied that its nursing staff were negligent in their treatment of Mr Vermeulen. It contended that, given Mr Vermeulen's predisposition to sustaining a bedsore and gravely ill condition, the development of the bedsore was unavoidable. In any event, as the only effective preventative measure, namely turning would have further endangered his life during the period of critical illness, the defendant contended that it was medically inadvisable to engage in such treatment. By agreement between the parties the trial judge (Mothle J) was asked to determine only the question of liability. He found in favour of Mr Vermeulen and ordered the defendant to pay costs. The learned trial judge granted the defendant leave to appeal to this Court against his judgment and Mr Vermeulen against costs which he disallowed.

[3] As neither the court below nor counsel addressed the legal test to apply in the determination of the issue of medical negligence, I consider it necessary to begin by setting out the applicable test. It was pointed out by this Court in *Mitchell v Dixon* 1914 AD 519 at 525 that:

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

In deciding what is reasonable, this Court in *Van Wyk v Lewis* 1924 AD 438 at 444 held that the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.

[4] In *Michael & another v Linksfield Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA) (para 35) it was observed that the *Van Wyk v Lewis* test is not always a helpful guide in determining the liability of a doctor for medical

negligence. The reason is that, in the absence of evidence of the general practice prevailing in a specialist field, or a collective or representative opinion in relation to that practice it is difficult to determine the general level of skill shown by practitioners in that field. The court is often faced with conflicting medical opinions in regard to what constitutes proper treatment of a patient with the particular condition under treatment. It must then evaluate this conflicting expert testimony.

[5] At paras 37-39, the court held that what is required in the evaluation of the experts' evidence is to determine whether and to what extent their opinions are founded on logical reasoning. It is only on that basis that a court is able to determine whether one of two conflicting opinions should be preferred. An opinion expressed without logical foundation can be rejected. But it must be borne in mind that in the medical field it may not be possible to be definitive. Experts may legitimately hold diametrically opposed views and be able to support them by logical reasoning. In that event it is not open to a court simply to express a preference for the one rather than the other and on that basis to hold the medical practitioner to have been negligent. Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently.

[6] This approach was first enunciated by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (QB) at 122 and later adopted by the House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL); [1997] 4 All ER 771 (HL). In *Bolam* McNair J, in summarising the true test for establishing negligence on the part of the doctor in medical negligence cases said (at 122B─C):

'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the

other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century". That clearly would be wrong.'

[7] In *Bolitho* Lord Browne-Wilkinson, with regard to the treatment of expert evidence in cases where a doctor's negligence is sought to be established, stated (at 778d-g):

'. . . in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In *Bolam's* case [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 587 McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men" (my emphasis). Later he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion" (see [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 588; my emphasis). Again, in the passage which I have cited from *Maynard*'s case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives ─ responsible, reasonable and respectable ─ all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.'

[8] After referring to various cases such as *Hucks v Cole* (1968) (1993) 4 Med LR 393 and *Edward Wong Finance Co Ltd v Johnson Stokes & Master (a firm)* [1984] AC 296, [1984] 2 WLR 1, Lord Browne-Wilkinson summarised the legal position as follows (at 779d-g):

'These decisions demonstrate that in cases of diagnosis and treatment there are cases where,

despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.'

[9] I now proceed to deal with the facts. Mr Vermeulen was first seen at the emergency rooms of Nelspruit Medi-Clinic on 17 May 2007 at about 15h15. He gave a history of having returned from Mozambique two weeks before. He had been feeling feverish and had shortness of breath. He gave a medical history of hypertension. He was transferred to the ICU at 16h30 with a diagnosis of malaria. His skin was noted to be 'intact' and a Waterlow scale assessment,[1] a tool used to assess the risk of development of pressure sores, was performed. He was scored as being 'at risk (10 ─ 14)'. In general, when a patient is considered to be vulnerable to developing pressure sores, interventions to control tissue loading such as turning; repositioning at regular intervals; providing a nimbus mattress, inserting pillows or foams beneath the sacral area and heels; or tilting the patient, are used.

[10] Mr Vermeulen's condition deteriorated and became worse during the period 20 May to 24 May 2004, which the parties described as the critical period. During this period, he was incapable of turning himself. It is during this period that the sacral pressure sore developed. It became well-established in the period between 23 and 26

1A Waterlow scale assessment is used by the nurses in recording the pre-existing condition of the patient on admission and is composed of the following risk areas; build/weight or height, skin type and visual risk areas, gender and age, appetite, continence, mobility, tissue malnutrition, neurological deficit, major surgery or trauma and medication. The higher the score, the higher the risk of pressure sores formation.

May 2007. By the time the critical period of illness had passed, Mr Vermeulen had a significant and irreversible sacral bedsore.

[11] On admission, Mr Vermeulen had a depressed level of consciousness and was having great difficulty in breathing. His pulse was 130 beats per minute and he was already showing signs of respiratory failure. He was thereafter intubated. His blood pressure was low (at 106/73) and his temperature was high. Quinine was administered through a peripheral infusion and a catheter was inserted into the bladder. Dr Theron, the treating physician also inserted a venous cannula via the right jugular vein and an intra-arterial cannula into the right radial artery. According to Dr Theron, within 48 hours of his admission, Mr Vermeulen needed inotropic[2] support to sustain his blood pressure. His cardiac output started dropping on 19 May 2007 and his blood pressure dropped to an extremely low level. He required an adrenalin infusion in an attempt to raise his blood pressure. It was noted on 20 May 2007 that his peripheral perfusion was poor, his extremities cold and his pedal pulses weak. Skin lesions were also noted. There is a note on 21 May 2007 that he had poor capillary refilling in his right leg. He was hyperglycaemic and insulin had to be administered. It appears that renal failure developed and dialysis was started on 21 May 2007. During the course of the third day Mr Vermeulen's condition worsened and it was during that period that the possibility of him developing a bedsore existed unless he was turned regularly.

[12] On 20 May 2007 at about 23h30 a nurse noted that the 'skin still intact appear very reddish and sacral allewyn in situ'. On 22 May blue marks were noted on the sacral area. It would appear from the assessment form completed on 25 May 2007 that Mr Vermeulen had lesions on the buttocks measuring 8cm by 8cm, 10cm by 10cm and a third one of 10cm by 5cm which had turned purple. Dr Botha recommended that he be treated on a nimbus mattress as he was concerned that Mr Vermeulen's skin lesions could develop into pressure sores having regard to the fact

2 Affecting the force of muscle contraction.

that he weighed 150kg and the fact that he was on an adrenalin infusion. At 17h20 on 25 May it was noted that the skin on his sacrum had turned ‘black’. Mr Vermeulen was eventually moved onto a nimbus mattress at 23h10 on 25 May 2007. Dr Smit, a general surgeon was consulted on 9 June and he performed three debridements. According to Dr Smit’s notes there was extensive necrosis of the wound and he reported weakness of the ankles before the procedures.

[13] As far as the cause of the sciatic nerve injury is concerned, Dr Retief’s evidence was that it was caused by the pressure sore, either via ischaemia due to external pressure or via local sepsis and must have occurred after the critical period. This was because the sacral pressure sore was located directly over the course of the sciatic nerves. The link between the sciatic nerve injury and the sacral pressure sore is to be found also in the evidence of Dr Van Wyk. He testified that he ‘kon omtrent ‘n driekwart van my vuis in daardie holte ingedruk het, . . . en die linkerboud kon ek ook ‘n vuis ingedruk het in die middel van die wond . . . .’

[14] The plaintiff’s case as developed at the trial and advanced in this Court appears to stand on two legs. First, that the pressure sores, at the very least regarding their severity if not completely, were avoidable by the implementation of a pressure care regimen of sufficient frequency and adequacy to either remove or relieve pressure from the sacrum, heels and nerves. The second was that despite the fact that Mr Vermeulen was critically ill with malaria, and despite the presence of factors predisposing him to pressure sores, it was eminently possible to implement a pressure care regimen. It was said that there was no credible evidence that haemodynamic instability in fact occurred, or motivated or influenced the decision not to implement the required pressure care regimen or that it was impossible to implement it for fear of causing Mr Vermeulen’s demise or aggravation of the instability.

[15] The defendant appeared to have accepted that Mr Vermeulen, who was in the top 1 per cent risk category for the formation of a pressure sore had to be turned on a regular basis for there to be any prospect of avoiding a pressure sore, but it contended that it would have been unreasonable for its nursing staff to have done so in the circumstances. It said that any interference with the haemodynamic stability of a critically ill patient such as Mr Vermeulen would have been unwise.

[16] The plaintiff bore the onus of proving that the defendant's nursing staff were negligent.[3] To that end, he called Dr Martin Lebos, a practising specialist surgeon, Professor W E Nel, a registered professional nurse and senior lecturer at the University of Johannesburg; Dr C F Retief, a neurologist; Dr H S Van Wyk, a general practitioner; Dr Buys, an anaesthesiologist and critical care specialist; and Mr F Theron, a physiotherapist. The defendant called Dr P Theron, a specialist physician and the consulting physician to Mr Vermeulen and Professor A R Coetzee, a specialist anaesthesist and critical care specialist, Executive Head of the Department of Anesthesiology and Critical Care at the University of Stellenbosch and Tygerberg Hospital. All the experts were agreed that Mr Vermeulen was gravely ill during 20 May to 24 May and that in general, it is unsafe to reposition, move or turn a patient who is critically ill if that patient's mean blood pressure is low. They were, however, divided on what would constitute a life threatening low mean blood pressure in the case of Mr Vermeulen. Dr Lebos and Dr Theron put it at 60mmHg, while Professor Coetzee put it at 75mmHg in the light of Mr Vermeulen's weight and his alleged undiagnosed diabetes.

[17] Professor Nel's evidence was that although most pressure sores are preventable some are unavoidable. She opined that the most effective strategy to prevent a pressure sore from forming, is to turn the patient every four hours 'from one side to another or on his back' if he is stable. But she pointed out that this strategy is unsuitable for 'extremely unstable' patients. She suggested that a

3 *Van Wyk v Lewis* supra at 444.

pressure sore for such patients can be prevented by either putting ‘a very soft pillow’ underneath the buttocks of the patient for half an hour or by treating them on a nimbus mattress, although its use does not absolve the nurses from applying further pressure care. She emphasised that the nature of the pressure care that was applied to Mr Vermeulen was inadequate. It was also her opinion that Mr Vermeulen should not have been left seated in a Lazy-Boy chair for hours on 3 to 5 June 2007 with clearly visible lesions. This was also the view expressed by Dr Buys.

[18] The court below rejected the defendant’s contention that the onset of the pressure sore was unavoidable. It also rejected the evidence of Professor Coetzee that turning him in order to prevent the development of a pressure sore was medically speaking unsafe. It found that there was evidence which demonstrated that during the critical period Mr Vermeulen was turned on his side while his mean blood pressure was less than 60 and that did not result in his demise. It also rejected Dr Theron’s evidence that failure by the defendant’s nursing staff to regularly turn Mr Vermeulen was as a result of an instruction he had given to them not to turn him when his blood pressure was below 60. It held that the case based on such instruction was not pleaded by the defendant and neither was it corroborated. It accordingly concluded that the defendant’s nursing staff assigned to care for Mr Vermeulen, failed to provide adequate care necessary to prevent, alternatively delay the onset of the pressure sore and that their ‘negligence was the cause of the development of pressure sores which resulted in the lesions on [Mr Vermeulen’s] back and heels’. In coming to this conclusion, the court below accepted and relied on the evidence of Dr Lebos to the effect that it would have been possible for the nurses to avoid the onset of the pressure sore by turning Mr Vermeulen in accordance with the defendant’s protocol and adopting other measures as suggested by Dr Buys and Professor Nel. The court below found that the defendant’s failure to call the nurses concerned to testify as to their role and conduct constituted a serious omission.

[19] It was submitted on behalf of the defendant that the court below erred in rejecting Professor Coetzee's view that during the critical period Mr Vermeulen was too ill to be regularly turned so as to prevent the onset of the pressure sores and that this could not be undertaken without endangering Mr Vermeulen's life. It argued that Professor Coetzee's view, which formed the basis of the defendant's defence, could not be said to be illogical or unreasonable. In arriving at the conclusion that it would have been very dangerous to regularly turn Mr Vermeulen when he was seriously ill, so the submission went, Professor Coetzee had considered comparative risks and benefits.

[20] On the other hand, counsel for Mr Vermeulen, arguing in support of the court below's findings submitted that Professor Coetzee's opinion lacked logical reasoning. In short, he submitted that there was simply no proof of the fact underlying Professor Coetzee's theory. He pointed out that the hospital records and ICU charts revealed that during the critical period there were occasions when the hospital staff turned Mr Vermeulen when his blood pressure was below 60 and such turning did not result in his death.

[21] An analysis of the experts' evidence, in particular that of Dr Lebos and Professor Coetzee is necessary to determine the correctness of counsel's submissions bearing in mind that the experts were agreed that regular turning of Mr Vermeulen from side to side was the strategy that the defendant's nurses had to implement in order to avoid or delay or minimise the development of a pressure sore.

[22] According to Dr Lebos once the patient is in an ICU setting pressure care is very important 'you cannot say well, I am going to save his life and ignore it' on the grounds that if he is turned his blood pressure may fall. He expressed doubt about

the notion that, turning a critically ill patient such as Mr Vermeulen could compromise his haemodynamic stability. He said that the treating doctor would need to be informed that on moving him there was a change in his haemodynamic stability and would need to assess how significant that change was. He maintained that there is no way to predict which patients will become unstable when they are turned, 'it just does happen and it can be alarming in certain patients that when they are turned, they drop their blood pressure significantly, it can go as low as half of what it originally was'. He emphasised that a treating physician will have to assess the amount of the drop, 'so unless it is compromising [the patient's] well-being he should be turned'. Although he conceded that certain pressure sores are unavoidable he said that this was not the position in this case, because in his view, Mr Vermeulen 'was not given optimum care to prevent pressure sores'. But the thrust of his opinion was that he would only take a decision not to turn the patient if he was convinced that turning him would cost him his life; not that it would nearly be life threatening. The basis for his hypothesis was that in his view the risk of the pressure sore killing a patient is 10 per cent and the risk of a critically ill patient's blood pressure dropping to a dangerously low level is less than 5 per cent. In that scenario he would take the option with the lowest risk and turn the patient, but in doing so, he would pay no attention to the patient's blood pressure levels because in his view whether or not a critically ill patient should be turned does not depend on the blood pressure. But he accepted that for a hypertensive patient such as Mr Vermeulen he would strive for a blood pressure of about 65 and would not turn such a patient if his blood pressure fell below 65. He conceded that if Mr Vermeulen was an undiagnosed hypertensive patient he would strive for a blood pressure higher than he would for a patient who was not an undiagnosed hypertensive.

[23] Professor Coetzee criticised Dr Lebos' approach as being too risky. He pointed out that the problem with Dr Lebos' approach is that once a patient has a mean blood pressure low enough to have resulted in cardiac muscle injury, any

further lowering will cause greater damage with the risk of acute severe myocardial injury and even ventricular fibrillation. In developing his theory, Professor Coetzee pointed out that if a patient was operating at a perfusion pressure lower than the acceptable levels for that patient, he would only allow turning to be attempted with caution. If the pressure further fluctuated during the attempt, he would instruct the nursing staff not to turn the patient until such time as the perfusion pressure had improved to safe levels when another attempt could be made. He opined that Mr Vermeulen's history of hypertension was relevant as the safe mean blood pressure would then be around 90 (and not 75) for him to have been safely turned. Given the fact that during the critical period a safe mean blood pressure of 90 could not be achieved it would therefore not have been advisable to turn him.

[24] In support of his analysis he referred to the notes on the ICU charts which, he pointed out, showed that from 16h00 on 20 May Mr Vermeulen had a critical low mean blood pressure of below 60 at which level it would have been ill advised to turn him. He said that if he were a treating doctor he would have advised the nursing staff not to turn him, especially if an attempted turn had already resulted in a change. Evidence revealed that Mr Vermeulen's condition as recorded over each 24 hour period was as follows: on 21 May the lowest blood pressure recorded was 47 and the highest 59; on 22 May the lowest was 48 and the highest 69; 23 May the lowest was 33 and the highest 78 and on 24 May the lowest was 56 and the highest 89. Professor Coetzee testified that where Mr Vermeulen's mean blood pressure dropped to 48, which was life-threatening, he would have given a firm instruction not to move him at all. He ascribed the development of the sacral pressure sore to poor perfusion in the sacral area which was due to other factors such as Mr Vermeulen's low blood pressure in turn resulting in poor perfusion; high tissue pressure due to his extreme obesity and finally the disruption to the tissue integrity due to his critical illness.

[25] To determine whether or not the defendant's nurses were negligent the court below had to have regard to the views of the parties' experts.[4] This is so because a court's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence. Failure to act in accordance with a practice accepted as proper in the relevant field, is necessary[5] and it was for the court to decide that issue. And in doing so, it had to be satisfied that their opinions have a logical basis and whether in forming their views, the two experts had directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter.[6]

[26] In my view, the court below erred in accepting Dr Lebos' opinion and deciding the issue of negligence on the basis thereof. It did not subject it to critical analysis with a view to establishing first, whether it had a logical basis and secondly, whether, in forming his views, Dr Lebos directed his mind to the question of comparative risks and benefits and reached a defensible conclusion on whether the pressure sore which Mr Vermeulen sustained was avoidable. The court below should have been vigilant in assessing whether the reasons given by Dr Lebos for the conclusion that Mr Vermeulen could be safely turned during the critical period were valid in the light of Professor Coetzee's evidence. In other words, in the assessment of medical risks and benefits undertaken by Dr Lebos in reaching his conclusion, the court below had to have regard to the evidence of Professor Coetzee as the assessment of medical risks and benefits is a matter involving clinical judgment. As Lord Browne-Wilkinson correctly pointed out in *Bolitho* supra (at 779j):

'it is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.'

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4 *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) para 14.
5 *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 at 639, [1984] 1 WLR 634 at 639.
6 *Bolitho*, supra at 778.

[27] There are several difficulties with Dr Lebos' theory. First, it proceeds from the premise that every bedsore is avoidable, because the majority of patients who are treated in critical care units worldwide do not get a bedsore if they receive pressure care as part of their treatment. That flies in the face of the evidence that some bedsores are unavoidable. Dr Lebos appeared to have believed that the fact that Mr Vermeulen sustained a pressure sore, meant that the defendant's nursing staff were negligent. In other words, he seemed to suggest that the mere fact that Mr Vermeulen sustained a bedsore during his stay in the defendant's hospital was prima facie evidence of negligence, the effect of which was that the onus shifted to the defendant to rebut the presumption of negligence. But that is to reason backwards from effect to cause or even to apply *res ipsa loquitur* which is impermissible. Secondly, in his opinion once a patient is treated in an ICU setting, those treating him have to administer to him pressure relief management irrespective of how critically ill the patient is. A treating doctor cannot ignore it and focus on attempting to save the patient's life because of the fear that if he attempts to turn the patient his haemodynamic stability will be compromised. This approach makes it clear that in forming his views, Dr Lebos did not direct his mind to the question of comparative risks and benefits. Thirdly, Dr Lebos' opinion that before taking a decision not to turn a critically ill patient, there has to be evidence that demonstrates that turning or moving a patient, affected the patient's haemodynamic stability, is too risky. According to him, he would only take a decision not to turn the patient if he was convinced that turning him would cost his life, not that it would be life threatening, and in taking that decision he would not take into account the patient's blood pressure level because in his experience 'there is no figure that says at [a certain blood pressure level] you should not turn the patient'.

[28] It is clear from Dr Lebos' analysis that in reaching the conclusion that Mr Vermeulen could be turned, he did not take into account Mr Vermeulen's blood pressure levels which, according to Dr Theron and Professor Coetzee was a relevant

factor which had to be taken into consideration in deciding whether or not a critically ill patient should be turned. Professor Coetzee explained why the approach postulated by Dr Lebos was unsupportable:

'Is daar 'n daadwerklike risiko indien jy 'n party met hierdie tipe bloeddruk in die posisie van mnr Vermeulen draai, dat hy kan sterf? --- Sonder twyfel is daar so 'n risiko en ek wou ook net met die hof bevestig die problem is dat, om te sien dat die bloeddruk val, moet jy draai. Nou jy weet nie vooraf hoeveel die bloeddruk gaan val nie. Nou jy gaan nou deur die oefeninge en jy toets die pasiënt en die pasiënt val onderkant die lewensbehoudende druk, en die hart virbuleer, so, jy sal eers uitvind van jou fout as jy dit doen. Derhalwe my versigtige benadering is nee. Dit is teoreties te laag, moet nie draai nie, want jy kan die pasiënt se lewe kos.'

[29] A decision whether or not to turn Mr Vermeulen during the critical period required an assessment of the medical risks and benefits of doing so. Professor Coetzee was of the opinion that, based on his blood pressure levels during the critical period and the manner in which he reacted to movement, it was unsafe to turn Mr Vermeulen and accordingly the pressure sore was probably unavoidable. He explained why a minimum blood pressure level was critical in deciding whether or not to turn Mr Vermeulen. He pointed out that Mr Vermeulen was a hypertensive patient and that being the case it was important to maintain his blood pressure within 30 per cent of his normal blood pressure. To illustrate this point, he pointed out that if Mr Vermeulen's blood pressure was 180 mmHg systolic, he would aim for a pressure of 126 mmHg systolic or a 93 mmHg mean.

[30] As regards the contention that the defendant aggravated Mr Vermeulen's injuries by keeping him seated in a chair (Lazy-Boy) for hours on 3 to 5 June, it was the opinion of Dr P Theron and Professor Coetzee that that was part of Mr Vermeulen's treatment. It was directed at ensuring that his lungs functioned properly. Professor Coetzee explained that Mr Vermeulen had been intubated and extubated on 2 June and reintubated on 6 June. He had been on ventilation for a few days and his lungs were not functioning properly. He had to be seated upright to

achieve that because ‘long fisiologie dikteer dit is baie beter vir die long’.

[31] In these circumstances there can be no basis for the conclusion that Professor Coetzee’s theory is not logically supported and should for that reason, be rejected. It is clear from his evidence that in coming to the conclusion that Mr Vermeulen’s injuries were unavoidable he weighed the relative risks and benefits of the suggested nursing care aimed at avoiding bed sores and concluded that such nursing care was medically inadvisable because of the risk it posed to the patient’s life. Thus on the evidence adduced at the trial Professor Coetzee’s cautious approach cannot be said to be unreasonable. Dr Lebos did not consider these aspects in reaching his conclusion. It is clear from Dr Lebos’ evidence that his theory was directed at preventing the development of a pressure sore at all costs irrespective of the risks to the patient’s life.

[32] It follows that the court below’s finding that the defendant’s nursing staff were negligent and that their negligence caused Mr Vermeulen’s present condition, cannot be sustained.

[33] In conclusion, the plaintiff has suffered such terrible consequences that there is a natural feeling that he should be compensated. But, as Denning LJ correctly remarked in *Roe v Ministry of Health & others*; *Woolley v Same* [1954] 2 All ER 131 (CA) at 139:

‘But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.’

[34] In the result:

1 The appeal is upheld with costs including the costs of two counsel.

2 The cross-appeal is dismissed with costs.

3 The order of the court below is set aside and replaced with the following:

‘The plaintiff’s claim is dismissed with costs including the costs of two counsel.’

_____

D H Zondi
Judge of Appeal

Appearances

For the Appellant:	R van Riet SC (with him A D Brown)
	Instructed by:
	Symington & De Kok, Bloemfontein
	Fairbridges Attorneys, Cape Town
For the Respondent:	W P de Waal SC (with him W L Munro)
	Instructed by:
	Honey & Partners Inc, Bloemfontein
	Adams & Adams, Pretoria