A ..../Mm

IN THE HIGH COURT OF SOUTH AFRICA
(TRANSVAAL PROVINCIAL DIVISION)

DATE: 8/4/05
CASE NO: 17818/02

REPORTABLE

IN THE MATTER BETWEEN

W.J. GEYER **PLAINTIFF**

VS

DR J. K. JEKEL DEFENDANT.

JUDGMENT

SHONGWE J

INTRODUCTION:

[1] This case concerns what is commonly referred to as professional medical negligence. The plaintiff instituted an action for damages against Dr Jekel, a general surgeon, (the defendant) who has a special interest in the neck and head of the human body. The said action is a sequel to a tragic incident resulting from the fact that the plaintiff's facial nerve on the left side was severed (interrupted) during a parotidectomy operation which the defendant performed on him on the 19th July 1999 at the Unitas Hospital in Pretoria.

[2] At the hear!ng of this matter the parties by agreement requested the court to order a separation of issues, in terms of Rule 33(4) & (5) of

the Rules of Court. The only issue to be determined is the liability as opposed to the quantum. Such an order was accordingly made.

[3] The plaintiff's particulars of claim, paragraph 6 in particular, enumerated a series of grounds upon which he based his allegations of negligence on the part of the defendant. As the trial progressed and after certain amendments were effected to the particulars of claim and certain concessions made, it became evident that only four grounds of alleged negligence remained in contention.

[4] It is common cause that the following are the specific grounds of negligence to be interrogated in this case, namely:

4.1 Whether the defendant failed to properly identify and preserve the plaintiff's left facial nerve;

4.2 Whether the defendant failed to ensure that the anatomical configuration of the plaintiff's left facial nerve was intact prior to closing the operation wound;

4.3 Whether the defendant failed to explain the risk related to surgery of the parotid gland to the plaintiff, with particular reference to neouropraxia and paralysis of the facial nerve, and

4.4 Whether the defendant failed to instruct the neuro-surgeon immediately after the operation to perform an anastomosis of the severed facial nerve without delay, <u>alternatively</u>, whether the defendant failed to take

immediate steps to effect an anastomosis of the said nerve.

[5] I must hasten to mention that it is not in dispute that the plaintiff's left facial nerve was severed (interrupted) by the defendant during the parotidectomy operation. It is furthermore not in dispute that the plaintiff suffered a permanent left side facial paralysis.

[6] The real and substantial issue is, was there negligence on the part of the defendant in the performance of the parotidectomy on the plaintiff on the 19th July 1999. Did the defendant act negligently in his postoperative assessment and management of the plaintiff's left side facial nerve paralysis?

BACKGROUND FACTS:

[7] What happened was that the plaintiff developed a lump or tumor around the area of his left jaw and neck towards the ear. After seeing a general practitioner who prescribed antibiotics, he was advised to consult a surgeon. On the 9th July 1999 he saw the defendant when this problem was discussed. The plaintiff was impressed and happy that he met a knowledgeable and experienced person who will assist him.

[8] The defendant then performed what is known as a fine needle aspiration to extract fluid or tissues for a pathologist to determine whether the tumor is malignant or benign. He also had a CT scan performed. The results of such needle aspiration are contained in a cytology report (page 3 bundle A) which was discussed by the plaintiff

and the defendant on the 13th July 1999. The report states that no malignant cells are present. The defendant advised him that the tumor should be removed by performing an operation. The plaintiff testified that the defendant said it was a simple operation which will not last more than 20 minutes and that the plaintiff will probably be out of work for a day or two. The defendant denied that he said it was a simple operation which will last for not more than 20 minutes. He says that he told the plaintiff that the malignancy of the tumour cannot be excluded. He also said that the surgery would be difficult as the tumour is situated in the superficial lobe of the parotid gland and that there is always a chance of damage to the facial nerve. This may affect the eye-lid and the edge of the mouth may droop.

[9] There is no dispute that the plaintiff was a healthy, fit and strong person before the operation. The operation was then scheduled for the 19th July 1999. In the theatre the defendant made a skin incision using a small 15 blade and a mosquito blunt forcep (Exh 1) to assist him to progress towards the facial nerve. The defendant testified that in order to find and identify the facial nerve one must first identify certain 'land marks' (See bundle D Xl sternocleidomastoid; X2 mastoid process; X3 Digastric muscle (posterior belly) X4 Pointer(Tragal cartilage). He indicated the parotid gland and was marked X5.

[10] The defendant said that he started his dissection from X6 (bundle D 1) into the parotid gland on his way to identifying the facial nerve. He encountered a lot of stiff and stern fibrosis as he was dissecting and

and there was bleeding from torn blood vessels. As a result he could not see properly, the whole process was hazardous. He decided there and then to stop the dissection as it was getting dangerous at this stage, according to him, he had not seen the facial nerve (I will refer to this procedure as the initial dissection and the following one as the second dissection).

[11] The second attempt dissection started at the marginal mandibular branch of the facial nerve. (marked *X7* on bundle D1). Using the same instruments this procedure was successful as he could feel the tumour in the parotid gland. He dissected up to the bifurcation (marked X8 bundle D page 1. He managed to remove the tumour. He sucked and cleaned the wound and closed it. He immediately prepared the operation report as appearing on page 6 bundle A). In this report the defendant described the procedure he followed and the problems he encountered during the operation. He then sutured the wound, and mentioned that there were no interoperative complications. As far as the defendant was concerned the plaintiff was under anaesthesia and his condition was satisfactory after the operation.

[12] Later in the evening of the 19th July 1999 the defendant saw the plaintiff again and immediately noticed that the plaintiff had a total facial paralysis: The plaintiff enquired what was wrong and the defendant replied that he was not sure but he would find out. The defendant believed that the nerve was intact and communicated this to the plaintiff. Later he met with Dr Terblanche, a neurologist, and

discussed the condition of the plaintiff with him. Dr Terblanche expressed the opinion that neuropraxia could cause a total paralysis. On the 20th July 1999 he also discussed the condition of the plaintiff with Professor Shah, who was apparently visiting South Africa from the U.S.A. Professor Shah advised him to give it time and wait. When the defendant saw the plaintiff later in the day he advised him that he spoke to Dr Terblanche and Professor Shah and he was satisfied that his condition will improve. The plaintiff was discharged and was given a drain, as discussed, and was requested to call after a week.

[13] On the 27th July 1999 the defendant saw the plaintiff and removed the drain. It is significant to mention that Dr Terblanche recommended an EMG. Dr Terblanche saw the plaintiff on the the 26th August 1999 and prepared an EMG report (See page 22 bundle A) he reported *inter alia,* that:

> " Geen motor eenhede kon dus waargeneem word nie
> Ek kan dus tans nie eletrofisiologies toon dat die senuwee intakt is nie.
> Miskien moet die studie oor 6 weke herhaal word, en indien dit dan nog steeds geen teken van herstel toon nie, kan mens miskien aan 'n operasie dink"

The result of the second test of the 6th October 1999 came and Dr Terblanche reported as follows :(See page 23 bundle A)

> " Motor geleiding van die linker fasiales kan nie gevind

word nie. Die regter fasiales het 'n normale motoriese geleidings.

EMG van die orbikulares okuli en oris toon slegs fibs. Met inplassing. Ongelukkig kan nog geen motor eenhede waargeneem word nie.

Elektrofisiologies kan ek dus nie tekens toon dat die fasiales begin regenereer het nie."

[14] The Defendant had spoken to Dr Van Rooyen, a plastic reconstruction surgeon, and after seeing the second EMG report of Dr Terblanche they decided to re-operate the plaintiff. The re-operation was difficult because of fibrotic tissues caused by the first operation. They started the re-operation at the distal branches and dissected backwards until they found the bifurcation and discovered that the facial nerve had been severed just after the bifurcation. They located the interrupted nerve, though with difficulty, and they managed to suture it together. This re-operation took place on the 18th October 1999. The Defendant testified that had he been aware that the nerve had been severed or damaged in any way, he would have taken the Plaintiff back to the theatre to explore the main stem immediately.

ANALYSIS AND THE LAW

[15] It is trite that the Plaintiff bears the onus to prove on a balance of probabilities that the Defendant acted negligently. Perhaps it

will be prudent at this stage to restate what negligence is. (Neethling Potgieter& Visser-4Ed. Law of Delicit p 128) put it as follows." A person is blamed for an attitude or conduct of carelessness, thoughtlessness or imprudence because, by giving insufficient attention to his actions he failed to adhere to the standard of care legally required of him,"

[16] Holmes JA (as he then was) in **Kruger vs Coetzee: 1966 (2) SA 428 (A) at 430** said-"For the purposes of liability culpa arises if-

(a) a *diligens paterfamilias* in the position of the

Defendant

(i) would foresee the reasonable possibility of his

conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against

such occurrences; and

(b) the Defendant failed to take such steps"

Despite what Holmes JA said above each case should be assessed on its own merits, no hard and fast rule can be laid down.

[17] LAWSA -Volume 17 p 204 (first Reissue) under the subject- 'liability for professional negligence', which topic is relevant to the present case say- "A medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner in his field. This includes care during the procedure itself as well as post-operative care. In deciding reasonableness the court will have regard to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. The test is how would a reasonably competent practitioner in that branch of medicine have acted in a similar situation? It must be established that a reasonable practitioner would have foreseen the likelihood of harm and would have taken steps to guard against its occurrence", It is the court ultimately which will decide whether in the circumstances the methods used were reasonable. **In Van Wyk vs Lewis: 1924 AD at 438-444** it was held that negligence could not be inferred from the mere fact that the accident happened but that the onus of establishing negligence lay upon the Plairitiff': This finding is contrary to what Neethling in Law of Delict p 31-315 said as quoted by the Plaintiff's counsel in his heads of argument that 'every factual infringement of the physical mental body is *per se contra bonos mores* or wrongful'.

[18] This brings me now to the specific grounds of negligence relied upon by the Plaintiff in the present case whether the Defendant failed to properly identify and preserve the Plaintiff's facial nerve. The evidence of the expert witnesses becomes relevant. Dr Pienaar, a general surgeon, called by the Plaintiff testified and also mentioned in his report that if the facial nerve was not identified, (p12 & 14 bundle "B") it would per se constitute negligence. However, under cross examination he conceded that he no longer supported his earlier statement that the mere fact that the facial nerve was severed per se constituted negligence. Dr Pienaar was referred to an article in the literature handed in, in the form of (Exhibit "G" chapter 41 p10) where the author Mark May, M.D deals with Medical Legal Aspects of Facial Paralysis (The Surgeon's Point of View) he says:

> "As discussed earlier in this text, surgical procedures in the posterior forsa , temporal bone, in extracranial region may cause intro-operative injury to the facial nerve which results in paralysis. This complication is shattering for the patient's family, but also causes a responsible surgeon great concern. Methods to avoid injuring the nerve were discussed in previous chapters, however, despite all precautious facial paralysis may still result from surgery near the facial nerve and physicians

> must be aware that legal action could be brought against them in such cases."

Dr Pienaar also referred to an article by Daniel D Lydlatt entitled- Medical Malpractice and facial Nerve Paralysis (See Exh E p. 16 & 19) where he said

> "Facial nerve paralysis rates vary but the incidence for parotidectomy, rhytidectomy and most elective otologic procedures is below 5%. All of these procedures have been refined over the years to identify, avoid, or otherwise protect and preserve the facial nerve. Proper training and careful surgical technique are indispensable, but facial nerve injuries happen to even the best surgeons. Dawer et al state that patients have a high expectation of successful outcome and are more inclined to sue for unsatisfactory outcome-A bad outcome is not evidence of malpractice, and negligence can never be imputed from unsatisfactory results." (My emphasis) Dr Pienaar agreed with the opinion expressed in this article. **In Van Wyk vs Lewis: 1924 AD p 438 Innes CJ** (as he then was) concluded that negligence could not be inferred from the mere fact that the accident or mistake happened but that the onus of establishing negligence lay upon the Plaintiff.

In LAWSA-Volume 17, para 204 it is said that 'a medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner in his field----as negligence is determined by the criterion of reasonableness, there may be no liability where a highly unusual complication occurs in the treatment of the patient. '

According to Carl E. Silver (in Atlas of Head & Neck Surgery) a literature handed in as Exh "G" on page 3 it is said that:

> "Various methods have been employed for identification of the facial nerve. These include identifying (i) the main trunk of the nerve as it emerges from the stylomastoid region, (2) a peripheral branch with retrograde dissection back to the main trunk,(3) the posterior facial vein as it leaves the tail of the parotid with dissection upward on the surface of the vain until a facial nerve branch is encountered crossing superficial to the vain, and (4) the submandibular branch at the point where it crosses the anterior facial vessels in the submandibular region. Although the peripheral approaches to the nerve may have value in cases where continuity of the nerve has been disrupted

> by tumour or trauma, the safest and simplest method for consistent identification of the facial nerve is by approaching the main trunk."

The evidence in court by the experts is clear that there is no one best method, it all depends on a number of factors. For example Dr Pienaar preferred the method of dissecting from around the mastoid process toward the back of the parotid gland where the nerve exits the gland in order to identify the nerve or main trunk. According to Dr Laage, also a general surgeon, called by the Defendant, Pienaar's method could prove difficult as one has to dissect next to the mastoid process which is a bony substance. By the way Pienaar did not criticise the initial method of operation adopted by the Defendant; he in fact said that his decision to abandon the initial discretion and start on a different route to trace and identify the nerve, as the Defendant did, was reasonable given the circumstances he encountered in the process of dissecting towards the main trunk. I must pause to mention that Dr Pienaar also said that it was improbable that fibrotic tissues could have been there in the area where the Defendant says he found them during the initial operation. Dr Pienaar accepted that the Defendant was an experienced surgeon who was also the head of the head & neck oncology department at Kalafong Hospital.

As indicated earlier, the defendant abandoned the first or initial operation direction because of fibrotic tissues and bleeding vessels. This was before he encountered the facial nerve. His evidence is that

he did not sever or interrupt the nerve when he decided to abandon the initial operation. Therefore, in my view, he did not fail to properly identify the nerve as he ventured in the second dissection through the mandibular branch and identified the nerve, proceeded to dissect until he successfully removed the tumour and closed the wound.

Mark May, M.D, Richard J. Wiet, MD on p 26 of Exh "G" had this to say:

> "The facial nerve may be injured during surgery in the cerebellopontine angle, temporal bone, face, or neck. Even the most experienced surgeon may unintentionally injure the facial nerve, particularly when surgical planes are distorted or obscured by inflammation, trauma, or tumors or the course of facial nerve is aberrant due to congenital anomalies."

The plaintiff contends that the Defendant is not telling the truth as to what happened during the initial dissection.It is said that the defendant must have gone deeper with his dissection than what he realised, and therefore made a serious error in judgment regarding the depth of his dissection. To me, this sounds like high speculation and, as the authorities have said, an error is not per se negligence. In **Mitchell v** Dixon: 1914 **AD 519-it** was held that a medical practitioner is not expected to bring to bear on a case entrusted to him the highest possible degree of professional skill but is bound to employ reasonable skill and care, and is liable for the consequences, if he does not.

In the present case apparently the severance of the nerve occurred while the Defendant was dissecting the parotid gland moving towards the main trunk of the nerve, therefore it cannot be said that the Defendant failed to obtain adequate exposure of the nerve thereby risking facial paralysis. It is significant to note that Dr Lemmer's evidence that there was no out of the ordinary fibrosis in the initial area operated. This observation he made at the laboratory, he did not participate in the operation itself. He examined certain tissues sent to him as a pathologist. It is risky to place much emphasis on his evidence in contradistinction to the uncontroverted evidence of the Defendant. The Defendant's clinical judgment was required at the time of the operation. I am unable, based on what Dr Lemmer and Dr Pienaar said, to reject the Defendant's evidence and prefer theirs. The ultimate question is whether the Defendant's conduct conforms to the standard of reasonable care demanded by the law.

[19] The next ground of alleged negligence is whether the Defendant failed to ensure that the anatomical configuration of the Plaintiff's left facial nerve was intact prior to closing the operation wound.

[20] The plaintiff contends that there was a duty on the Defendant to inspect the area of operation of the initial dissection for possible damage to the nerve before closing the operation wound, which he failed to do. The Defendant's evidence is that he was not aware that he had interrupted the main trunk of the nerve. His clinical judgment was that he had not gone near the nerve and had not severed it

because he stopped way prior to reaching it, as he experienced dense fibrotic tissues and the bleeding of blood vessels which made his task difficult. The logic is that he could not continue to dissect and explore the main trunk of the nerve beyond the bifurcation as the same circumstances which compelled him to terminate the initial dissection still prevailed.

[21] The Defendant considered it a good surgical practise not to proceed beyond the bifurcation, as such a move would have been more risky and disadvantageous to the entire purpose of the operation. The question is, would a reasonable surgeon under the circumstances have proceeded beyond the bifurcation in order to explore the main trunk of the nerve? On the evidence before me I am unable to find that the Defendant acted unreasonably and therefore negligent. My view is fortified by the evidence of Dr Laage to the effect that he could not find the Defendant's decision in the circumstances unreasonable. Even if the Defendant had made an error in his clinical judgment, it is an error which a reasonably competent surgeon could have made, and that does not amount to negligence (See **Castell vs De Greef 1993 (3) SA 501(C) at 511 I-512 B)**

[22] The evidence of Dr Van Rooyen, a plastic reconstructive surgeon, specialising in micro-vascular surgery, becomes relevant and important. He is the one, together with the Defendant, who performed the operation on the 19 October 1999 during which an anastomosis of the Plaintiff's facial nerve was done. He confirmed that the Defendant

is an experienced head and neck surgeon whose clinical judgment and opinion he valued. Under cross-examination he confirmed that it was acceptable and good surgical practise to stop the dissection if the surgeon was unable to identify the main trunk of the facial nerve due to the presence of severe fibrosis which resulted in very hard tissue. On the evidence of the Plaintiff's own expert, the Defendant's decision not to proceed with the dissection beyond the bifurcation to identify the main trunk of the nerve was reasonable and acceptable in the circumstances. (See **Michael &. Another vs Linksfield Park Clinic (Pty) Ltd and Another 2001(3) SA 1188 at 1200 (Para 34))**

[23] In my view there can be no question of negligence on the part of the Defendant regarding whether the Defendant failed to ensure that the anatomical configuration of the Plaintiff's facial nerve was intact prior to the closing of the operation wound. The evidence of Dr Van Rooyen supports that of Dr Laage. Both eminent surgeons give imprimatur to the Defendant's conduct as reasonable in the circumstances.

[24] I now turn to the third alleged ground of negligence. i.e. whether the Defendant failed to explain the risk related to surgery of the parotid gland to the Plaintiff with particular reference to neuropraxia and paralysis of the facial nerve. The Plaintiff stated that the Defendant told him that the operation was a small one that would not take more than twenty (20) minutes. To some extent the Plaintiff's wife corroborates him on this aspect in the sense that the Plaintiff told her so. The plaintiff further stated that had he been aware of the risks and

possible complications of the operation he would have obtained a second opinion.

[25] The Defendant denies completely that he told the plaintiff that the operation will not take more than twenty (20) minutes. He testified that he has performed about one hundred parotidectomy operations and is quite aware that each operation is nothing less than two hours. He also testified that he mentioned to the Plaintiff that the tumour could be malignant, though there was only a small possibility of this being the case. I am unable to conclude that the Plaintiff deliberately lied to this court, however, I am of the view that because this incident took place about six years ago, the possibility exists that the story is no longer as fresh as it was then. Therefore the reliability of his evidence is questionable. He could not clearly remember how many times the Defendant saw him after the operation on the same day. His evidence is contradictory to the hospital records (bundle "A" p 73) which indicate that on the day of his admission he arrived at the hospital accompanied by his wife, whereas his evidence is that he arrived alone.

[26] The probabilities are overwhelming that the possibility of the tumour being malignant was conveyed to the Plaintiff and that in such an event, even if the complications had been explained to him, he would nevertheless have agreed to the operation. The Plaintiff bears the onus to prove that if the risks of the parotidectomy operation, including the risk of permanent facial paralysis, had been explained to him he would

have refused to consent to the operation. All the Plaintiff said is that he would have consulted with his wife and probably have obtained a second opinion. The failure to prove that he would not have consented to the operation, had he been properly informed of the risks inherent in the operation is fatal to his case on this ground. (See **Braude vs McIntosh & Others 1998 (3) SA 60 (SCA) at 68 G-69E.**

[27] The last ground of alleged negligence is whether the Defendant failed to instruct a neuro-surgeon immediately after the operation to perform an anastomosis of the severed facial nerve without delay, **alternatively** whether the Defendant failed to take immediate steps to effect an anastomosis of the said nerve. It is common cause that at about 6 pm after the operation on the 19 July 1999, the Defendant saw the plaintiff and noticed that he had a total facial paralysis. Even at that stage he was convinced that he had not severed the nerve. He, however, assured the plaintiff that he would look into what could be the cause of this paralysis. The Defendant immediately after walking away from the Plaintiff's bedside consulted with Dr Terblanche, a neuro-surgeon and told him of the condition of the plaintiff. Dr Terblanche told the Defendant that a neuropraxia could cause a total paralysis. The next day the Defendant telephoned Dr Lemmer, the pathologist. The Defenadnt was not sure if he did not inform the Plaintiff that he would also discuss his condition with Professor Shah, a colleague from the United States of America. He did, however, discuss

the Plaintiff's condition with the Professor at Kalafong Hospital when he met him on the 20th July 1999.

[28] The Plaintiff contends that the Defendant should immediately have taken steps to investigate the possibility of a neuronotnese (total disruption of the facial nerve) including tests by a neurologist as soon as possible. That he should have sought advice from other experts on the possibility that the injury was due to his initial dissection near the stem of the facial nerve. That he should have considered and discussed as soon as possible with other colleagues the possibility of a re-exploration of the operation at the area of the initial dissection to establish whether the stem of the facial nerve was intact, and if not, to take steps to perform an anastomosis and that he should have taken steps to join the nerve much sooner than he did.

[29] It is significant to note that Dr Pienaar conceded that if he was convinced that the facial nerve was left intact, it would have been acceptable conduct to have diagnosed a neuropraxia as a probable cause of the facial paralysis. He also confirmed that under the circumstances it would have been acceptable to consult Dr Terblanche, which the Defendant did. He concluded that under the circumstances it would also have been acceptable to adopt a wait and see approach. In *casu* the defendant discussed with Dr Terblanche immediately he noticed the total paralysis and proceeded in terms of the advice of Dr Terblanche. He telephoned Dr Lemmer the following day and embarked on the process of investigating the condition immediately.

He discussed the condition with Professor Shah who also expressed an opinion of waiting.

[30] Dr Laage supported the Defendant's decision to follow the waiting approach and not to take the Plaintiff back to theatre for re-exploration and sanctioned it as reasonable based on his clinical judgment and experience. Dr Laage based his opinion on the fact that the Defendant was concerned about the Plaintiff's total facial paralysis and carefully considered the possibilities of neuropraxia versus interruption and that he was justifiably reasonably certain that he had not interrupted the nerve. That Dr Lemmer also confirmed that the histology specimen did not contain any nerve fibres. Dr Van Rooyen also confirmed that fundamental to the decision whether to adopt a wait and see approach and whether to take the Plaintiff back to theatre as soon as possible for a possible reconstruction of the nerve, was the clinical judgment of the Defendant who is an experienced head and neck surgeon.

CONCLUSION:

[31] Based on the evidence before me there was not even a fair degree of certainty that the nerve had in fact been interrupted. On the contrary the Defendant was certain that he had not severed the nerve, therefore there was no need or urgency to take the Plaintiff back to theatre immediately. The steps taken by the defendant conclusively demonstrate his concern and his sense of urgency is exhibited by the swiftness of his consultations with his colleagues.

[32] It is said that the paterfamilias does not have 'prophetic foresight'. The test is not how the occurrence could have been prevented but whether the occurrence was reasonably foreseeable. (See S **v Bochris Investments (pty) Ltd and Another 1988 (1) SA 861 (A) at 866** J **- 876** B). In **overseas Tankship (UK) Ltd v** Morts Doc **& Egineering Co Ltd** (The Wagon Mound) [1961] AC 388 (PC) ([1961] 1 or All ER 404) Viscount Simonds said at 424 (AC) and at 414 G-H (in ER):

> "After the event, even a fool is wise. But it is not the hindsight of a fool, it is the foresight of the reasonable man which alone can determine responsibility"

[33] I have no doubt that the *maxim res ipsa loquitur* is not applicable in this case and I do not find it necessary to deal with it for obvious reasons. I share the view that the defendant cannot be faulted for interrupting the nerve unwittingly, especially in view of the fact that he had stopped his initial dissection at a stage when in his clinical judgment he had not reached or identified the main trunk of the facial nerve.

[34] I find that the witnesses of the Defendant were credible, reliable and satisfactory, save for minor points which related to how much could the Defendant remember of the conversations that took place between himself and the Plaintiff or Dr Terblanche. I also find that the evidence of Dr Laage and Dr Van Rooyen was very helpful in as far as it related to what was reasonable in the circumstances of this case. As indicated

earlier the Plaintiff cannot be said to have deliberately lied to this court. The thrust of his evidence affected the reliability thereof. So too, the experts called by the Plaintiff assisted this court to a certain extent. Though my finding is that the gist of their evidence did not stand the test of logic, in particular the evidence of Dr Pienaar. The other witnesses called by the Plaintiff, whom I did not specifically mention, did not take the Plaintiff's case any further. Nothing more should be inferred from my silence.

[35] I share the sentiment that the severance of the Plaintiff's facial nerve was or is a tragic incident which caused him and his family substantial anxiety and discomfort. I really have great sympathy for him. What I find on the analysis of the evidence is that the Plaintiff's evidence as supported by the experts fell short of establishing on a balance of probabilities that the Defendant acted negligently. This is because of . the difficulty the Plaintiff and his witnesses found themselves in, as they did not witness the operation. The thrust of their evidence is circumstantial. (See **S vs Blom 1939 (AD) p 188 at 202)**

[36] On page 75B in the case of **Broude v McIntosh and Others** *(supra)* Marais JA said the following:

> *"When a patient has suffered greatly because of something that has occurred during an operation a court must guard against its understandable sympathy for the blameless patient tempting it to infer negligence more readily than the evidence objectively*

justifies, and more readily than it would have done in a case not involving personal injury. Any such approach to the matter would be subversive of the undoubted incidence of the onus of proof of negligence in our law in actions such as this. "

[37] **In the result the following order is made:**

1. **The Plaintiff's claim is dismissed.**
2. **The Plaintiff is ordered to pay the costs of the action, such costs to include:**

    2.1 The cost occasioned by the previous postponement of the matter on 16 October 2003, which costs are to include the qualifying and reservation fees and the fees for attending court on 16 October 2003, of the defendant's expert witness, Dr Laage;

    2.2 The qualifying and reservation fees and the fees for attending court for the period of 8 February 2005 to 18 February 2005 (excluding 14 February 2005), of the defendant's expert witness, Dr Laage;

    2.3 The costs attendant upon the employment of senior counsel by the defendant;

J B SHONGWE
JUDGE OF THE HIGH COURT

HEARD ON	: 8 February 2005- 18 February 2005 :
FOR THE PLAINTIFF	Adv J.H. STRoH SC
INSTRUCTED BY	: MACROBERT INCORPORATED
FOR THE DEFENDANT	: Adv J.K. KUKARD
INSTRUCTED BY	: CHRISTO BOTHA ATTORNEYS
DATE OF JUDGMENT	