IN THE HIGH COURT OF BOTSWANA HELD AT GABORONE

CAHGB-003267-15

In the matter between:

GOFAONE MEDUPE JONAS **PLAINTIFF**

AND

ATTORNEY GENERAL **DEFENDANT**

Attorney Ms K.N.E Kewagamang for the Plaintiff

Attorney Ms T. Motsumi for the Defendant

JUDGMENT

LEBURU J:

1. The Plaintiff, Gofaone Medupe Jonas, brought a delictual claim founded on medical negligence and sought payment of general damages in the sum of BWP 2,000,000.00 (two million pula) against the Defendant.

2. The Defendant denied liability in *toto* and further contended that, assuming it was liable, the Plaintiff had failed to prove the quantum of damages sought.

The Plaintiff's Case

3. The Plaintiff gave evidence and called three witnesses. Two of the said witnesses were experts, namely Professor Roland Edgar Mhlanga (PW3) an Obstetrician and Gynecologist and Dr Jabulani Maphisa Maphisa, (PW4), a Clinical Psychologist. The other witness was the Plaintiff's sister, Resego Cindy Lesolame (PW1).

4. The Plaintiff is a 49 year old female, employed as a teacher at Molefi Senior Secondary School, Mochudi. She was diagnosed with intra-uterine fibroids in 2011 and was to undergo a total abdominal hysterectomy operation at Sekgoma Memorial Hospital, Serowe. The said operation was done on the 15th September 2012. Before the said operation, she signed a consent form, after she was advised that the operation entailed the removal of her uterus, which would result in her not bearing children.

5. She was discharged on the 17th of September 2012. The doctor who performed the operation advised her on how to clean the wound. She was given medication to take and was further informed to visit any health facility, 10 days thereafter, to have the stitches removed.

6. As advised, the Plaintiff, on the 27th September 2012 visited a local clinic in Mochudi so that the stiches could be removed and same were removed. As at that time, the wound appeared healed. Surprisingly, during the night of the 27th September 2012, she started to experience excruciating pain, around the pelvic area, which she described as surpassing labour pains. Unable to bear the increasing pains, the Plaintiff was taken to Deborah Relief Memorial Hospital, Mochudi that same night by her colleague, as she could not drive herself thereto.

7. The Plaintiff, whilst at the Accident and Emergency Department, experienced a greenish fluid leakage from her vagina. She was immediately taken to Princess Marina Hospital, Gaborone, that same night. Upon her arrival thereat, she testified that the unbearable pain persisted, to the extent that she could not walk on her

own. She was then put on a wheelchair, and was admitted at the Accident and Emergency Department.

8. The flow of the greenish fluid intensified. She was given heavy duty pads to put on. She testified that the doctors who attended to her, namely Dr Fifi and Dr Katse did not inform her about the cause of the fluid leakage, despite her persistent enquiry.

9. The Plaintiff was later informed that the leakage was water collecting in the hole where the uterus had been. She was treated with antibiotics.

10. She testified that her situation resulted in her stress levels rising to a point where she had to take high blood pressure medication, a condition she did not have before the botched operation. She is now permanently taking high blood pressure medication.

11. The Plaintiff was discharged from Princess Marina Hospital on the 4th October 2012. At that time, the fluid was still leaking. She was given a supply of maternity pads, and antibiotics.

12. The Plaintiff obtained a second opinion from Dr Bethuel of Jobert Medical Centre in Mochudi. The doctor advised her to go back to Sekgoma Memorial Hospital, to seek further clarification about her condition and for the doctors thereat to treat her condition.

13. On the 12th October 2012 the Plaintiff returned to Sekgoma Memorial Hospital where she was readmitted. A catheter was inserted into her vagina. She was also given diapers to use. The Plaintiff was informed that the leakage would eventually stop. She was discharged with diapers and a catheter to use. The leakage had subsided. What remained was emotional pain and stress.

14. The catheter that was placed inside her vagina hung in between her legs. Whenever she had to sit down, she would need a blanket or cloth to cover it up. The Plaintiff contended that she was never counselled.

15. At home, the Plaintiff's husband displayed loss of affection. She testified that the husband would not sit next to her and that at night he would sleep on the floor. Due to constant flow of urine, she said she developed a stench of urine and this strained the

marriage. Her home caretakers were only her mother and sister.

16. After some days, the Plaintiff resumed work at the school where she was teaching, still on diapers and a catheter. She alerted the Headmaster about her condition. The Headmaster allowed her to go home frequently, during office hours, for purposes of changing her diapers.

17. The Plaintiff was readmitted at Princess Marina Hospital on the 24th October 2012. She was admitted for a week. The catheter was still attached. She was discharged after a week and was asked to come back for checkup on the 9th January 2013.

18. On the 17th December 2012, the Plaintiff returned to Sekgoma Memorial Hospital and was attended to by Dr Kgosi and Dr Chishika. It was explained to her that her ureter had been injured at the time of the operation and that this was suspected to be a uretero vaginal fistula, which is different from the suspected vesico vaginal fistula that was earlier suspected and noted.

19. The Plaintiff was referred to a gynecologist at Nyangangwe Referral Hospital in Francistown on the 6th February 2013, where she was attended to by Dr Valery, who later referred her to Dr Toma. Dr Toma did an examination of the Plaintiff on the 1st March 2013 and diagnosed a utero vaginal fistula. The Plaintiff consulted Dr Toma on multiple occasions and in one of those occasions around March 2013, he removed the catheter as the leakage had now subsided, but directed her to continue using diapers.

20. According to the Plaintiff, Dr Toma informed her that the hospital did not have all the necessary equipment to rectify the injury, hence the referral of the Plaintiff to South Africa. On the 18th March 2013, the Plaintiff went to Pretoria Urology Hospital in South Africa and was attended to by Dr Van de Merwe.

21. According to Dr Van de Merwe's finding's, the leakage of urine from the Plaintiff was caused by two holes, ureter fistula and the vesico vaginal fistula. The ureter fistula had healed and the vesico vaginal fistula was still healing. The said doctor repaired the vesico vaginal fistula. She was discharged and she came back to Botswana.

22. The Plaintiff told the court that due to her condition, it became impossible for her and the husband to enjoy conjugal rights. As a result, the marriage broke down irretrievably and resulted in their divorce. She stated that from the day she was admitted at Deborah Relief Memorial Hospital until the catheter was removed, she used diapers as she was unable to control her bladder and had to endure the persistent smell of urine. She is currently having urinary incontinence and has to travel with extra underwear in her bag in case she urinates on herself.

23. During cross examination of the Plaintiff by the defendant's attorney, the Plaintiff informed court that she holds a Bachelor's Degree in Special Education and further stated that she was satisfied by the doctor's explanation concerning the associated risks of the operation, (total abdominal hysterectomy). In amplification, the Plaintiff said the only risk of the operation that was explained to her was that she would no longer be able to have children. When asked if she read the hospital consent form before the operation, she stated that she did not read it as she

was happy with the explanation given by the doctor, but nonetheless signed the consent form.

24. Resego Lesolame (PW1), the Plaintiff's sister, gave evidence in support of the present claim. She stated that the Plaintiff informed her about the medical operation in question. At the time that the Plaintiff was hospitalised at Princess Maria Hospital, Gaborone, the witness visited her and found the Plaintiff to be in pain.

25. According to PW1, the doctors gave her scanty information about the Plaintiff's progress. On the 3rd of October 2012, Dr Dikobe informed her that the fluid flowing from the Plaintiff's vagina was water that had collected in the hole where the uterus was. The witness was further informed by the said doctor that the condition would heal by itself.

26. After the Plaintiff's discharge from hospital, PW1 testified that she was the caregiver to the Plaintiff. She changed the Plaintiff's bedlinen on several occasions and further that she provided counselling to her sister. She stated that her sister became a recluse as a result of her condition. About her physical movements, she stated that the Plaintiff was physically challenged to

move freely because of the catheter that was inserted in her and the fact that she had to change diapers frequently.

27. The witness stated that the Plaintiff suffered emotional stress and even developed high blood pressure, such that in 2019 and in 2020 she suffered a minor stroke. She stated that as a result of the emotional stress, the Plaintiff consulted a private psychiatrist based in Letlhakane.

28. Professor Roland Edgar Mhlanga (PW2) an Obstetrician and Gynecologist testified via a video link. According to the expert, the most important thing in assessing a patient with fibroids, who is due to undergo a hysterectomy operation, is a thorough assessment of the patient and to ascertain if there are no alternatives to hysterectomy, considering that such an operation is a major one.

29. For a patient to undergo hysterectomy, such patient should be in optimal good health and should have acceptable levels of haemoglobin and electrolytes, that the kidney function should be normal and that the patient should not be suffering from any chronic

condition like high blood pressure or diabetes. If such conditions are excluded, then an examination of the cervix would be undertaken.

30. A pap smear would also be done to exclude the presence of cancer. Using fingers, the fibroids would be assessed and checked, as well as the uterine. If there is some doubt on the mobility of the uterine, an intravenous process would be undertaken. An ultra-scan would also have to be done and the results of all these tests would then be documented in writing on the patient's notes.

31. Depending on the size of the uterus, then the surgeon would decide where to cut on the abdomen. The up and down cut is the preferred one. After perusing the Plaintiff's notes, PW3 testified that there was no record of the cut on the Plaintiff's abdomen. He reiterated that it was important to record such information about the cut, so as to fathom if the operation was a difficult one or not.

32. He continued and explained the process of the cutting and opening of the abdomen, an inspection of the abdomen to check if there are any abnormalities. If

there are abnormalities, normalcy ought to be restored first. Then the swab is packed so that the intestines are far from the uterus. A check of a previous caesarean section operation would also be undertaken.

33. According to the expert, most injuries to patients occur at the ureter, which is very close to the bladder and the cervix. During the operation , the cut would be done on the uterus, which should then be kept away from the uterine and then clamped. If there is a bleeding, a suture is put. Then a cleaning up is done. A check of any fluid leakage would be undertaken. Once there is no bleeding and or leakage, a close up is done. All the process, according to the expert, must be recorded down.

34. For an operation of this nature, one requires the requisite medical qualification and experience. The surgeon's qualifications and names should also be recorded on the patient's records.

35. Before an operation is done, a patient would be informed about the nature, risks and extent of the operation. A written consent from a patient must be obtained.

36. Concerning hysterectomy, the risks of complications are common and serious, hence whenever any injury occurs, such injury should be repaired at that material time and where possible, calls from other experts will have to be made.

37. After the operation, an observation period of the patient is undertaken to check for injuries. The colour of the urine is a good litmus test for any injuries as well as the pulse rate. Normally, a patient would be kept for 3 days in the hospital, if there are no complications.

38. Before discharge, a thorough examination is done on the patient, including checking the pad, the vagina, any visible sores, the smell of the pad and to check if there are any leaking fluids or discharge. An X-ray examination would also be done. If there is a urine leakage, it may take 3-6 months for the injury to heal itself.

39. The said operation invariably has pains and the level of pain varies from one patient to another.

40. According to PW3, the Plaintiff was brought to his surgery in Pretoria, South Africa. Upon reviewing her

records, he noticed that the records were incomplete, were poorly maintained by the doctors who attended to her. He stated that there were no results shown for tests done, no record of a pap smear, the operation itself did not have notes recorded as well as the names and qualifications of the doctor who operated on her. He also determined that the urine leakage was chronic and that the constant smell of urine on her was demeaning. Incontinence of urine, according to the expert, is a shameful experience, hence the need for clinical counselling.

41. Concerning the use of catheters, he stated that the patients required periodic review to check for possible infections arising from such usage. Due to higher risk of complications in hysterectomy operations, there is an ardent need for extra care during the operation and for post operation care.

42. Having assessed the Plaintiff's records, he stated that it was inconclusive to state where the Plaintiff's injury or cut was. He further stated that the Plaintiff was discharged after 2 days of the operation and was then informed to go for a check-up at a local clinic. In his opinion, this was startling in that the doctor who

operated on her will not be available at the said local clinic.

43. During cross examination, PW3 conceded that vesico vaginal fistula, which is a hole in the bladder connecting to the vagina, is a known risk or complication arising from total hysterectomy operation. He further conceded that even for experienced surgeons, injuries may still occur. He further conceded that it is possible to miss a fistula during examination. He stated that if a fistula is discovered immediately after operation, it can be repaired immediately but if it is discovered later, then the bladder ought to be kept empty and that the injury generally heals after 3-6 months.

44. The next expert witness to be called by the Plaintiff was Dr Jabulani Maphisa Maphisa, (PW4) a Clinical Psychologist. He informed the court that it is a common practice within his field of expertise for mental health practitioners to do a retrospective analysis of a patient through evaluation of records.

45. From a review of the Plaintiff's medical records, he opined that the Plaintiff suffered from mental anguish following a medical operation done on her. He stated

that the Plaintiff was socially withdrawn, lacked confidence and that her symptoms showed depressive syndrome. Furthermore, that she suffered from an ongoing medical complication which caused an abrupt life changes, which unfolded over a period of time, resulting in loss of dignity. Urinal incontinence, he said, affected the Plaintiff's life.

46. The clinical psychologist (PW4) also did two interviews with the Plaintiff. Based on two clinical interviews he had with the Plaintiff on the 30th November 2019 and 2nd December 2019 and given her stress level, PW4 opined that she needed professional counselling.

Defendant's Case

47. The Defendant, in his endeavour to thwart the Plaintiff's case, called one witness, Dr Ndiwo Memo, (DW1) a gynecologist, employed by the University of Botswana. He reviewed the Plaintiff's medical records and found that the Plaintiff sustained a vaginal fistula, as a complication arising from an operation done on her at Sekgoma Memorial Hospital, Serowe. He stated that a vaginal fistula is a communication between the bladder

and the vagina and that it leads to urine leakage from the bladder through the vagina.

48. In this view, the vaginal fistula was caused by the gynecological operation done closer to the bladder. He stated that the bladder sits right in front of the uterus and that there is a small space between the said organs.

49. During a hysterectomy he stated that there is a need to separate the bladder from both the uterus and the vagina and that injury may occur during this separation, either through cutting or through burning using electro-gadgets. It may also occur through suturing of the vagina after the removal of the uterus.

50. In terms of treatment of fistula, it involves a conservative operation which would minimise urine flow through a catheter and then allow the body to heal itself. If conservative treatment fails, then an operation is done, which involves cutting out of the dead tissue and then closing up the hole.

51. The effects of a fistula is that patients continuously leak urine, which affects their livelihoods. Counselling will then be necessary to assuage their feelings. A catheter,

sanitary pads or diapers will then have to be used to reduce urine leakage. The possibility of rash developing is always existent.

52. In terms of the body healing itself, DW1 stated that it may take 3-6 months (conservative treatment).

53. From a perusal of the Plaintiff's medical records, the Defendant's expert witness stated that Plaintiff took 2-10 days for urine to start leaking. In his view, the treatment given to the Plaintiff was sufficient, except that it was done at various hospitals by different specialists. He further informed the court that the Plaintiff was referred to South Africa for further management and investigation of her condition on account of limited resources available at government facilities.

54. In his view, there was no negligence during the operation and during the after - care of the Plaintiff. Having a complication, according to the expert, is not synonymous with negligence.

55. During cross examination, the expert conceded that he was not present during the operation as well as during the after-care period. He conceded that there were no

pre-operation notes as well as post-operation notes written down concerning the Plaintiff. He stated that such notes are of prime importance. He also conceded that from the records, there is no name of the doctor who performed the operation. He also conceded that there is no record evincing Plaintiff's counselling.

Common Cause Facts

56. In terms of the proposed final order by the parties, the facts outlined hereunder are common cause, namely:-

(a) The Plaintiff was admitted at Sekgoma Memorial Hospital for total abdominal hysterectomy which was done on the 15th September 2012.

(b) On the 26th September 2012 (about 10 days after her discharge from hospital) urine started leaking from the Plaintiff's vagina and that the Plaintiff felt severe pain around the groin area.

(c) The Plaintiff was attended to by medical personnel based at Sekgoma Memorial Hospital,

Nyangangwe Hospital and Princess Marina Hospital.

(d) The Plaintiff, post the operation, lodged a complaint of malpractice with the Permanent Secretary, Ministry of Health.

(e) Dr Kgosi and Dr Chisika examined the Plaintiff's X-ray films and opined that the Plaintiff's ureter had been cut during the operation and then referred her to Nyangagwe Hospital in Francistown.

(f) Nyangangwe Hospital referred the Plaintiff to Pretoria Urology Hospital, in South Africa, where the vaginal fistula was repaired.

(g) In March 2013, the Plaintiff was transferred to Pretoria Urology Hospital in South Africa where she was diagnosed with vesisco vaginal fistula, which occurred as a result of the operation done at Sekgoma Memorial Hospital.

(h) Dr H Van Der Merwe conducted a procedure to mend the vaginal fistula.

57. Over and above the parties' agreed common cause facts, I make, *mero motu,* the following findings of facts, namely:-

(a) the qualifications and names of the person who carried out the operation (total abdominal hysterectomy) on the Plaintiff are unknown, on account of the failure or omission to write such details on the Plaintiff's medical records.

(b) Both pre-operation, operation and post operation notes were not recorded on the Plaintiff's medical records.

(c) The Plaintiff's medical records did not contain any entry evincing Plaintiff's counselling.

Germane Issues for Consideration

58. From the factual matrix, the following issues present themselves for assessment and interrogation, namely:

(a) Whether the performance of the operation on the Plaintiff was negligent;

(b) Whether the Defendant was negligent during the post-operation care of the Plaintiff, and

(c) If negligence had been proved, whether the Plaintiff suffered damages as a result of such negligence, and

(d) The quantum of damages suffered.

Delictual Claim for Negligence

59. As a matter of general proposition relating to a delictual claim founded on negligence, the test for negligence was neatly articulated in the case of **Kruger v Coetzee** 1966(2) SA 428 (A) and at page 430 E the Court said:

"For purposes of liability, culpa arises if-

(a) A diligence 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.

60. It is trite that in a delictual claim, the Plaintiff is enjoined to prove, on a balance of probabilities, patrimonial loss suffered as a result of the wrongful act or omission of the Defendant, which is attributable to the Defendant's fault, either in the form of *dolus* (wrongful intention) or culpa (negligence). See **Petersen v Ansyl (Pty) Ltd t/a Guma Island Lodge** [2008]3 BLR 7 (HC) and **Oppelt v Head, Health Department, Western Cape** 2016(1) SA 325 (CC).

61. The Plaintiff is further enjoined to prove causation or causal connection between the wrongful act allegedly committed and the damages or loss suffered by the Plaintiff. The alleged loss should thus not be too remote. The test applicable thereto is the "but for" criterion. What is of fundamental importance is what would have happened, but for the unlawful act of the Defendant. See **Neethling J and Potgieter: The Law of Delict** 8th ed (Lexis Noxis) 2015 at p 283.

62. In *casu,* the alleged delict arises from the medical operation that was done on the person of the Plaintiff. Thus the said medical professionals owed a duty of care to the Plaintiff, pre-operation, during and post the operation. Put, differently, a medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner, in his field. When assessing such 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 concerned medical professional belongs. I am fortified hereto by the following cases, namely: **Kgari v The Attorney General [2012] 1 BLR 1105 (HC).**

63. It is also trite that experts are not guarantors of what they say or do. As it was stated in **Knight v Findley** 1934 NPD 185 at p210 and **Durr v ABSA Bank Ltd & Another** 1997 (3) SA 448 (A) "... he does not undertake, if he is attorney, that in all events you shall gain your case, nor does a surgeon undertake that he will perform a cure".

64. The role of experts in *casu* looms large, hence the need to foreshadow the applicable guidelines that attach to the role of experts.

Role of Experts

65. As a point of departure, an expert witness is required to assist the court to lay a factual basis for his/her conclusions and to further explain his/her reasoning to the court. An expert should not usurp the function of the court. An expert's primary role is to present the necessary scientific and objective criteria to the issues raised. See **Bee v. Road Accident Fund** 2018 (4) SA 366 (SCA) and **Michael & Another v Links field Park Clinic (Pty) Ltd & Another** – 2001(3) SA 1188(SCA).

66. An expert's opinion should be underpinned by proper and logical reasoning, in order for the court to assess the cogency of the opinion. Absent any reasoning, then the opinion is unreliable. The Court is not bound to swallow, *holus bolus,* the view of an expert. Put differently, the court is not a rubber stamp for acceptance of the expert's opinion. To that extent, the court is not expected to blindly accept the assertion of the expert, without full explanation. In this

connection, see **Prime Water House Coopers & Others v National Potato Co-operative Ltd and Another** 2015 ZASCA 2.

67. The facts upon which an expert expresses an opinion must be capable of being reconciled with all other evidence adduced. In the case of **National Justice Compania Navera SA v Prudential Assurance Co. Ltd** [1993] 2 Lyod's Rep 68 at pages 81-82, Creswell J devised a code of conduct pertaining to duties of an expert witness, as follows:

(a) Expert evidence presented should be seen to be an independent product of an expert, uninfluenced as to form or content;

(b) An expert witness should provide independent assistance by way of objective, unbiased opinion, in relation to matters within his/her expertise. An expert witness should not assume the role of an attorney or advocate;

(c) An expert witness should state the facts upon which his/her opinion is based. He or she should

not omit to consider material facts which could detract from his/her concluded opinion;

(d) An expert should make it clear when a particular question or issue falls outside his/her expertise;

(e) If an expert's opinion is not properly researched because he/she considers that insufficient data is available, then this must be stated, with an indication that the opinion is no more than a provisional one.

68. Armed with the above formulation about the expert's role, the next port of call is to determine if there was negligence.

Whether the Defendant was Negligent

69. In determining negligence, I shall bear in mind that the defendant's employees owed the Plaintiff a duty of care to perform the operation in question (total abdominal hysterectomy) with care, reasonable skill and diligence demanded from a medical professional with the requisite qualifications, skill and expertise.

70. In *casu,* the identity and qualifications of the personnel at Sekgoma Memorial Hospital, who performed the operation in question are unknown. There is no annotated record of who performed the operation. The Defendant has not provided any evidence of who performed the operation.

71. The absence of the identity of the person who performed the said operation, in my view, is unpardonable, viewed through the prism of medical protocols and ethics, as I will demonstrate hereunder.

Medical Records

72. It is trite that medical records are documents that explain, all details about the patient's history, clinical findings, diagnostic test results, pre and post-operative care, patient's progress and medication. A good medical record therefore serves the best interest of the medical practitioner as well as the patient. See **Benjamin B.: Medical Records, London, William Heinemann Books Ltd** (1990).

73. Record keeping serves the useful purpose of proving that the treatment or operation was carried out properly. The records are the source of the truth. They facilitate good care and allow a subsequent caregiver to understand the patient's condition and the basis for the current investigation and treatment. They provide a method of communicating with other team members. See **Weiss M.J. Health Information Privacy: A Disappearing Concept: Bulletin of Science Technology and Society.** (2000).

74. The keeping of such records also satisfy legal and ethical obligations, for instance, as may be required by medical regulatory authorities and hospitals. Such Medical records, in my view, are the best alibi for the medical professionals when sued for malpractice. In the absence of such records, the alibi is dislodged and the professional will be placed at the *locus delicti,* as it were.

75. Failure to document relevant data, in my view, is a breach of and a deviation from the standard of care expected from a medical professional, always bearing in mind that the quality of patient care is directly linked to the quality of the medical record maintained. In the

case of **McManns v Medical Council** [2012] IEHC 350, it was held as follows:

"However inconvenient and burdensome it may be to write up medical records accurately, such records constitute a vital safeguard for both medical practitioners and patients alike in any situation where it later becomes necessary to conduct any form of investigation as to what transpired during the course of a patient's treatment".

76. According to Dr Mhlanga an expert urologist or a trained specialist doctor like a gynecologist are best suited to perform the operation in question. Furthermore, it has been stated by both experts for the Plaintiff and the Defendant that there ought to have been operation notes recorded by the operating doctor.

77. The Plaintiff's expert witness (Dr Mhlanga), gave a concise and detailed account of procedural steps that are to be taken before, during and after the operation. The details were amply confirmed by the Defendant's expert witness (Dr Memo).

78. The pre-operation procedures, operation procedures and post operation procedures are required to be recorded on the patient's card. In *casu,* there is no record.

79. The actual operation procedure would then entail the decision by the doctor on the kind of the cut or incision to be made, based on the size of the uterus. An assessment of any abnormalities in the anatomy would also be done. A swab would then be used to pack away the intestines, such that the doctor would completely see the uterus.

80. The bladder would also be moved and packed away to avoid it being injured. The doctor would clamp and cut from the top to the bottom to separate the uterus from the tubes. According to Dr Mhlanga, most injuries happen where the ureter, blood vessels, bladder and vaginal roof are concentrated. The clamping therefore ought to be carefully done to prevent any injury. The ureter, that is situate behind the bladder would have to be checked and then moved to avoid any injury thereto.

81. In terms of this operation process, it is common cause that none has been recorded by the person who performed the operation. There is no record of steps

taken, sutures done, how the ovaries looked and the stitch used to closed the wound.

82. The inadequacy of recording is also manifest with respect to the immediate post operation procedure. There is no record if at all the vagina bled nor a record of whether there was urine leakage and if so the colour thereof.

83. In my view, the lack of records of how the operation was conducted explains the trial and error approach by the Defendant at attempting to diagnose what could have happened to the Plaintiff during the operation. After she was initially admitted at Princess Marina Hospital, the Plaintiff was informed that what was leaking from her vagina was water collecting in the uterus from her other body parts and that the problem would go away on its own through antibiotic treatment.

84. From the date of initial hospitalization in 2012 until March 2013, there was no definitive diagnosis of her condition. As I have demonstrated above, this was primarily on account of lack of records of the operation.

85. Basic tests that did not require sophisticated and expensive resources were not carried out. Dr Mhlanga testified that the basic tests that could have been done were tests on the fluid.

86. Although the Defendant's expert witness testified that a diagnosis could not be made due to lack of resources for such diagnostic test, Dr Mhlanga's evidence to the effect that basic bedside tests, which were readily doable, were not done, has not be controverted.

87. The prolonged lull, without a proper diagnosis meant that the Plaintiff's suffering continued unabated. The Plaintiff at the time the complications occurred could not control her bladder to the point that she had to change from using sanitary pads to using adult diapers, as the leakage was now excessive.

88. According to the Defendant, the fistula that the Plaintiff suffered was a natural consequences of the surgical operation that was done, and that there was no negligence. It was further submitted that in any event, the Plaintiff had signed a consent form for purposes of consenting to undergo the said operation. The other defence raised was that government hospitals generally

in Africa lack the requisite resources to perform at a higher level.

89. In terms of post operation care, the Defendant stated that the Plaintiff was adequately cared for, that she was given a catheter and diapers to control leakage.

90. In conclusion the Defendant submitted that the Defendant's employees were not negligent in the carrying out of the operation, as well as the aftercare provided to the Plaintiff. In the absence of negligence, it was contended that the question of damages is a *non sequitur* or did not arise.

Analysis and Determination

91. In *casu,* the names and qualifications of the person who performed the operation on the Plaintiff are unknown. The evidential burden of adducing evidence on the identity and qualifications of the person who carried out the operation is on the defendant. The Defendant has failed to adduce evidence in that regard. The Court is therefore not in a position to ascribe the standard of

care, expertise, skill and qualifications possessed by such personnel.

92. The record of the pre-operation, operation and post the operation was never documented. The court was in a position to ascertain if the requisite care and skill was exhibited during the operation.

93. It is trite that the Plaintiff bears the onus of proving negligence on a balance of probabilities. The Plaintiff has adduced evidence to show how the Defendant's personnel were negligent in the performance of the operation as well as how she was not afforded reasonable care after the operation. On this score, inspiration is derived from the dictum of Moroka J in **Kgari v The Attorney General,** supra, at page 1111 para E-F where he poignantly determined negligence as follows:

" Therefore the qualifications, experience and levels of skill of the doctor who performed the surgery are matters which fall within this evidential burden. The Defendant has not discharged this burden. There is no admissible evidence of what qualifications the doctor who performed the surgery had, when and

what levels of experience he had. In the absence of the doctor who performed the operation, not only are we deprived of the evidence of the level of skill and care he undertook, we are also deprived of evidence of his levels of qualification, and experience.

94. In *casu,* the Plaintiff led evidence that her ureter was negligently cut by the unknown medical professional. She further stated that her vaginal wall was cut during the operation. The Plaintiff's expert witness was detailed as to how such operation was to be conducted, as well as the record to be kept. He opined that the defendant was negligent. Having assessed his credibility, his enviable experience and solid qualifications, I believe him. The defendant's expert witness, although believable in some respects, unreasonably absolved his former employer from any negligence. From a preponderance of probabilities, fortified by the scientific criteria placed before me, in my view, the person(s) who performed the operation failed to isolate the organs properly, such that the removal of both the uterus and the cervix should not have resulted in the injuries sustained.

95. After the operation, the Plaintiff was moved from one hospital to another. The doctor's failed to do a proper

diagnosis of the nature of the injury sustained. Simply put, the post operation care fell short of the reasonable care expected to be given to a patient who had suffered a utero vaginal fistula and a vesico vaginal fistula.

96. Having regard to the above factual matrix, I have no hesitation in determining that the Defendant was negligent during the performance of a total abdominal hysterectomy on the person of the Plaintiff, on a preponderance of probabilities.

97. The fact that the Plaintiff signed the consent form to undergo the operation did not mean that she was consenting to negligence. See **Castell v. De Greef** 1994(4) SA 408(C) it was held that for consent to be a defence, the following criteria ought to be satisfied, namely:-

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

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

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

(d) The consent must be comprehensive, that is extend to the entire transactions, inclusive of its consequences.

98. In *casu,* none of the above requirements have been established, such that the Defendant can be absolved from liability, arising from the consent form.

99. The Plaintiff has therefore succeeded in proving her case on a balance of probabilities.

The Quantum of Damages

100. The Plaintiff is claiming P2million as general damages arising out of the Defendant's negligence. Subsumed under the general damages, she stated that she suffered mental and emotional anguish, shock, pain and suffering that her mode of living was drastically affected by the negligent cutting of her ureter and vagina wall and for the Defendant's failure to provide timeous and adequate care, post the operation.

101. It is trite that the basic principle informing the award of damages under Aquilian action is that the compensation to be awarded must, as far as possible, place the injured person in a position that the concerned person would be in but for the injury. The assessment of general damages is an arduous and complex exercise. In **Sandler v Wholesale Coal Supplies Ltd 1941 AD 194 at p199**, Watermeyer J.A acknowledged this onerous task of assessment of general damages as follows:

> *"It must be recognised that though the law attempts to repair the wrong done to a sufferer who has received personal injuries in an accident by compensating him in money, yet there are no scales by which pain and suffering can be measured, and there is no relationship between pain and money which makes it possible to express one in terms of the other with any approach to certainty. The amount to be awarded as compensation can only be determined by broadest general considerations and the figure arrived at must be necessarily be uncertain,*

depending upon the Judge's view of what is fair in all circumstances of the case"

102. By its nature, general damages are broad and multifaceted. On that score, amenities of life, just like pain and suffering, emotional shock etc form part and parcel of general damages. Such damages, as the appellation connotes, are general as opposed to special damages.

103. Loss of amenities of life, as a component of general damages has been described and defined by Hoexter JA, with refreshing and poetic articulation in the case **Administration – General, South West Africa & others v Krul** 1988 (3) SA 275 at p288 E as follows:

"The amenities of life may further be described and consider, as those satisfactions in ones everyday existence, which flow from the blessings of an unclouded mind, a healthy body, and sound limbs. The amenities of life derive from such simple but vital functions and faculties as the ability to walk and run, the ability to sit or stand unaided, the ability to read and write unaided, the ability to bath, dress, feed oneself unaided,

and the ability to exercise control over one's bladder and bowels. Upon all such powers individual human self-sufficiency, happiness and dignity are undoubtedly highly dependent"

104. In **H-West & Son Ltd v Shephard** 1964 AC 326, Lord Devlin described "loss of amenities of life" as a diminution in the full pleasure of living. See also **Motlhagodi v Debswana Diamond Company (Pty) Ltd** [2013] at BLR 405 (HC).

105. General damages are legally presumed to flow from an unlawful act or breach of contract and thus require to be pleaded. Generally such damages fall within the judicious discretion of the court. See **Mothuba & Another v Molefi** [2008] 1 BLR 378 (CA).

106. When assessing general damages to award, it is pertinent that comparable and helpful awards from other similarly circumstanced cases be thrown into the balance, always bearing in mind that each case is founded upon its own unique circumstances and factors. I am fortified by the decision of **Attorney General v Makhumalo** [2009], I BLR 74 (CA), wherein the Court of Appeal held, inter alia, that previous

comparable awards form a useful guide in the assessment of damages and further that the changes in the value of money is another useful criterion, when assessing such comparable awards.

107. It has been held in various cases that an award for general damages should tend to lean towards conservatism, rather than liberality. See **Bay Passenger Transport Ltd v Franzen** 1975 (1) SA 269. In other words, that a degree of caution ought to be exercised.

108. In *casu*, it is common cause and not disputed that the Plaintiff underwent a surgical operation, a total abdominal hysterectomy on the 15th September 2012. Ten days after her discharge from hospital, she felt excruciating pain that she described as surpassing labour pain. The pain was so unbearable that she could not drive herself to the hospital.

109. When she was referred to Princess Marina Hospital on the 27th September 2012, she was still in pain and could not walk by herself. She was put on a wheelchair. On account of the heavy vaginal fluid leakage, she was given pads.

110. The Plaintiff testified that her situation resulted in her stress levels rising to a point where high blood pressure medication had to be administered. She had never been diagnosed with high blood pressure before. As of to date, she suffers from high blood pressure and is on such medication.

111. When she was discharged on the 4th October 2012, the fluid was still leaking from her vagina. A catheter was ultimately inserted. The leakage was through both the catheter and the vagina. Whenever she had to sit down, she would cover the catheter to hide it from people. All these factors are clearly demeaning.

112. She testified that she never received any counselling from the Defendant. This was never controverted by the Defendant.

113. When she resumed her teaching work, she still had the catheter on and also used diapers. She said she suffered humiliation as she had to constantly move around with a catheter. She struggled to enjoy life or amenities of life. Her marriage collapsed as the husband lost interest in the enjoyment of conjugal rights, arising out of her persistent leakage.

114. As a result of her urine incontinence, wherever she travels, she packs extra underwear in her bag. Often when she coughs or sneezes, urine leaks. She is now a recluse and is ashamed to mingle with the public because of the urinal stench.

115. All the above circumstances that the Plaintiff endured were corroborated by her sister, PW1, who acted as her caregiver. Dr Mhlanga testified that 50% of patients like the Plaintiff become social outcasts and even contemplate suicide. He further said that they are constantly miserable. I have no qualms in doubting such scientific criteria.

116. Dr Maphisa (PW4), the psychologist who conducted an evaluation of the Plaintiff, testified that the Plaintiff showed signs of a low or depressive mood, that she became withdrawn. He testified that she suffered public ridicule and suffered loss of dignity due to the urinal incontinence. Again, I entirely agree with the expert witness.

117. In my judgment, I have no hesitation in concluding that the Plaintiff suffered pain and suffering as a result

of the botched and negligent operation that caused the cutting of her ureter and vaginal wall. All these caused her to suffer emotional trauma, psychological stress. She was diagnosed with depressive episode and mood swings.

118. The Plaintiff's loss of amenities of life speak for themselves. She became a recluse. She had a catheter inserted on her, which restricted her social interaction. She suffered urinal incontinence. She had to use diapers for a considerable length of time (more than 6 months). She could not perform her teaching duties with ease. She exuded urinal stench. She did not enjoy sexual intimacy with the husband, as a result of the stench and persistent leakage.

119. In assessing general damages I will also have regard to the award made in **Kgari v The Attorney General**, supra, wherein an award for P150 000.00 was made for general damages resulting from a botched and negligent operation, which resulted in a fistula, like in *casu*. The award was made about ten years ago and in that case, there was one fistula whereas there are two fistulae in casu.

120. Having regard to all the necessary indicia pertaining to assessment of damages, it is my view that the award to be made should thus be fair to the Plaintiff, and assuage the pain and suffering, the psychological trauma and the loss of dignity she endured. A reasonable amount for compensation (general damages) should thus be P400 000.00.

121. It is ordered as follows:

a. The Plaintiff is awarded P400 000.00 as general damages;

b. Interest thereon at the rate of 10% per annum, a *tempore morae;* and

c. The Defendant shall bear the costs of the suit.

DELIVERED IN OPEN COURT AT GABORONE THIS 29TH DAY OF MARCH 2022.

M. LEBURU
[JUDGE]