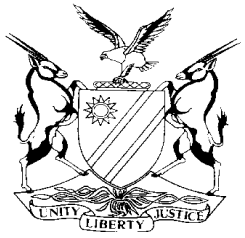

'Not Reportable'

CASE NO.: (P) I 198/2007

IN THE HIGH COURT OF NAMIBIA

In the matter between:

IMMANUEL GOMACHAB **Plaintiff**

and

MINISTER OF HEALTH & SOCIAL SERVICES **First Defendant**
DR HAILEMARIAM **Second Defendant**

***CORAM*:** **SILUNGWE, AJ**

Heard on: 2009 May 26; 2009 July 20; 2009 August 5 – 10; 2009 September 16

Delivered on: 2011 September 16

JUDGMENT

SILUNGWE, AJ: [1] This is an action in delict which was instituted by the plaintiff against the defendants on March 23, 2006. The action is based on negligence against the second defendant – a medical practitioner and gynaecologist – in the service of the first defendant. Obviously, the first defendant is being sued vicariously, as an employer of the second defendant, for the latter's alleged negligent conduct during the course of his employment.

[2] The gist of the plaintiff's particulars of claim is that the second defendant conducted himself negligently in that:

1. he conducted a complicated appendicitis operation at Swakopmund (State Hospital) without instantaneously and timeously referring the plaintiff patient to Windhoek State, or Katutura State, Hospital;

2. being a gynaecologist, he failed to realize that it was a complicated appendix which would best be treated by a specialist surgeon;

3. post operatively, he failed to refer the plaintiff to the aforementioned referral centres for follow-up and decision regarding further medical attention. A further allegation is that he failed to provide post surgery care to the plaintiff.

[3] Mr Murorua appeared for the plaintiff; and Mr Narib was for the first and second defendants.

[4] Early in the trial, the parties mutually agreed to deal (for the time being) with the issue of liability only, and the agreement was sanctioned by the Court.

[5] The following facts are not in dispute. At the hearing of this matter, the plaintiff – a married male – was aged 43 years. He was an employee of a Road Contractors Company. On February 3, 2002, the plaintiff attended Swakopmund State Hospital for treatment. He was seen by the second defendant (a senior medical officer) who, after examination, performed appendectomy (i.e surgery of

the appendix) on the patient. The "post-operative" care was undertaken by Dr Moisel who discharged the plaintiff on February 8, 2002. On February 11, 2002 however, the plaintiff returned (and was readmitted) to the Swakopmund State Hospital with a problem of wound infection (wound sepsis). The wound was opened by the second defendant and pus was drained under local anaesthesia and sedation.

[6] One expert witness was called by the plaintiff and, similarly, one other such witness was called by the defendants. Mr Maseme, a Principal Specialist Surgeon, testified for the plaintiff, while Mr Kamble, a Specialist Surgeon, testified for the defendants. It is appropriate to start with Mr Kamble's Expert Report which is the shorter of the two Reports.

[7] Mr Kamble's Report reads, *inter alia*, as follows:

> "I have studied the Clinical Booklet and the report documented by Dr Hailemariam.
>
> In summary, a 35 yr male presented with severe right lower abdominal pain. Examination was consistent with features of acute appendicitis with local peritonitis.
>
> An emergency appendectomy was planned.
>
> At Surgery a gangrenous appendix was found with omental adhesions to the appendix and the caecum. Some pus was detected.
>
> The adhesions were released, appendix removed, pus drained, that part of the peritoneal Cavity was washed and the surgical wound closed in layers.
>
> Post Operative Management.
> Intravenous antibiotics ampicillin and Gentamycin. However ampicillin was discontinued on day one. By day two and three there was return of bowel

functions, and by day three patient was on fluid diet. His I V fluids and antibiotics were discontinued. Patient was discharged on the fourth post operative day with good wound healing.

Patient however was readmitted three days later with wound sepsis. The wound was opened, pus drained following exploration twice and managed with antibiotics (Zinacef, and gentamycin)."

[8] Mr Maseme's Report gives a more extensive perspective in these terms:

"According to the medical records, Mr Immanuel Gomachab was admitted to Swakopmund State Hospital on the 3rd of February 2002 by Dr Hailemariam with a diagnosis of Acute Appendicitis. The patient was assessed to be stable. He was taken to theatre for an operation later on the same day by Dr Hailemariam. The findings at operation revealed omental adhesion to the caecum and an inflamed appendix with free pus. After freeing the adhesions, appendicectomy was performed and the wound was closed in layers. The operation was "uneventful". The patient was discharged from the hospital on the fifth post-operative day (8/02/02).

On the third day (11/02/02) after discharge, he was re-admitted with a problem of wound sepsis. Wound drainage was performed under local anaesthesia and sedation in the ward by Dr Hailemariam. A drain was also inserted after draining 100cc of pus. The patient was discharged six days later (14/02/02).

On the 15th of July 2002 (five months later), he was admitted with a problem of incomplete bowel obstruction. That was most probably due to adhesions caused by the previous operation. The problem settled without any operative intervention. It is not clear as to how long he stayed in hospital.

On the 3rd of October 2002, he was admitted to Windhoek Hospital with a problem of acute urine retention i.e inability to pass urine. This was caused by a urethral stricture. The urethra is a passage that runs through the genital organ, connected to the bladder, allowing urine to be passed from the bladder to the exterior. This passage was tightly narrowed making it impossible to pass urine. A suprapubic catheter was inserted by Dr Gonzales. This is an alternative and direct route of draining urine from the bladder when the normal (urethral) route has problems. Four days later (7/10/02), he was taken to theatre by Dr Gonzales for internal

> (endoscopic) urethroplasty (repair of the narrowed urethra). Unfortunately that was not successful. He was discharged on the 10th of October 2002. He was advised that he needed perineal (open & external) repair of the stricture. The operation would be performed once he had decided on it. It is not clear in the records as to whether he ultimately agreed to and was offered the operation."

[9] At the time of the hearing, the plaintiff had not been able to return to his work; he was unable to pass urine and was thus using a catheter; and he was unable to enjoy sex.

[10] Identifying areas of dispute, Mr Murorua, for the plaintiff, submits that some of such areas are as follows:

> The parties are in dispute as to whether:
>
> 1. the plaintiff, on admission to Swakopmund State Hospital, presented a medical or surgical emergency?
>
> 2. the operation was a complicated appendicitis?
>
> 3. there should have been a primary wound closure or delayed wound closure?

[11] Mr Murorua adds that, though arguable, the Court need not decide each and every aspect of the listed areas of dispute in order, ultimately, to determine the question of delictual liability.

[12] I am going to comment on some of the areas of dispute. Take, for instance, the first area listed with a view to answering the ultimate question as to whether negligence on the part of the second defendant has been established.

[13] The second defendant stated in his official notes, and maintains in evidence, that on admission to the hospital on February 3, 2002, the plaintiff presented a surgical emergency as he was experiencing severe right lower abdominal pain which, on examination, was consistent with features of acute appendicitis with local peritomitis which required surgery to be performed with dispatch. While Mr Kamble endorses the second defendant's diagnosis and the surgical action taken by the second defendant, Mr Maseme is of a contrary opinion, stating that there was no surgical emergency and that surgery should have been delayed as this was a case of complicated appendicitis.

[14] On the contrary, the second defendant and Mr Kamble do not share Mr Maseme's opinion that that was a case of complicated appendicitis. Mr Maseme opines that appendicitis is a common condition and that a doctor does not necessarily have to be a specialist surgeon to perform a simple appendicectomy on an uncomplicated appendicitis. But Mr Kamble and the second defendant maintain that that was not a complicated appendicitis. It is noteworthy that the second defendant is a senior medical officer with experience in performing appendicectomy.

[15] Having considered the evidence before the Court and the expert opinion proferred, I am not persuaded that the second defendant's diagnosis and the attendant surgical action constituted negligence on the part of the second defendant.

[16] The question whether the case was one of a complicated appendicitis has been previously dealt with in the preceding para ([15]). Hence there is no need to belabour the point.

[17] With regard to primary or delayed wound closure, Mr Murorua submits that this remains arguable on the evidence adduced. It is thus unnecessary to take the matter further as such a step, or the result thereof, would not impact on the question of delictual liability in the matter.

[18] Mr Maseme's evidence suggests that the plaintiff suffered from a chronic state of inflammation. But medical records suggest that the plaintiff presented himself to the Swakopmund State Hospital on February 3, 2002, with an acute appendicitis. Mr Maseme based his opinion on what the plaintiff had told him, namely, that he had suffered (from appendicitis) for about a fortnight. Mr Maseme deduced that the plaintiff's long suffering resulted in the formation of appendicular mass (i.e appendicular absess) and consequently, that when the plaintiff presented himself to the hospital on February 3, 2002, he did so with a complicated appendicitis. But when the plaintiff was confronted, in cross-examination, with the question that he had waited too long before he sought medical attention, the following exchange took place:

Q: When you felt pain you did not go to hospital in good time?

A: I approached hospital timeously so that I could be cured.

It is noteworthy that the plaintiff never mentioned in evidence a period of suffering before he approached the State Hospital on February 3, 2002, for medical attention.

[19] On the question of (the alleged) catheterization, on February 3, 2002, it is evident that Mr Maseme raised it for the first time in his medical report when he suggested that an injury to the urethra could have been caused as a result of catheterization. There is no hospital official record whatsoever to show that the plaintiff was catheterized on February 3, 2002. The second defendant denies that the plaintiff was ever catheterized by him. Further, the plaintiff's particulars of claim make no reference at all to any negligent catheterization resulting in urethra stricture. Mr Maseme testified that damage to the urethra would later result in a scar formation but that this happens from four to six weeks from the date of injury. He further testified that from the date of catheterization, the plaintiff should have formed urethra stricture during May 2002. From medical evidence, however, it is clear that the plaintiff's urethra stricture only developed around October 2002. There is thus no causal nexus between the plaintiff's urethra stricture and the operation on February 3, 2002. Hence, Mr Maseme's evidence that the second defendant catheterized the plaintiff should be taken with a pinch of salt.

[20] One critical issue remains to be considered and resolved, namely, appropriate post surgical care of the defendant. In this respect, both Mr Maseme and Mr Kamble are *ad idem* that responsibility for the provision of post-operative care rests upon a doctor who performs surgery, in this case, the second defendant. The test for medical negligence was pointed out in the case of ***Dube v Administrator, Transvaal 1963 (4) SA 260G at 266G-267A,*** wherein TROLLIP,J stated that when a hospital accepts a patient, its staff owe him a duty to attend to

and treat him with due and proper care and skill. The hospital's practitioners must exercise that degree of care and skill which a reasonable practitioner would ordinarily have exercised in South Africa under similar circumstances. Any breach of that duty would constitute negligence. Furthermore, the case of ***S v Britz 1990 NR 293 at 297E - F*** distinguishes between negligence consisting of an act and an omission, such as the case where the wrong medication is administered, on the one hand, and, on the other hand, the mere failure to watch a patient properly so that complications can be detected at an early stage and timeous action taken which might possibly save the patient's life.

[21] There is sufficient evidence to show that some of the complications that arose in this case are attributable to lack of adequate and proper care after surgery. Had the plaintiff been kept long enough in hospital under the medical surveillance and care of the second defendant and the provision of the necessary medical attention, such medical complications that subsequently emerged could possibly have been averted or properly and timeously take care of. This responsibility fell squarely upon the second defendant’s shoulders, but he failed to discharge that responsibility. On the evidence adduced, it is self-evident that the plaintiff was prematurely discharged on February 8, 2002, only to return to the hospital three days later (on February 11, 2002) with an avoidable wound sepsis. It thus manifest that the second defendant acted negligently in that he failed to watch the patient properly, as is evidenced by the plaintiff’s early discharge, and, consequently, he was unable to detect or prevent any complications that has occurred. To that extent, the delictual liability has been established directly against the second defendant and, vicariously, against the first defendant.

[22] In the circumstances, I make the following order:

1. The claim against the first and second defendant is upheld,
2. The first and second defendants are jointly and severally liable.
3. Costs will follow the event.

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SILUNGWE AJ

COUNSEL ON BEHALF OF THE PLAINTIFF:

Mr L Murorua

Instructed by: Murorua & Associates

COUNSEL ON BEHALF OF THE DEFENDANTS:

Adv. G Narib

Instructed by: Government Attorney