Editorial note: Certain information has been redacted from this judgment in compliance with the law.

THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Reportable

Case no: 211/2018

In the matter between:

R B **APPELLANT**

and

DR SAMUEL JOHANNES SMITH **RESPONDENT**

Neutral citation: *R B v Smith* (211/2018) [2019] ZASCA 48 (01 April 2019)

Coram: Navsa AP, Zondi, Dambuza and Mocumie JJA and Mokgohloa AJA

Heard: 22 February 2019

Delivered: 01 April 2019

Summary: Delict – claim for damages based on failure to obtain informed consent to medical procedure for hernia repair – factual finding of trial court on whether the patient was informed, confirmed – no dispute on material risks inherent in competing surgical procedures – information given to patient met the required standard – common cause that there was no negligence in the performance of elected surgery – appeal dismissed

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ORDER

On appeal from: Gauteng Division, Pretoria (Tuchten J sitting as court of first instance):

The appeal is dismissed with costs.

JUDGMENT

Dambuza JA (Navsa AP, Zondi, Dambuza and Mocumie JJA and Mokgohloa AJA concurring):

Introduction

[1] This appeal is about whether the respondent, Dr Samuel Smith (Dr Smith), a surgeon who performed a laparoscopic[1] hernia repair on the appellant, Mrs R B (Mrs B) is liable for damages for the alleged failure to provide the appellant with sufficient information so as to enable her to give informed consent for that surgery. Mrs B instituted a claim for damages against Dr Smith, alleging that the doctor negligently omitted to inform her that the hernia repair could be done by way of a laparotomy[2] procedure. Such failure, so she contended, caused her to give uninformed consent to the laparoscopy, and resulted in her suffering damages as a result of colon perforation during that procedure, which, it was asserted, was less risky. Mrs B's claim was

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[1] Laparoscopy is a medical procedure in which examination of the interior of the abdomen is done my means of a laparoscope. See Dorland's Illustrated *Medical Dictionary* 25 ed. Small incisions are made to introduce a camera which allows the surgeon to see where to introduce the necessary instrumentation.

[2] According to Dorland's Medical Dictionary, Laparotomy is "surgical incision through the flank" or "abdominal section at any point." It may be a long incision from the sternum to the pubic area. It is generally accepted that Laparoscopy is less intrusive than open surgery. Compare with fn 1.

dismissed by Tuchten J in the Gauteng Division of the High Court, Pretoria (high court). This appeal is with leave of the high court.

Background

[2] The following events preceded the high court proceedings. During November 2011 Mrs B was admitted to Victoria Hospital in Mahikeng, complaining of abdominal pain and distention. She was treated conservatively and Computer Tomography (CT) scans were taken. From the images, Dr Kibowa, the treating doctor at Victoria Hospital, identified a cystic mass lesion in the right iliac fossa (pelvic groove), an ovarian cyst or abscess and a femoral hernia in the right inguinal (groin) region. Dr Kibowa referred Mrs B to Dr Smith, a general surgeon practising from the Life Anncron Hospital in Klerksdorp, as there were no specialist surgeons in Mahikeng.

[3] Mrs B attended Dr Smith's consulting rooms on 21 February 2012. She informed Dr Smith that she had experienced the abdominal pain for about a week, but that it had worsened in the three day period since she had been seen by Dr Kibowa. Having considered the referral letter from Dr Kibowa, together with Mrs B's medical history, which included three previous operations, and the report from the radiologists on the Axial and CECT[3] scans of Mrs B's abdomen and pelvis, Dr Smith made a differential (provisional) diagnosis of 'sub-total bowel obstruction secondary to previous surgery, an ovarian cystic mass, and an inguinal hernia'. Mrs B had had two previous appendectomies, a hysterectomy and a cholecystectomy. The CT scan showed two hernias, at one of the old appendix scars, and a left femoral hernia. Mrs B had, however, not brought all the images of the CT scans done on her to Dr Smith.

[4] Having consulted Mrs B on 21 February 2012, Dr Smith caused her to be admitted to Life Anncron Hospital. He would have preferred to view all the CT scan images, presumably, to be more certain about the diagnosis. Hence, the following day, 22 February 2012, he consulted local radiologists on the radiologist report attached to the referral letter. The local radiologists could not be of much assistance as they also required all the scans in order to interpret and assist in the further diagnosis. It appears that it would have been preferable to have the scans re-done. Mrs B's medical aid was

[3] Contrast Enhanced Computer Topography.

however not likely to approve that expense, since scans in relation to the same complaint had already been done at Victoria Hospital. On the same day, 22 February 2012, Dr Smith wrote to Mrs B's medical aid scheme, motivating for the approval of a laparoscopic hernia repair, as follows:

'I would like to motivate for a laparoscopic incisional hernia repair on above patient.

The patient is quite obese and laparoscopic repair is considered the gold standard repair for incisional hernia, especially in obese patients for the following reasons:

GENERAL ADVANTAGES OF LAPAROSCOPIC SURGERY

- faster operation time
- less pain for patient
- shorter ileus period
- faster recovery
- faster discharge from hospital
- quicker return to work for patient

SPECIFIC ADVANTAGES OF LAPAROSCOPIC HERNIA REPAIR

- Much lower incidence of wound complications, superficial wound infection and wound dehiscence.
- Smaller wound has much quicker healing time even if wound infection does occur.
- If wound infection does occur, the wound is far away from the hernia site and mesh, thus mesh infection with subsequent mesh sepsis, chronic wound drainage and re operations to remove septic mesh, and redo of hernia repair is much lower with laparoscopic surgery.
- To manage an infected open hernia repair with mesh sepsis is massively unsatisfying, costly, time consuming.
- The cost of the mesh for open or laparoscopic hernia repair remains the same, as intra peritoneal mesh placement is used for both techniques. With open hernia repair, the wound is directly over and above the mesh, making it susceptible for infection, but with laparoscopic repair the wound is about 5cm away from the lateral edge of the mesh.
- Patients that undergo an open hernia repair often needs ICU management for 24-72h post op for pain control and observation, and another 3-5 days in the ward before discharge, where laparoscopic repair patients routinely returns to the ward and can be discharged within 24-72h.'

On 23 February 2012 Dr Smith, assisted by Dr Dries,[4] proceeded to do the laparoscopic hernia repair on Mrs B.

[5] During the intricate laparoscopy Dr Smith found a Spigelian hernia with the bowel attached to it at the location of the old appendix scar. He repaired the hernia by reducing it and placing mesh over it. He also did an oophorectomy (removal of an ovarian cystic mass) - the mass aspirated from the right ovary was sent for histology. However, despite complicated and extensive adhesiolysis (dissection of a number of adhesions) during the two and a half hour operation, and the deep exploration of the abdomen, Dr Smith could not find the reported femoral hernia. Mrs B was discharged from hospital on 28 February 2012.

[6] Three days after her discharge from hospital, on 1 March 2012, Mrs B was readmitted to the hospital, presenting with acute abdominal pain and rectal bleeding. In theatre Dr Smith performed an emergency 're-look procedure'. He found a colon perforation from which emanated a trickle of septic fluid. It was on the rectum, about 15cm from the anal verge. Dr Smith thought that it had been caused by traction on the rectum during the adhesiolysis, as he was looking for the femoral hernia. He performed a Hartmann's operation[5] and washed out the peritoneal cavity with saline. He removed the mesh and did an end colostomy, leaving drains in place. Mrs B was admitted to Intensive Care Unit (ICU) and put on a ventilator.

[7] Three further surgical procedures were performed to clean out Mrs B's peritoneal cavity. A foley catheter was inserted in her rectum to control possible fistula. She received wound care and remained in hospital with an open abdomen covered with a split skin graft until 19 April 2012 when she was discharged. Her incisional hernia was subsequently repaired and her colon anastomosed by another surgeon.

[8] On 4 April 2014 Mrs B instituted proceedings for damages against Dr Smith and the Life Anncron Hospital. Having set out the *sequelae* resulting from the operations

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[4]

[5] Resection of the rectosigmoid colon with creation of colostomy.

performed by Dr Smith, which included a further hernia at the site of the surgery, disfigurement to her abdomen, and chronic lower back pain, Mrs B alleged in the particulars of claim that these resulted from the negligence of Dr Smith and the medical staff at the hospital in breach of their legal duty to exercise reasonable skill, care and diligence. She also alleged that they failed to obtain informed consent from her before performing the hernia repair surgery.

[9] Specifically, as against Dr Smith, the allegation was that he negligently elected to perform laparoscopic surgery instead of a laparotomy, despite the higher risk of bowel and vascular injury posed by the former to obese patients. It was also alleged that the removal of the ovarian cyst had been unindicated and unnecessary. Mrs B later withdrew her claim against the Life Anncron Hospital.

[10] In his plea Dr Smith contended that Mrs B gave him informed consent orally on 22 February 2012, following an explanation by him of the contemplated laparoscopic surgery and the laparotomy option, together with the attendant material risks. He contended further that the written consent signed by Mrs B shortly before the operation on 23 February 2012, which formed part of the record, was confirmation of the oral consent given the previous day, following his explanation of both procedures.

[11] In her evidence Mrs B denied that Dr Smith explained both procedures to her. She also denied that the doctor had made a provisional diagnosis. She insisted that, in her first consultation with Dr Smith on 21 February 2012, the latter told her that he would first consult with the radiologists on her scans and thereafter perform a ‘quick . . .15 to 20 minute operation’ to repair her hernia with a mesh, and, in ‘two or three days’ she would be home. On her version, Dr Smith made the decision to do the laparoscopic hernia repair on her during the first consultation, on 21 February 2012, even before consulting the local radiologists. She suggested that the reason for admitting her on that day was to perform the laparoscopy. In her words ‘If the defendant did not want to operate on me, why did he admit me?’. According to her, Dr Smith instructed his secretary to book a bed for her; and said that he would ‘prep’ her for an operation on 23 February 2012.

[12] In her evidence, Mrs B denied having signed the written confirmation of informed consent form and also denied that she was at the theatre at 05h00 on 23 February 2012 when the consent form was signed. She also sought to suggest that it was only shortly before the trial that she became aware that Dr Smith had removed her ovarian cyst, although in the summons she alleged that Dr Smith unnecessarily removed the ovarian cyst.

[13] Mrs B testified that if she had been informed that the hernia could also be repaired through a laparotomy she would have discussed her options with her family and would have opted for the less risky of the two procedures. But she trusted Dr Smith and believed him when he told her that the laparoscopy was a simple procedure that would take 15 to 20 minutes and that she would be discharged from hospital in three days.

[14] Dr Smith testified that during the consultation on 21 February 2012 he considered that surgery might be required if Mrs B's condition did not improve through conservative treatment. On the morning of 22 February 2012 he had a consultation with Mrs B, during which he informed her of the nature of each of the two medical procedures open to her and the attendant material risks and benefits. He told Mrs B that his opinion was that the laparoscopic procedure would be better. Thereafter, Mrs B gave oral informed consent to the proposed laparoscopic procedure. The oral consent was confirmed in writing in the early morning of the following day, the day of the operation.

[15] Dr Smith explained the benefits of a laparoscopy as – smaller wounds, quicker healing, less scarring, less pain, a lower wound infection rate, a shorter hospital stay, and a shorter recovery period. This is in line with his motivation to her medical aid scheme. The significant risks were bowel perforation and the possibility that the procedure could have to be converted to laparotomy. As to open surgery the risks were bowel injury (although lower than in laparoscopy), long incision, hernias, wound dehiscence and increased risk of infection, particularly for obese people and smokers.

This explanation is consistent with that given by Dr Bizos in his evidence regarding the risk and benefits of each of the procedures.

[16] Mrs B was high risk for wound infection because of her morbid obesity. At 41 years old at the time she weighed 125.9kg, was 1,65m tall and therefore had a body mass index (BMI) of 46. She was a smoker. Further, having had three previous operations meant that she would have adhesions in the peritoneal cavity, she was therefore a high risk case for bowel injury during laparoscopic surgery or even for laparotomy. Dr Smith was of the opinion that performing the hernia repair laparoscopically was the better option for Mrs B, because of her excessive weight, the likelihood of adhesions due to her previous operations and because she was a smoker.

[17] Professors Desmond Pantanowitz and Damon Bizos, both specialist surgeons, gave evidence on behalf of Mrs B and Dr Smith, respectively. Importantly, they agreed that a laparoscopy was indicated; that there was no negligence in the performance thereof; in particular, that the bowel perforation was not caused by negligence on the part of Dr Smith; and that Dr Smith's post-operation management of the appellant was acceptable. The experts were also in agreement that because of Mrs B's weight, the three previous abdominal operations which were likely to have caused adhesions in the peritoneal cavity, she was high risk for bowel injury. The evidence of both experts was that the incidence of bowel perforation was higher in laparoscopic surgery than in laparotomy, and that the risk of post-operative wound infection was higher in laparotomy for obese patients and smokers. Even Prof Pantanowitz, Mrs B's expert, did not dispute the opinion that laparoscopy was the safer option for Mrs B. His only concern was whether informed consent had been obtained beforehand.

The High Court

[18] At the start of the trial the high court granted an order in terms of Rule 33(4) of the Uniform Rules of Court 'deferring the determination of quantum of the plaintiff's claim and directing that the trial proceed on all other issues raised in the pleadings.' The high court considered the claim to have been founded on contract. It must be said though that in the particulars of claim Mrs B had alleged that the hospital and Dr Smith were 'under a legal duty of care to ensure that the rendering of medical care, treatment

and advice to [her] with such skill, care and diligence as could reasonably be expected of medical practitioners and nursing personnel in similar circumstances, obliging [them] to ensure that proper, sufficient and reasonable health services were provided to members of the public'. She also pleaded that her injury resulted from the *negligence* of the medical staff at the hospital who, together with Dr Smith in, amongst other things, failing to obtain informed consent from her before performing the laparoscopic procedure. Mrs B's claim therefore was founded on delict.

[19] In dismissing the claim, the high court found, in favour of Dr Smith, on the conflicting versions of what had been communicated. It found that Mrs B was not a reliable witness. This, the court attributed to her physical and emotional state shortly before the operation. It found that she had been passive and trusting of the doctor and was not likely to recall the discussion regarding the risks and benefits of the two procedures. Although there was no evidence to this effect, the high court was of the view that Mrs B would have taken pain control medicine and would therefore not have been quite attentive during the days preceding the operation. She was therefore unlikely to recall the conversation that she had with the doctor on 22 February 2012. The court rejected Ms B's version that on 21 February 2012, during the first consultation, Dr Smith had already made the decision to operate on her. It accepted the doctor's version that he had explained the different surgical procedures to her. It also found, as Mrs B testified, that Dr Smith had considerable patience – this was further demonstrated during rigorous cross-examination. He was, by all accounts, a caring and diligent doctor. The informed consent issue was therefore decided on the version tendered by Dr Smith. I interpose to state that it was never Mrs B case that she was unable, because of medication or otherwise, to appreciate what was being communicated to her by Dr Smith. Her case was that she was never fully informed of her options and the risks and benefits.

Submissions on appeal

[20] We are called upon to determine what Dr Smith imparted to Mrs B and whether that constituted sufficient information to the appellant to enable her to give informed consent to the laparoscopy.

[21] Mrs B, in seeking reconsideration of the high court's factual finding that Dr Smith did provide her with the necessary information, insisted that the hospital records did not support Dr Smith's version. Chief amongst her contentions were that although the hospital records show that the doctor had a consultation with her at 08h00 on the 22 February 2012, during which, according to Dr Smith, the information was given, there is no recordal of the details of the purported informed consent discussion. The fact that Dr Smith was unable to recall the identity of the staff member at the hospital who made the relevant entry was criticized. The submission was that, in the absence of evidence on the details of such consultation and on the identity of the author of the recordal, a conclusion should be drawn that Dr Smith never gave Mrs B the necessary information on that day as he alleged. Further, even, if Dr Smith gave her some information, it was not sufficient to enable her to make an informed decision. In this regard Dr Smith was cross-examined at length regarding his failure to inform Mrs B that the consequences of wound sepsis (which was high risk in laparotomy) would be ameliorated by the specialist wound care health facility at Wilmed Park, in close vicinity to the hospital. The suggestion was that this was a material benefit which should have been communicated to Mrs B.

Discussion

[22] It is trite that the powers of an appeal court to overturn factual findings by a trial court are restricted.[6] But where the findings of a trial court are based on false premises or where relevant facts have been ignored, or where the factual findings are clearly wrong, the appeal court is bound to reverse them.

[23] Indeed, the doctor's evidence was entirely reliant on his memory regarding what transpired over the relevant period. But several aspects supported his version. As the high court reasoned, Dr Smith's demeanour and diligence, which Mrs B also confirmed, was more consistent with the version that he would have explained the contemplated treating methods than not. The judgment of the high court was based on the available

[6] D T Zeffert and A P Paizes *The South African Law of Evidence* (2 ed) at 942; *Rex v Dhlumayo and Another* 1948 (2) SA 677 (AD) at 705.

evidence. The medical records supported the doctor's version rather than the version tendered by Mrs B. For example, a note made on the first day of consultation in Dr Smith's case book showed that surgical intervention was not uppermost in his mind. The note read 'treat conservatively as obstruction if not responding, theatre.' Against this record the allegation by Mrs B that, from the onset, Dr Smith had firmly decided, early on, to perform a laparoscopy, was improbable. Her attempt to distance herself from her written consent, and her evidence that Dr Smith made light of the laparoscopy as a 15 to 20 minute procedure, impugned her credibility. It was also inconsistent with the doctor's undisputed caring and diligent nature.

[24] An entry made in Mrs B's hospital records at 20h30 on 22 February 2012 shows that she was 'aware of the diagnostic procedure' that was to be performed on her the following morning. This suggests that there had been a more substantive discussion between her and Dr Smith than she was willing to admit. The written representations made to Mrs B's medical aid after the consultation during the morning on 22 February 2012 reveal that the material risks and benefits attendant in the medical procedures occupied the doctor's mind. Nothing in the medical records contradicted Dr Smith's evidence. On the other hand, a response by Mrs B during cross-examination, that she had lost a lot of memory, is indicative of her poor recollective faculties. Consequently, there is no basis to overturn the factual finding by the trial court that Dr Smith's version was probable and that of Mrs B was not.

[25] In claims for damages based on negligence for failure to warn a patient of material risks or complications attendant in a treatment or surgical procedure, courts employ a patient based approach. The reasoning is that a patient's freedom to self-determination includes the right to decide whether she wants to undergo surgery. A patient is entitled to refuse medical treatment. If she consents to surgery or medical treatment she accepts responsibility for unintended harm in the medical treatment, in the sense envisaged in the principle *volenti non fit injuria.*[7] However, a patient must have had knowledge and must have appreciated the nature and extent of such harm or material risk. Therefore, for a patient's consent to constitute justification that excludes

[7] *Castell v De Greef* 1994 (4) SA 408 (C).

wrongfulness, a doctor is obliged to warn a patient of the attendant material risks in such procedure. A risk is regarded as material when a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it; or where the medical practitioner is aware that the patient, if warned, would likely attach significance to it.[8]

[26] It was not in dispute that bowel perforation and wound infection were the relevant material risks in relation to the two medical procedures under consideration, it is reasonable that Mrs B, as a reasonable patient, would attach significance thereto and Dr Smith would have been aware of that. The evaluation above shows that Dr Smith did inform Mrs B of these risks. The high court's rejection of the arguments that Dr Smith was obliged to inform Mrs B of the presence of a renowned wound clinic was correct. If that were required it would be too high a standard. Hospitals are in any event expected to have in place measures to deal with potential negative consequences following surgical procedures.

[27] The consent that Mrs B gave for the laparoscopy is consistent with what a reasonable person would have opted for immediately prior to the surgery. The evidence of Prof Pantanowitz was that the decision of a patient such as Mrs B was a 50/50 decision. With the level of trust that Mrs B had in Dr Smith, her election to consent to the laparoscopy was consistent with the balance of the evidence.

[28] Dr Smith testified that on 22 Feburary 2012 he went to the Radiology Department of the hospital. Thereafter he went to the ward in which Mrs B was and examined her. It is at that stage that he made the decision that she needed to have surgery. He then explained the two options available – the laparoscopic and open surgery. He explained that laparoscopic surgery entailed small incisions, using the Afrkaans word 'gaatjies', whilst the laparotomy would be a big cut. He told Mrs B of the 'pros' and 'cons' of each. His evidence was:

'the risks and benefits are explained to her M'Lord and it generally comes down to two that I told her. The one is with laparoscopy, the disadvantages you can have a bowel injury but it [is] also

[8] Ibid at 426F-H. See also, *Sibisi NO v Maitin* 2014(6) SA 533 (SCA).

possible with open surgery. So it is not necessarily zero when you open someone up and I mean laparotomy. And the other one is conversion to open laparotomy. By that I mean even if you make gaatjies you can still end up opening the patient.

. . .

So with all those information at hand M'Lord I decided to give her the option of laparoscopic or open and I gave her advice and I would [have chosen] the laparoscopic if it was my [choice].'

He could not recall the exact words that he used. Neither could he recall if he used the word 'adhesions'. But he was certain that in the consultation on 22 February 2012 the risk of bowel injury did 'come up'. He also recalled that he told Mrs B about her high risk status. He emphasised that he considered her to be a high risk patient in respect of both surgical procedures.

[29] Prof Pantanowitz described the information necessary for a patient to give informed consent as follows:

'. . . if you are going to undertake this type of surgery, and in a patient who has had previous abdominal surgery, you need to say to the patient there is a risk of bowel injury, there is a risk of vascular injury and if we use the open technique there is more of a risk of sepsis. And eventually you can say I advise you to do this, but the patient has to make the final decision, because it is almost a 50/50 problem.'

[30] He explained that his personal preference was the 'open method'. However, according to him, many surgeons preferred the laparoscopic technique in relation to obese patients, because of the danger of wound infection. His evidence was 'it is controversial about whether you should prefer one to the other in an obese patient but I my personal view is that I myself would advise my patient to have it open, but there are many surgeons who would advise them to have closed technique'.

[31] Dr Bizos' evidence was that he would have explained thus:

'. . . there are two ways of dealing with this. The one is to do a minimally invasive or minimal access surgery where we put a laparoscope in and we take a look and the other is that, we do an incision to try and find out where the problem is and I would – it is difficult for me to say precisely how big where this incision is going to be. If we do it open and then I would say to them, "Look, you need this operation and there are certain risks of any operation in the

abdomen and they include risks of bowel perforation, leaking bowel, bleeding and then if we do the big operation, wound, wound infection, as well as general problems with an operation." . . .if we had to list every and all complications, we would be there for half a day, and I don't' think a patient would ever have an operation, because there are very real problems that can occur with any form of surgery.'

[32] Viewed in light of the expert evidence the information imparted by Dr Smith to Mrs B, which the high court rightly accepted, meets the standard of a reasonable expert.[9] It covered the range of surgical procedures and treatment options available to Mrs B and the associated benefits and risks. It could therefore not be said that there was negligence in relation to obtaining the informed consent from Mrs B. A further difficulty faced by Mrs B is that it is unclear that perforation and consequent sepsis would, in any event, not have ensued, even if a laparotomy had been performed.

Costs

[33] There is no reason why the costs should not follow the cause. However, counsel for Dr Smith graciously indicated, taking into account the difficulties experienced by Mrs B and her personal circumstances, that Dr Smith would not pursue costs.

[34] In the result the following order is made:.

The appeal is dismissed with costs.

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N Dambuza

Judge of Appeal

[9] See *Van Wyk v Lewis* 1924 AD 438.

APPEARANCES

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