Kalea v Attorney General

Judgment

Court:	High Court of Malawi
Registry:	Civil Division
Bench:	Honourable Justice Mkandawire
Cause Number:	[1993] 16(1) MLR 152 (HC)
Date of Judgment:	July 27, 1993
Bar:	Nyirenda, Counsel for the Plaintiff Chanthunya, Counsel for the Defendant

In her re-amended statement of claim, the plaintiff is claiming the sums of K3 724-80 and R1 525-00, being special damages for the alleged negligence committed by members of staff of Queen Elizabeth Central Hospital. She is also claiming general damages for the alleged acts of negligence.

It is common cause that on 23 March 1985, the plaintiff underwent a caesarian operation at Queen Elizabeth Central Hospital. It is also common cause that the said caesarian operation was conducted by Dr John Chiphangwi, a gynaecologist,

and was assisted by a nurse by the name of Mrs Catherine Malenga. It is alleged in the re-amended statement of claim that Dr Chiphangwi and Mrs Malenga discharged their duties negligently during the said operation and particulars of the alleged negligence are as follows:

I. Dr John Chiphangwi was negligent in that:

(a) during the ceasarian operation he left a placental tissue or placenta accreta in utero;

(b) he failed to advise or warn the patient that she had placenta accreta or that a piece of placental tissue was left in the uterus;

(c) using a sharp curette he damaged the uterine wall in that he perforated the same in the course of removing the placenta and wilfully failed to inform the plaintiff subsequently that she had a damaged uterus;

(d) he failed to inspect or thoroughly inspect the uterus after the delivery of the placenta to ensure that no placental tissue was left in the uterus;

(e) he failed to record in the patient’s notes that the plaintiff had placenta accreta or that a placental tissue was left in the uterus. He further failed to record in the patient’s notes that he had damaged the uterine wall with the curette.

(f) the plaintiff will rely on the fact, as evidence of negligence, that a placental tissue was found on the cervical OS.

II. Mrs Malenga was negligent in that:

(a) having noticed a placenta accreta or placental tissue in the uterus, she failed to alert team leader Dr Chiphangwi of the presence of a placenta accreta or placental tissue in the uterus as a result of which failure Dr Chiphangwi closed the uterus leaving the placenta accreta or placental tissue in the said uterus;

(b) she, in the alternative, introduced the tissue in the uterus without telling the doctor;

(c) she failed to make a record of the retention of the placental tissue or placental accreta in the theatre book and on the patient's notes as required by midwives' rules;

(d) the plaintiff will rely on the fact as evidence of negligence that a placental tissue was found on the cervical OS.

Paragraph 3 of the re-amended statement of claim gives a detailed list of particulars of injury which the plaintiff suffered by reason of the alleged negligence. It is not in dispute that after the caesarian section the plaintiff was admitted in Ward 1A. It is alleged in the re-amended statement of claim that the nursing and medical staff in Ward 1A were negligent as follows:

the nursing staff was negligent in that they failed to report to the doctors on duty the abrupt cessation of red lochia on the fourth day after operation and further failed to conduct post natal examination on the plaintiff which examination would have led to an early arrest of the negligence of Dr Chiphangwi and nurse Mrs Catherine Malenga.

III. The Medical staff of Ward 1A namely Dr Ndovi and Dr Patel were negligent in that:

(a) having noted a low grade fever following the operation and having satisfied themselves through blood tests that malaria was not the cause of the low grade fever, did nothing to investigate other probable causes, such as an infection.

(b) they discharged a patient with low grade fever.

It is again not in dispute that after she was discharged from hospital, she visited the hospital as a patient to complain of her continued illness and to get treatment, but the nurses on duty, Mrs Chikopa and Mrs Hara, so negligently discharged their duties that she did not get treatment and continued to experience further pain and suffering. The particulars of the alleged negligence are given as follows:

IV. Mrs Chikopa was negligent in that:

(a) on or about 5 April 1985 she as midwife failed to follow up the plaintiff's complaint that she had felt a tissue on the cervical OS when having a bath;

(b) she ignored without justification the plaintiff's caution of a possibility in change of position of the tissue if examined in a lithotomy position as the plaintiff had felt the tissue in a squatting position;

(c) she failed to record in the patient's notes the examination she had carried out and her findings, which notes would have been of assistance to other staff.

(d) she failed to call a doctor on duty to attend to the plaintiff upon seeing dark brown, reddish blood on normal examination of the affected area and on a bi-valve examination.

V. Mrs Hara was negligent in that:

(a) when the plaintiff saw her and complained of the dark brown reddish blood and that the plaintiff had felt a tissue on the cervical OS, she did not refer the plaintiff to the doctor on duty when she should have done so but persuaded the plaintiff to go home;

(b) she failed to record in the patient's notes the plaintiff's complaint and her decision on the matter.

In the alternative, the plaintiff pleads generally that the staff or the servants/agents of the Malawi Government were negligent and/or in breach of duty in the performance of the caesarian operation and by reason of which the plaintiff suffered injury and experienced great pain and suffering. The particulars of the alleged negligence or breach of duty are listed as:

VI. The said servants or agents of the Malawi Government are negligent in that:

(a) during the said operation they left a placental tissue or placenta accreta in utero;

(b) the plaintiff will rely on the fact, as evidence of negligence, that a placental tissue was found on the cervical OS;

(c) the plaintiff repeats the particulars set out in paragraph 2A (b), (c), (d) and 2B (a) and (c) hereof.

VII. The said servants or agents of the Malawi Government breached their duty in that they did not comply with the Rules and Regulations for Midwives promulgated under the Nurses and Midwives Act, (Cap. 36:02) of the Laws of Malawi in that:

(a) they failed on various dates to maintain a record or make entries in the patient's notes the plaintiff's complaint, the examinations carried out by them, their findings and treatment administered as required under article 1c and 6 of section D of the said Rules and Regulations for Midwives;

(b) they failed to refer to a doctor a patient (plaintiff) suffering the ailments or experiencing the problems set out in article 3 of section 3 of the Rules and Regulations for Midwives;

(c) they failed to carry out observations on the plaintiff as a mother as required of them under section D of the Rules and Regulations for Midwives;

(d) they failed to carry out post-natal examinations;

(e) they discharged the plaintiff when she had low grade fever and failed to investigate other probable causes of the fever apart from malaria.

The plaintiff is a qualified Malawi registered nurse and midwife. She graduated as a registered nurse from Kamuzu College of Nursing in 1973 and as a registered midwife in 1978. After completion of her course, she worked as a theatre nurse

for about a year and then worked at the then Blantyre School of Nursing also for one year as an assistant tutor. She also served as a Nurse-in Charge for some nine months at the Under-Fives Clinic.

From 1981 to 1983 she was at the Medical University of Southern Africa where she obtained a Bachelors Degree in Nursing Administration and Nursing Education. She also obtained a Diploma in Community Health Nursing. On her return in 1983, she was allocated to the Blantyre School of Nursing as a Professional officer in Nursing, where she served until the school was taken over by the University of Malawi.

In 1984 she decided to have another pregnancy. She then consulted Dr Ndovi, a gynaecologist, whether it would be safe for her to do so. She found it necessary to consult a doctor because she had a medical problem called Hemiplegic Migraine. She was advised that it would be safe. On 2 March 1985, when she was around 36 weeks pregnant, she was admitted through the labour ward to Ward 1A because of severe headache, rise in blood pressure and oedema, which means excessive tissue fluid which causes the swelling of tissues. When her urine was examined, she was found to be albumen positive.

It was her evidence that upon her admission, all the necessary information was taken and the checking of vital signs was done. Blood pressure, pulse, respiration, fundal height and the foetal heart rate, were all checked. But, before delivery, some complications developed. Early in the morning of 23 March 1985, she felt dizzy and had a severe headache and was seeing flashes of light. When

the nurse on duty examined her blood pressure, it was found to be high and she said she was contacting a medical doctor. The doctor who was contacted was Dr Chiphangwi, and upon examining her, he told her he was taking her for a caesarian section due to imminent enclampsia.

When she was taken to the theatre, she asked and was told that the scrub nurse would be Mrs C Malenga, and she did see Mrs Malenga. The anaesthetists were Mr Malambo and Mr Kamenyani. It is the scrub nurse who assists the doctor during the operation. She looks after the sterile instruments and passes them to the surgeon as required. She is also responsible for counting all the swabs and abdominal parts and assists the surgeon generally. It is also the duty of the scrub nurse to record details of the operation in a theatre register. After all was ready, the anaesthetists put the plaintiff to sleep.

When she gained consciousness, the plaintiff found herself in a sideward in Ward 1A. She then discovered that she had delivered a live female baby. After delivery, she was admitted for 10 days. On the first post-operative day she bled heavily. When Dr Chiphangwi came in for ward rounds, she told him and he ordered a unit of blood to be transfused. On the second and third day she also bled heavily. But on the morning of the fourth day, she noted that she had an abrupt complete cessation of the bleeding. She said this was very strange and she got alarmed and so she reported it to the nurse on duty. The reply she got was a casual one, that it sometimes happens, but no action was taken.

From her experience, after delivery, she should have bled lochia up to around the tenth day, but the colour of the discharge would change as days went by. She told the court she was very concerned by the abrupt complete cessation of lochia. She kept on complaining to the nurses, but no action was taken. It was her evidence that the tendency at Queen Elizabeth Central Hospital was that if a nurse was admitted, complaints or demands from her were interpreted as calling for special attention and showing off that she knew a lot. And so she restrained herself from making demands. From the fifth day after the operation, she developed fever and general body pains and headache. She reported this to the Sister-in-Charge of the ward. She examined her and confirmed the fever. The Sister-in-Charge then phoned a doctor.

It was Dr Ndovi who came and he prescribed treatment for malaria. There was no improvement, and so the doctor ordered a blood test for malaria. The results were negative, which meant that the cause of the fever was not malaria. But no other examination was ordered to determine the cause of the fever.

So, she continued complaining of fever, headache and general body pains up to the eighth day. On the ninth day, she was seen by Dr Patel, who said that the headache might be migraine and ordered rest in a dark room and some treatment. Apart from the fever, it was her evidence that she had told Dr Ndovi and Dr Patel of the abrupt cessation of lochia; and yet nothing was done about it. On the tenth day, Dr Patel wondered why she continued having a low grade fever. The doctor then discharged her and said she had to come back to see a Medical Specialist for the blood pressure.

The plaintiff testified that although abrupt cessation of lochia was reported, the nurses did not conduct any post-natal examination, which they were supposed to do. All they did was to check blood pressure, pulse, temperature and respiration. They did not check the fundal height, lochia, the amount of the discharge and colour. They also did not check lactation and the state of breasts. They were obliged to check on all these things under the rules of the Nurses and Midwives Council of Malawi. Turning to records, she said that no records relating to fundal height, lochia, lactation and state of breasts were maintained.

After she was discharged on the tenth day, she still felt general body pains and fever at home and she spent most of the time in bed. On the evening of this day, she had an urge to push and felt labour-like pains. She rushed to the toilet where she passed a big blood clot. It was her evidence that this alarmed her. She then went to a next-door neighbour, Mrs Linyenga, who happened to be a State Registered nurse/midwife, so that she should witness the blood clot. When Mrs Linyenga confirmed that it was indeed a blood clot, she suggested that they go to hospital, which they did.

They went straight to the labour ward of Chatinkha Wing, Queen Elizabeth Central Hospital. The nurse on duty received them and took temperature, pulse and blood pressure which she recorded on the discharge slip. Thereafter, the nurse on duty called the doctor on call, and that happened to be Dr Masanjika. The plaintiff then told the doctor about the blood clot and that she had brought a witness who saw it, since she could not pick it from the toilet. She also told the

doctor that she had complete cessation of lochia on the fourth day. After examining her, the doctor was of the opinion that the blood clot could be the old remains of blood in the uterus coming out. He then prescribed a full course of Tetracycline, to prevent infection, if at all any was starting.

She returned home, but with no real improvement. The next morning, when she was having a shower, and in a squatting position, she felt a tissue on the cervical OS. She was alarmed and quickly went to see Mrs Linyenga about it. They rushed to hospital, fearing that what she felt could mean a retained product of conception. This time they were joined by the plaintiff's husband. They again went to the labour ward of Chatinkha Wing, where they were met by Sister Chikopa. She explained her history about the cessation of the lochia, the blood clot and then the tissue she felt in a squatting position. The Sister took her to a couch for examination and asked her to be in a lithotomy position. After putting on gloves, the sister made a vaginal examination first with her fingers and then with an instrument called a speculum. Mrs Chikopa said she found nothing wrong, but she did not record her examination on the discharge slip which the plaintiff had produced.

She returned home, but was still unwell. When she was having a shower the following morning, she felt that something was coming out and the cervix opened. She was alarmed and she immediately stopped washing. She was quickly rushed to hospital, where she met Mrs Hara in the Chatinkha Maternity Wing. She explained what she felt when she was having a bath and said she was having lower abdominal pains and headache. Mrs Hara conducted a vaginal examination and said there was nothing wrong. Like Mrs Chikopa, Mrs Hara's

examining fingers were covered with reddish, dark brown blood. The plaintiff insisted that she felt a tissue when she was having a bath. Thereupon, Mrs Hara gave her own example that she once had a retained placental tissue which got expelled spontaneously at home, so that if the plaintiff had a retained placental tissue, it would get expelled. Before examining her, Mrs Hara had tried to get a doctor, but she was unable to find any. The plaintiff was very reluctant to go back home, but was finally persuaded to return.

The plaintiff's condition did not improve. As a matter of fact, it was getting worse. She was still feeling feverish, abdominal pains and headache. On the afternoon of the following day she felt faintish and she asked her husband to bring a watch so she could count her pulse. She asked him to pray for her. There was no watch and so she could not count her pulse. Instead, she slept and sweated heavily. Her condition was so bad that the husband had to look for transport to take her to hospital.

Having visited Queen Elizabeth Central Hospital thrice after her discharge, without much assistance; the couple decided to change hospitals. This time they went to Adventist Health Centre. As the plaintiff put it, she decided to go to Adventist Health Centre out of desperation. From her previous experience, she thought that even if she went back to Queen Elizabeth Central Hospital, she would not get proper attention. It was important to go to a hospital where she would immediately be attended to by a doctor. Her condition was really bad. She was sweating, had abdominal pains, headache and was unable to carry her own baby. She had to be assisted when going up or down some steps. She felt dizzy and when she put down her feet, it was as if she was going into a trench. Her

abdomen looked distended.

When she arrived at the Adventist Health Centre, she was received by Mrs Chitalo, who is a State Registered nurse. Mrs Chitalo got the plaintiff's history, which included the passing of the blood clot, the feeling of a tissue and, of course, the general condition of her body. On that particular day, while having a bath, the plaintiff discharged what she said was a human tissue and she took this with her to the Health Centre as evidence of her deteriorating condition. She said it was darkish, and she handed this to the nurse. The nurse then took her temperature, blood pressure and pulse. She then contacted a doctor who was within the hospital. It was Dr Ronald H Mataya who was contacted and the nurse narrated the plaintiff's history.

Thereupon, the doctor made an abdominal examination and found that the fundal height was high. The doctor said she needed evacuation, as there was a possibility of retained products of conception. All this took place in the examination room. She then went out on the foyer to have a word with her aunt, Mrs Doreen Chirambo. While there she came into contact with Mrs Malenga, who wanted to know why she came to that hospital. The plaintiff told Mrs Malenga that she was going for an evacuation. Thereupon, Mrs Malenga disclosed in the presence of Mrs Chirambo and others that the plaintiff had a placenta accreta and a retained placental tissue. She, Mrs Malenga, was therefore not surprised that the plaintiff was going for an evacuation.

It was the plaintiff's evidence that she was quite alarmed to hear that. That was the first time the plaintiff knew she was in this awkward situation. She then asked Mrs Malenga why she did not tell her earlier, when she was in Ward 1A. Mrs Malenga's reply was that she expected the doctor to advise her of that condition. Then Mrs Chitalo beckoned her to go to the theatre, as all was ready. She told Mrs Chitalo what she had just learned from Mrs Malenga. Mrs Chitalo's advice was that she should tell the anaesthetist before she was put to sleep. The anaesthetist happened to be Matron Harvey, and when she learned of the plaintiff's condition, she said she would not put her to sleep until she narrated that to the doctor herself. That is exactly what happened, and when the doctor heard the news, he held his arms akimbo and said "what?" According to the plaintiff, the doctor was alarmed by the revelation. The doctor then asked her if she had known all along that she had a placenta accreta or a retained placental tissue. She answered in the negative and then he thanked her for the information and told her that instead of doing a straight evacuation, he would start with an examination under anaesthetic. Then they prayed and she was put to sleep.

When she later regained consciousness, she was feeling very weak. She was at the Adventist Health Centre for five days. After she was discharged she still felt a lot of pain and had a lot of vaginal discharge. On the eighth day she literally fell down because of pain, and so she was rushed to hospital, where she was examined by Dr Mataya. After examination, he told her that she had accumulated blood clots in the pelvic area. The following day she was taken to theatre where all the blood clots were swept off and the vaginal opening was closed. A few days later she went back to Adventist Health Centre because of high temperature and diarrhoea. In all, she was re-admitted twice at this hospital. After some three months, she resumed duties, although she had not

fully recovered.

When she resumed duties, she raised the question of payment of bills at Adventist Health Centre with her employers. She explained why she found herself at Adventist Health Centre instead of Queen Elizabeth Central Hospital. She was requested to submit a written report, which she did and she tendered this as Exhibit P3. In compiling the report, she got assistance from her medical file at Queen Elizabeth Central Hospital from which she made photocopies of certain papers. It was her evidence that some documents in the file, and in particular the labour graph, was not fully completed as it should have been. For example, the fundal height, lochia and purpurain, had not been recorded. Again, the Nursing Care Record left out a lot of information unrecorded. Records pertaining to the operation do not show that the plaintiff had a retained placental tissue or a placenta accreta. This should have been recorded immediately after the operation. Going back to the bills, she said she settled two bills, one for K2 112-30 and the other for K413-00. Her employers refused to assist her.

As already indicated above, although she resumed duties, she had not fully recovered. As a matter of fact, she was in a very poor state of health. From the date she started work, she only worked for some two weeks, then she was back in hospital. In brief, for her, hospitalisation had become a way of life. She was in and out of hospital. Sometimes she would be discharged in the morning, only to be re-admitted in the afternoon of the same day. Within a short space of time, she had more than ten admissions, or re-admissions.

On one occasion she had severe abdominal pains and so she went to see Dr Chiphangwi at the gynaecological clinic. After examining her, the doctor announced that she had a vaginal vault prolapse, meaning that the top part of the vagina had collapsed inwards and was in need of repairs. She also had recurrent urinary infections, vaginal infections and abdominal pains. It was her evidence that before the caesarian section, she did not have these complications. She enjoyed a normal life. When she saw that her health was deteriorating further, she suggested to Dr Chiphangwi that she wanted to go to the Republic of South Africa at Ga-Rankuwa Hospital. Dr Chiphangwi did not raise any objection. He gave her a referral letter and asked her to make her own contacts at the hospital in South Africa. The plaintiff did make contacts, and she was responsible for all the financial implications of the trip.

On the trip to South Africa, she was accompanied by her husband. When she got to Ga-Rankuwa Hospital, she was met by Dr Gerrant. She was also seen by a Urologist, Professor Reif, as well as an obstetrician/gynaecologist, Professor Mokgokong. She was also attended upon by Professor Fehrsen, of the Family Medicine, and a surgeon, whose name she could not remember.

The first examination she had was Microscopy and it was discovered that she had blood in the urine. Thereafter, she had a full blood count and she was sent to the Urology Ward. In this ward, she was taken to theatre for inspection of the bladder under anaesthetic. From there she was taken for intra-venous phylogram. This was to check the functioning of the kidneys and the urinary system. Her abdominal cavity was scanned. From the Urology Ward, she was referred to the obstetrician/gynaecologist who, upon examination, discovered that she had

severe vaginal infection and abdominal tenderness, together with thickened parametria. She was given treatment for all these findings. She also underwent a special investigation called barium meal and follow-up. She was at this hospital for four-and-a-half weeks.

Due to financial constraints, her husband came back earlier. She could not afford to spend all the time in the wards. So, in order to minimise expenses, half of the period she was accommodated by a Malawian student. When the doctors were finally through with her, they gave her some reports to take home and these were tendered as Exhibits P11, P12 and P13.

On the question of expenditure, she said that she and her husband spent MK587-00 on air fare plus MK10-00 airport fee each, making a total of MK1 194 00. The hospital bill was R725-00. She had contributed a total of about R500 00 for her upkeep at the Kamwendo family and spent some R30-00 on taxis. She came back home in January 1986.

After she returned from South Africa, her health had not improved remarkably. She still complained of lower abdominal pains, swelling of the abdomen and urinary infection. She was admitted three times. She also had some admissions in 1987 and 1988. She vividly remembers that in February 1988 she was admitted in Ward 2A at Queen Elizabeth Central Hospital. When she was being discharged, she told a doctor that she was still not feeling well. In reply, the doctor told her to learn to live with her condition. That gave her the impression that the hospital was fed up with her, so she decided to go to Makwasa Hospital,

where they did not know her. Apart from her medical condition, she also suffered a lot of psychological trauma. The nursing staff at Queen Elizabeth Central Hospital had labelled her an attention-seeker.

At Makwasa Hospital, she was seen by Dr Hayton. He ordered anti-inflammatory analgesic and took her through several examinations. He did an intra-venous phylogram as well as a retrograde phylogram. The doctor also did a plain-chest x-ray and then took her for raparascopy under anaesthesia. This was in fact an operation involving the abdomen. She was at Makwasa from February to March 1988. It was her evidence that after the operation at Makwasa her health improved.

It was in fact Dr Ronald Hosten Mataya who was the first witness for the plaintiff. He is employed by the Seventh Day Adventist Church. In April 1985, he was working at the Adventist Health Centre, Blantyre. He has a Doctor of Medicine Degree. He also has a degree in Obstetrics and Gynaecology and Ultra Sound Scanning. However, at the time he attended upon the plaintiff he had not completed his degree studies in Obstetrics and Gynaecology, although he had experience in that field. To be precise, in 1985, he was a general practitioner.

When the plaintiff, Mrs Rosemary Kalea, went to see him, she complained of fever and vaginal discharge. When he was obtaining the patient’s history, she told him that she had a caesarian section at Queen Elizabeth Central Hospital. She also told him that the nurse who had assisted in the operation at Queen Elizabeth Central Hospital, Mrs Malenga, informed her that the caesarian section

was associated with a placenta accreta. Her abdomen was distended and she also mentioned that she was feeling something coming out of her vagina.

She was admitted immediately and it was decided to examine her under anaesthesia. When he did that, he discovered that there was a large piece of tissue sitting on the outside opening of the uterus. The tissue was in fact sitting on the urine opening, thus blocking that passage. He evacuated the tissue without much resistance. Upon examining it, he found that it was a placental tissue. He told the Court that it was disturbing when he saw that it was a placental tissue.

Upon further examination, he saw that the placental tissue was in a necrotic condition, or put simply, it was in a rotten state. It did not look healthy and there was no life in it. That was easy to tell from clinical experience. He was in no doubt that there was an infection, since there was a foul smell. When the tissue was taken out, he did what is called a uterine sounding, that is, measuring the length of the uterus, and there is a special instrument for doing that. When the instrument was put inside, it went right through without meeting any resistance. Nothing stopped him from pushing further. He suspected that there must have been a perforation of the uterus. He then decided to look inside and when he opened it, he found that the hind wall of the uterus had a hole. It was because of that perforation that he met no resistance when he tried to measure the length of the uterus. Not only was the uterus perforated, but the upper part was rotten. The rot was more on the interior side. The area rotten was about 3 x 3 square cm. The extent of damage to the uterus was such that repair was impossible.

At the same time, it was difficult to save the plaintiff's life without removing the uterus. He, therefore, decided to remove it in a bid to save the plaintiff's life. During the operation, she bled heavily and it became necessary to ask for more blood. At one time during the operation, there was a heart arrest. It was the doctor's evidence that after gaining consciousness, the plaintiff underwent much pain. As a matter of fact, she was in a very critical condition the first two days after the operation. The type of operation the plaintiff underwent is known as total abdominal hysterectomy, and it is a major operation.

After she was discharged, Dr Mataya saw her a couple of times. On her first visit, she explained that she was having profuse discharge. The reason for this was that during the operation an opening was left in the vagina to allow all the infected materials to drain away. After a hysterectomy, the vagina is not closed immediately. However, examination revealed that she had some blood clots. The doctor proceeded to remove these blood clots and close the opening this time.

Her next visit was due to severe diarrhoea. This might have been due to a secondary yeast infection because of the very big doses of antibiotics after the operation. During the operation, he was assisted by Matron Harvey, who was the Anaesthetist, and Mrs Theu and Sister Ordelheite.

Dr Mataya told the court that one cannot properly practice medicine without keeping records. In that regard, he made notes and a full report of what he had

done to the plaintiff. Records not only help the doctor who performed the operation, but they are also of great assistance to colleagues who may be taking over the case in the absence of the operating doctor. The court was informed that it is part of a doctor’s duty to keep legible and understandable records. The duty to keep records is a very important one and it is an international practice. After the operation, Dr Mataya verbally explained to Dr Chiphangwi what the plaintiff’s problem was and what he did to her. Later, he submitted a written report, which was tendered as Exhibit P1.

In cross-examination, the defendant sought to show that at the time he performed the operation he was not sufficiently qualified and he lacked in experience. In reply, Dr Mataya explained that although in his first degree he did not do obstetrics and gynaecology as a basic, he had sufficient knowledge and experience gained overseas and here at home.

Overseas he did six months and here at home he spent two years working with Dr Chiphangwi in obstetrics and gynaecology. It was his evidence that he had a lot of surgical experience through Dr Chiphangwi.

On the evidence before me, I am satisfied that Dr Mataya had the necessary knowledge and experience to carry out the life-saving operation. He was competent enough to carry out the total abdominal hysterectomy. I may venture to say that, had it not been for this operation, the plaintiff might have crossed to the other world.

Again, in cross-examination, he conceded that a doctor's job involves risks. He explained, however, that it is a doctor's duty to reduce risks. He said there were two methods of managing a placenta accreta. Each method has its advantages and disadvantages. The first method is the conservative method. By this method, you do not remove the uterus; you leave it there in the hope that the placenta will resolve by itself. The advantage of this method is that you preserve the uterus. Its disadvantage, however, is that the risk of infection is high. If the placenta fails to resolve, then it becomes necrotic and infection follows. In that case, the patient suffers from fever, lower abdominal pains and vaginal discharge. He conceded that this may have been the case with the plaintiff.

Alternatively, a doctor may perform a hysterectomy, and this is the type of operation the plaintiff underwent at the Adventist Health Centre. This method involves removing the uterus. The advantage of this method is that bleeding is reduced and the possibility of infection is also reduced. The disadvantages, however, are that it is a major operation and that the patient loses her uterus.

Dr Mataya also conceded in cross-examination that doctors do not normally remove uteri from young women. Mrs Kalea was a young woman when her uterus was removed. She was only about 30 years. Dr Mataya, however, explained that it all depends on the clinical judgement. If the clinical judgement has been properly exercised and the situation has been properly explained to the patient, she would not suffer from psychological problems for having lost her uterus. In the instant case, he removed it because it was damaged beyond repair

and he had to save the plaintiffs life. He said that if he was faced with a placenta accreta himself, he would, depending on the clinical situation, leave the uterus intact in the hope that it would resolve by itself. But then if he did that, he would record it and then tell the patient about it. He would advise the patient that if she saw anything coming out, she should not worry, but if she bleeds a lot, then she should come and see the doctor. He said patients have a right to know what is happening to them. In the case of a placenta accreta, a patient must be told about it, so that she knows of the dangers involved and what she should expect.

Asked as to why he did not send the uterus he had removed for a pathological examination, he said that the damage and rot were quite obvious. It is not a requirement for a doctor to send any part removed for pathological examination. He would only have sent the uterus for examination if he suspected something like cancer or TB. Further, there was no need to examine the uterus under a microscope, since the tear of about 3 x 3 cm was so obvious to the naked eye.

The third witness for the plaintiff was Dr Claude-Gary Halquart. He is a physician, holder of a Doctor of Medicine Degree. He qualified in 1973 and he is a doctor of vast experience, both abroad and here at home. He was working at the Adventist Health Centre in Blantyre. In April 1985, he assisted Dr Mataya in carrying out the operation on Mrs Kalea. They removed the uterus because it was damaged. He saw it and it was obvious that it had to be removed. There was no way it could have been repaired, because the damage was large. The perforation was about 3 cm. It was his view that the rot was due to obstruction of blood flow to the uterus. The obstruction itself could have been caused by infection. It was his evidence that the plaintiff’s life was in jeopardy. The damaged uterus could not

be salvaged due to the size of the defect.

It was his evidence that it is important to tell the patient of her condition. At the same time, a proper record of what has been done must be kept. A proper record reminds the doctor what he must do and then assists anyone who comes after him. The court was informed that it is a professional duty to keep and maintain records.

The witness conceded in cross-examination that whatever method is used has risks. Any method has advantages and disadvantages. He said that the conservative method has more risks and complications.

Matron Irene Harvey was the next witness for the plaintiff. She qualified as a State Registered nurse in 1967 and in 1968 as an anaesthetist. Most of her evidence merely corroborates what Dr Mataya and Dr Halquart said. Mrs Kalea was a pale-looking woman with high fever. She brought a blood clot for the hospital to see. The clot, which was a piece of placenta, was infected with blood. After doing all that was required of a nurse, she called the doctor. Then she prepared for the theatre. The patient requested not to be put to sleep until she had talked to the doctor. When the doctor arrived, the plaintiff told him that she had a caesarian section which was associated with a placenta accreta. Thereafter, Matron Harvey administered anaesthesia and the patient went to sleep. In the course of examination, the doctor pulled out a tissue from the vagina with forceps. Details of the operation itself have already been given out by the preceding two witnesses.

Mrs Jane Ansty Mwamondwe was the fifth witness for the plaintiff. She is a State Registered nurse and midwife working at the Adventist Health Centre. In 1985, she had attended to the plaintiff as a patient. The problem was fever and the passing of blood clots. She told the court that while at the Adventist Health Centre, Mrs Malenga told her that the plaintiff had a placenta accreta following a caesarian operation. At that time Mrs Malenga had a child admitted at the Health Centre. On her part, the witness alerted Dr Mataya about the plaintiff's condition. That was before the doctor went into the operating theatre. Mrs Mwamondwe would not know if Mrs Malenga had told any other person. She said that the presence of a placenta accreta is a serious matter which must be recorded. She stressed the importance of keeping records generally, both on the part of doctors and nurses.

The last witness for the plaintiff was her husband. His evidence was that after her discharge from Queen Elizabeth Central Hospital following a caesarian section, she spent most of the time in bed because she was unwell. She told him that she discharged something strange when she was having a bath. She called a friend, Mrs Linyenga, to see what it was. Then he took her to Queen Elizabeth Central Hospital for treatment. He later took her back, but there was no improvement. She kept on complaining of having abdominal pains. She also complained that she was feeling something in the vagina when she was having a bath.

On two other occasions he took her to Queen Elizabeth Central Hospital for examination and treatment. It was his evidence that the plaintiff was confused

because the nurses who examined her said they did not find anything wrong. On one occasion, she woke up at midnight sweating. She asked for a watch so that she should count her pulse. Then she said prayers. Her condition was very bad indeed.

One morning she told him she expelled a tissue and this time they decided to go to Adventist Health Centre. When going to the Health Centre the plaintiff took this tissue with her. Immediately after they arrived, she was examined by a nurse and then she was referred to Dr Mataya. Subsequently, she was taken to the operating theatre. Later, the doctor told him that he had seen a badly damaged and rotten placenta in the uterus. The doctor said he was going to perform a major operation and that he might remove the uterus. He wanted four pints of blood. Mr Kalea consented to the operation and supplied the four pints of blood. He was lucky to find willing relatives.

It was his evidence that after the operation the plaintiff was in a very bad state. Sometime later he went to Queen Elizabeth Central Hospital and told Dr Chiphangwi of the emergency operation. But before he saw Dr Chiphangwi, he met Mrs Malenga in the corridor. Together they went to Dr Chiphangwi. Mrs Malenga also told the doctor the nature of the operation and the drugs the plaintiff had received at the Adventist Health Centre. Mr Kalea was surprised to hear that because Mrs Malenga was not employed there. He invited Dr Chiphangwi to go to Adventist Health Centre to see the plaintiff, but he refused. Later, Mr Kalea explained his wife’s condition to the Medical Superintendent. Later, a meeting was arranged at which he complained of the manner in which his wife had been treated. Hospital bills were discussed at this meeting.

In December 1985, he accompanied his wife to the Republic of South Africa for further treatment. He came back earlier due to financial constraints. The treatment in South Africa had not improved her health remarkably. She still complained of stomach pains and severe headache. After her return she went back to Queen Elizabeth Central Hospital for treatment and then to Makwasa.

The first witness for the defence was Mrs Margaret Chikopa. She qualified as a State Registered nurse and midwife at the National School of Nursing in 1969 and 1978 respectively. In 1985, she was working in the labour ward of Gogo Chatinkha Maternity Wing at Queen Elizabeth Central Hospital. On 5 April 1985, the plaintiff came to the labour ward with complaints. She complained that when she was having a bath in the morning she felt something coming out of her vagina. She wanted the witness to check her if indeed there was something.

At that time Mrs Chikopa was busy in the labour ward so she did not attend to the plaintiff quickly. Later, she found some time to examine her. She told the court that the labour ward was the wrong ward for post-natal mothers. However, she examined the plaintiff. She made her lie on her back and inserted two fingers in the vagina, but she did not feel anything. The plaintiff insisted that she be examined in a squatting position, but that was impossible to do. Examinations are not done in a squatting position. The witness then used a special instrument called a bi-valve speculum, which opens up the vagina. Mrs Chikopa was able to see through up to the cervic, but she saw nothing. She then suggested to the plaintiff that she should go to the out-patient department where she could see a

doctor who would either recommend admission or examine her under anaesthetic or D and C.

The plaintiff did not accept the suggestion, saying she was tired of staying in hospital. It was not possible for the witness to call a doctor, because post-natal mothers are not examined in the labour ward. She did not record her findings because Mrs Kalea did not bring her discharge certificate. The witness concluded her evidence by saying that, as a discharged mother, she should have either gone to her previous ward – 1A, or to OPD2. She later attended a meeting organised by her employers.

When cross-examined, she said Mrs Kalea was not very sick and desperate. She was able to walk around and check on the baby. Mrs Chikopa knew that the plaintiff had a caesarian section, but she did not suspect that what the plaintiff felt was a retained part of the placenta. The witness told the Court that had Mrs Kalea told her that she had a placenta accreta, she would have called a doctor. When she inserted her fingers, there was dark reddish blood, but no foul smell and no puss. She suggested that the plaintiff should go to OPD2 because she was not satisfied with the examinations.

The next witness for the defence was Mrs Mary Hara. She qualified as a State Registered nurse and midwife at Kamuzu College of Nursing in 1970 and 1986 respectively. On 6 April 1985, she was the Sister-in-Charge in the labour ward at Queen Elizabeth Central Hospital. Mrs Kalea went to the labour ward in the evening of that day. At that time Mrs Hara was delivering a mother. The plaintiff

said she felt something when she was having a bath. She wanted to be examined, but Mrs Hara advised her to go to the post-natal ward, since delivered mothers do not go to the labour ward. The plaintiff would not go to the post-natal ward, with the result that the Sister-in-Charge referred her to the Clinical Officer, Mr Kambiya.

She later examined her in a sleeping position by inserting her fingers, but she saw nothing strange. The plaintiff suggested that she be examined in a squating position, but the witness said that was impossible. The Clinical Officer suggested that she should go to OPD2, but she did not go there. On that day the plaintiff did not take her discharge certificate with her.

The third witness was Mr Maulino Kambiya. He qualified as a clinical officer in 1983 at the Lilongwe School of Health Sciences. He works at Queen Elizabeth Central Hospital. On 6 April 1985, he was on call at Chatinkha Maternity Wing. In the afternoon of that day, he met the plaintiff in the doorway to the labour ward. She told him that she had passed a blood clot. At that time he was rushing to the theatre to do an operation on a patient who was already there. As a working colleague, he asked her if he could call Dr Drisden, the senior obstetrician. But she said she would prefer to be seen by Dr Chiphangwi. On that day, Dr Chiphangwi was off-duty. Since he was rushing to the theatre, he asked her if she could report to the labour ward office to see Sister Hara, who would examine her. Later on, the Sister reported to him on the phone that after examination she did not see anything significant.

The next defence witness was Mrs Catherine Malenga. She qualified as a State Registered nurse and midwife at the National School of Nursing. She was trained in Theatre Science in South Africa. She has worked in the theatre for more than 10 years and she has vast experience. Her evidence is quite interesting. On 23 March 1985, she assisted Dr Chiphangwi in operating on the plaintiff. She told the court that the placenta was a bit difficult to get out, but it was done. After the caesarian section, the plaintiff was taken to Ward 1A and it was up to the doctor and the post-natal ward staff to follow up the case.

In April 1985, she met the plaintiff at the Adventist Health Centre. She had a son admitted there. She did talk to the plaintiff, who said she was going for D and C. The plaintiff said she did not go to Dr Chiphangwi because she had been mishandled. Later that day, she met Dr Mataya, who told her that he had removed the uterus and the plaintiff was in the intensive care unit. Dr Mataya asked her to go and tell Dr Chiphangwi about the operation.

At Queen Elizabeth Central Hospital she met Mr Kalea who was looking for Dr Chiphangwi, so they went to see the doctor together. After telling the doctor about the plaintiff’s operation, she went back to Adventist Health Centre. Next morning, she was summoned to the Medical Superintendent’s office, where she found Mr Kalea, among other people. Mr Kalea was complaining that Mrs Malenga was discussing his wife’s operation at a bus stage. She denied the allegation. She was asked to apologise, but she refused. However, the Medical Superintendent said he would apologise on her behalf.

In cross-examination, she said the placenta was a little difficult to remove because there was a placenta accreta. She said there are stages of placenta accreta and this one was in the first degree. The doctor was aware of it and he managed to remove it. Dr Chiphangwi removed it by scraping with a curette where the placenta had stuck. He scraped on the wound where the placenta was removed. She was able to see all this because the uterus was taken out. It was her evidence that the remaining tissue of the placenta was scraped off. She informed the court that although the placenta was scraped off, there was no damage to the uterus.

Asked about the maintenance of records, she said it was important to keep records. She said that details of the operation must be recorded. As a scrub nurse, she made sure that everything was properly recorded in the register, but that book missed in 1987. Asked if she had recorded the presence of placenta accreta, she said she did not, because she did not see it in the doctor's notes. Doctors do not record in the register, they write in the patient's file. What the doctor writes in the patient's file is supposed to tally or agree with what the scrub nurse records in the theatre register. A scrub nurse must check the notes in the patient's file and then compare these with the entries she has made in the theatre register.

In this case, however, Mrs Malenga did not check in Mrs Kalea's file because she took it for granted that everything was in order. She was shown the doctor's notes tendered in court as Exhibit P6 and she said that the presence of placenta accreta had not been recorded. She thought that the doctor had forgotten to record that. When pressed, she agreed that at Adventist Health Centre she had

told Mrs Kalea that she had a placenta accreta. She said she did not know that up to that time Mrs Kalea did not know of the placenta accreta. In re examination, she said she had only told Mrs Kalea of her own experience of placenta accreta.

The next witness was Dr John David Chiphangwi. He obtained his first medical degree in 1966. Later, he specialised in Obstetrics and Gynaecology and he was elected Fellow of that Society. Indeed, his qualifications are not in question. He was the Chief Specialist (Obstetrics/Gynaecology). On 23 March 1985, he was on duty at Queen Elizabeth Central Hospital and he attended upon the plaintiff. She had raised high blood pressure and was partially paralysed while pregnant. She was taken to the theatre where he performed a caesarian section. The placenta was abnormal, in that it did not come out as expected. A small part of the placenta had pierced the uterus and, for that reason, the placenta was attached to the uterus. It was, therefore, removed piecemeal by cutting the part that was attached to the uterus. After removing the placenta, the uterus and the abdomen were closed.

When the operation was over, the patient was sent to the ward. Dr Chiphangwi had followed the conservative method. The other method, which is much more radical, is to remove the uterus completely. The Court was informed that each method has its own advantages and disadvantages. In making a choice, one weighs the pros and cons relating to the particular patient’s problems. The advantage of the conservative method is that it is a simpler operation. Its disadvantage is that, in certain cases, the uterus can go septic in the process. The advantage of the more radical method, where the uterus is removed, is that there is less bleeding and infection is reduced. The disadvantage is that it is a

major operation and could be dangerous.

In the case of Mrs Kalea, he chose the conservative method, because she had high blood pressure and partial paralysis and had been ill for a long time. Dr Chiphangwi was aware of the possible consequences and so he told his colleagues about it, so that when he was away they could look after her properly. He made notes of what happened and wrote in as much detail as he possibly could. However, knowing the type of patient he was dealing with, he left out certain information.

The plaintiff was fond of reading her file, and recording every detail would only cause her anxiety. Since she had high blood pressure and partial paralysis, the possibility of brain haemorrhage could not be ruled out. Bleeding into the brain would cause anxiety, and that he tried to avoid. He intended to tell her of the placenta accreta when her condition improved. Prior to this occasion, he had treated her several times and he knew her well enough. When she had a problem, she used to phone him. Later, he learned that she had been to Adventist Health Centre for an operation. He first heard it from Mrs Malenga, then Dr Mataya. The third person to tell him was Mrs Kalea herself. When the news reached Ministry Headquarters, he was asked to submit a report, which he did.

In cross-examination, he said that the accreta was removed with either a scissors or a curette. He said that in such cases, close attention is called for and it is for that reason that he told Dr Ndovi and Dr Drisden about the placenta accreta. He

could not remember the date when he told these doctors. He also told the Sister in-Charge of Ward 1A. He said that after the operation, he prescribed antibiotics for two days, to prevent infection. It is not always necessary to prescribe the full course. On the question of records, he said that a doctor is duty-bound to maintain records. These records help other people to follow-up. There are, however, no written rules that records must be kept, and sometimes communication can be done verbally. In this particular case, he had told fellow doctors.

The last witness for the defence was Dr Eric David Mdovi. He is an obstetrician/gynaecologist and at the material time he was working at Queen Elizabeth Central Hospital. After the caesarian operation, he used to visit the plaintiff frequently as a colleague. When he visited her on one occasion, she looked quite well and she wanted to be discharged, but he told her that she could not be discharged before the stitches were removed.

On 30 March 1985, he got a phone from the ward that she had fever. He prescribed treatment for malaria. He visited her again the following day and he found that she was doing well. The wound was all right and so he ordered the nurses to remove stitches. However, she complained of headache. He was not available when she was discharged, because he went on compassionate leave. He told the court that Dr Chiphangwi had told him that the plaintiff had placenta accreta. Dr Chiphangwi said he had tried to remove it with instruments. Dr Chiphangwi had asked him and Dr Drisden to look after her closely. Dr Ndovi told the court that doctors are duty-bound to keep records, but sometimes they do not when they think that what they write will disturb the patient.

When cross-examined, he said that Dr Chiphangwi had told him of the placenta accreta on the day of the operation. They were only two when this communication was made. Dr Chiphangwi had told him not to inform the patient but no reason was given for the concealment. Dr Ndovi said that placenta accreta is a serious matter and the risk of infection is high when the conservative method is applied. In order to prevent infection, it is usual to give the antibiotics for seven days. When dealing with a patient with placenta accreta, one should watch out for symptoms of infection, and according to him, those symptoms are general body pains, lower abdominal pains, fever, abnormal vaginal discharge, and dark brown blood would also be an indicator.

Usually, a patient is told to go for check-up after one week, but the plaintiff was given four weeks. Dr Ndovi told the court that upon discharge he would disclose the nature of complications to the patient so that she must take care. He would also tell the patient about her condition if she wanted to know. He conceded that a patient who was not told of the complications would be more anxious when she saw the symptoms. He also conceded that Mrs Kalea had told him that she had discharged a blood clot and that she was feeling a tissue. He also said that while the patient was in the ward, no nurse had told him that Mrs Kalea had lost blood excessively and the nurses' records did not show that there was heavy bleeding. Excessive bleeding would be another indicator of infection. Asked as to why he did not order tests for infection, he said he did not do that because there were no signs of infection. Instead, he only ordered a test for malaria.

Time has come for me to evaluate the evidence. I must mention at the outset that it is not Dr Chiphangwi's qualifications and experience that are in question. The issue which this court must determine is the manner in which he performed this particular operation. The defendant did deny in general terms the allegation of negligence, and proceeded on the basis that if Dr Chiphangwi acted in accordance with a practice accepted as proper by a reasonable body of skilled men in that particular art, then the defendant cannot be held liable. The case of Bolam v Frierin Hospital Management Committee (1957) 1 WLR 582 was cited for this.

The plaintiff's case is not that the choice of the conservative method was wrong or that the method is not acceptable in the profession. The plaintiff's case is that having elected to apply that method, the defendant's servants did not exercise due care and attention.

In its defence, the defendant denied that the plaintiff had placenta accreta and also denied using a sharp instrument by the name of a curette in the course of the operation. The plaintiff had sent a notice to admit facts and some of the facts the defendant was asked to admit relate to the presence of placenta accreta, use of a curette in removing the placental tissue and whether in fact Dr Chiphangwi had recorded in the plaintiff's file that she had a placenta accreta. There was no response. I believe that had the defendant admitted these facts, there would have been a saving both in effort and in costs.

In the course of performing the caesarian operation, Dr Chiphangwi discovered that the plaintiff had a placenta accreta. Acting upon his clinical judgement, he decided to deal with the placenta accreta by applying the conservative method. But when Dr Mataya was faced with an emergency, he performed a hysterectomy. It was agreed that both methods have advantages and disadvantages. It was also agreed that a doctor's work involves risk. It is not in dispute that it is the duty of a doctor to minimise risks. The advantages of the conservative method are:

(i) the patient retains her uterus; and

(ii) it is a minor operation.

On the other hand, its disadvantages are:

(i) the patient bleeds heavily;

(ii) the risk of infection is high; and

(iii) in the event of the placental tissue refusing to resolve, the uterus gets septic and the patient would be in great pain.

Perhaps I should mention that all the three Obstetricians/Gynaecolo-gists, that is, Dr Mataya, Dr Chiphangwi and Dr Ndovi, were unanimous that the presence of a placenta accreta is a serious matter calling for close attention. In the case of Mrs Kalea, the conservative method meant that the risk of infection was high. All the three gynaecologists were agreed that in a situation like that it was important to place Mrs Kalea under close attention and watch out for symptoms of infection. It

was Dr Ndovi who supplied the list of symptoms of infection. He said these were:

(i) general body pains;

(ii) fever;

(iii) lower abdominal pains;

(iv) excessive bleeding; and

(v) dark brown blood.

It is common knowledge that Dr Chiphangwi was expected to perform the caesarian section with due care and diligence. His duty did not end with the operation. It went further than that. It was also his duty to set up such machinery as would ensure that Mrs Kalea was under close attention so as to prevent infection. If symptoms of infection were seen, then it was the duty of the defendant to arrest that development at the earliest.

As a specialist, what was Dr Chiphangwi's standard of care in law? The duty of a specialist is higher than that of an ordinary practitioner or a general practitioner, so to say. This duty was laid down in Bever on Negligence, (4 ed) at paragraph 1355:

"The duty of a specialist is referable to a higher test than that of an ordinary practitioner. Special profession involves higher duty and the standard to be attained is that of the specialist amongst medical men, and not that of the general practitioner and this includes proper instructions to the nurses and to the patient for their conduct in the intervals of the doctor's attendance." (The

emphasis is mine). There is also the case of Mccaffrey v Haue (1949) 4 ALR 291. It is unfortunate that the full report is not available, but a summary can be found at page 526 of the English and Empire Digest, Volume 33. It says:

“A higher degree of skill than that of the general practitioner is required of one who holds himself out as a specialist in medicine.”

The defendant cited the case of Lanphier v Phipos (1838) 8 C & P 475. The report is not available, but a summary can also be found at page 526 of the English and Empire Digest, Volume 33. That case would not apply to Dr Chiphangwi. Equally, it would not apply to Dr Ndovi, who is also a specialist in gynaecology. The case of Lanphier sets out what is known as the reasonable standard of skill and care. It is clear from a reading of the summary that the case is referable to the general practitioner and not to the specialist. The standard set down there is that of the general practitioner.

It is interesting to note that the case recognises that there may be persons of higher education and greater advantage. Indeed. Dr Chiphangwi and Dr Ndovi as specialists are persons of higher education and greater advantage and so they belong to a class of their own. They cannot be mixed up with the general practitioners. They must discharge a higher degree of skill and care when dealing with patients than the general practitioner. I think that this is just right, otherwise having specialists would make no difference to the profession.

Having found that Dr Chiphangwi and Dr Ndovi were required to discharge a higher degree of skill and care, the question that immediately follows is: Did they discharge that duty? I shall answer this question in four stages:

(1) during the caesarian section itself;

(2) during the post-operative period when the plaintiff was in Ward 1A;

(3) after discharge; and

(4) withholding information from the patient.

I start with the caesarian section itself. In its defence, the defendant denied that a sharp instrument by the name of a curette was used. But it was clear from the evidence of Mrs Malenga and Dr Chiphangwi himself that a curette was used. The doctor said that he used this instrument to cut out as much of the placenta accreta as could possibly be removed and left that part that was imbedded in the uterus, in the hope that it would resolve by itself. Mrs Malenga said that the doctor used the curette to scrape the uterus where the placenta was attached. She said the wound where the placenta had been was scraped.

Now, the uncontroverted evidence of Dr Mataya was that the uterus was perforated. Not only was it perforated, but it was necrotic or rotten. That was also the evidence of Dr Halquart. The uterus was grey and damaged. The extent of the damage was such that repair was impossible. Indeed, it came out very clear in the evidence that the plaintiff's life could not have been saved without removing the damaged uterus. Dr Mataya may not have performed wonders, but he did save the plaintiff's life. He was asked in cross-examination whether he had

seen the perforation under a microscope. In reply, he said that the use of a microscope was unnecessary, since the tear, which was some 3 cm, was obvious to the naked eye. I agree with the doctor. If someone cannot see a tear which is 3 cm, then there is something seriously wrong with his sight, in which case, he can get no assistance from a microscope.

Dr Mataya was also asked if he had sent the removed uterus for pathological examination. He said in reply that it was so obvious that the uterus was rotten. It was grey and there was a foul smell. He was corroborated in this by Dr Halquart. He said since it was obvious that the uterus was rotten, he could only have sent it for pathological examination if he suspected cancer or TB. In this case, he formed the firm view, after clinical examination, that the rot was due to infection. The evidence on the point was so clear and overwhelming that I must find it as a fact that the uterus was indeed perforated, damaged and rotten. I think that the perforation and damage could only have been done during the caesarian section. I think that the curette did more than just removing the placenta. It damaged the uterus. It cannot be said, therefore, that Dr Chiphangwi had discharged his duty to the requisite standard of skill and care. His standard fell short and I find in the result that he was guilty of negligence.

I now move on to the post-operative period. This period covers Dr Ndovi, Dr Masanjika, Dr Patel and the nurses in Ward 1A. Dr Chiphangwi said he was aware of the risk involved and the possible consequences. To ensure that the plaintiff was closely monitored, he verbally told Dr Ndovi and Dr Drisden about the placenta accreta. He also told the Sister-in-Charge of Ward 1A. He conceded that he did not record the placenta accreta anywhere in his notes. He said he left this

out deliberately, because the plaintiff was in the habit of reading her file. He feared that if he made that entry, she would read it and that would cause her anxiety. His intention was to spare her the anxiety. I think that this omission was quite unfortunate and I will come back to it later in the judgement.

It is very hard to believe that Dr Ndovi was told about it, because his conduct did not show that he was aware of the serious situation. The Sister-in-Charge of Ward 1A was not called to testify to that. I do not think it is true that the nurses in Ward 1A were told. It was submitted that there was no need to call the nurses in Ward 1A, because they were not negligent. Sure, if they were not negligent, then they should have been called to rebut the allegation of negligence and the allegation that they had breached their statutory duty.

In his own testimony, Dr Chiphangwi said that records are important because they assist other doctors and personnel to follow up the case. In this particular case, he omitted to record the presence of placenta accreta. His reasons for not doing so are lame and invalid. He knew that after the operation he would be going to Lilongwe. That made it even more important that he should set up machinery to ensure proper monitoring of the case. As a matter of fact, besides recording the placenta accreta, he would have instructed a particular nurse to monitor the patient. No machinery was set up to ensure proper monitoring of the case. Dr Ndovi, who is said to have been told, left for the North on 31 March 1985 on compassionate leave. He was not around when the patient was discharged on 4 April 1985. There is no evidence as to what instructions Dr Ndovi left and there is no evidence as to what part Dr Drisden played. The catastrophic consequences of not recording the placenta accreta and not setting up a proper machinery

were ably described by the plaintiff and I can do no better than reproduce what is recorded as having been said:

“In the first place I think Dr Chiphangwi wronged me. The staff in Ward 1A, I feel sorry for them, if they had known that I had placenta accreta and retained placenta products, the post-natal examination which they took for granted, would have been done.

Secondly, the doctors who looked after me namely Dr Ndovi, and Dr Patel, would have taken much more interest; after the complications arose, that is the abrupt cessation of red lochia on the third day, the fever which I developed, these would have alerted them when the malarial parasite was not found in the blood. When I told Dr Masanjika, Mrs Hara, Mrs Chikopa that I was not feeling well, i.e. I had low abdominal pains and I had passed a clot and I was feeling a tissue when bathing, all these were signs and symptoms. If he did not want to tell me there were other people he would have told, there was my husband and there was the sister-in-charge, who were each capable of telling me.”

I entirely agree with what Mrs Kalea said.

Dr Ndovi said in his own evidence that fever was one of the symptoms of infection. And yet, when the plaintiff complained of fever, all he did was to order a malarial test. When that test turned out to be negative, he did not investigate further as to what might be the cause of the fever. One would have expected Dr Ndovi to order a test for infection. In cross-examination, he said he did not test for infection because he did not see any symptoms of infection. How would he honestly say that he saw no symptoms when the plaintiff was having persistent

fever? As a matter of fact, Mrs Kalea had all the symptoms of infection as enumerated by Dr Ndovi. All this goes to show that, as a gynaecologist, he did not take sufficient care to prevent infection.

In short, he was negligent. The evidence speaks out loudly that the nurses in Ward 1A did not do any post-natal examinations. They were not aware that the patient had a placenta accreta. Had they been aware, perhaps they would have been more careful. But even assuming that the plaintiff did not have a placenta accreta, the nurses/midwives were still required by the Rules and Regulations for Midwives to carry out post-natal examinations. These Rules and Regulations were tendered as Exhibit P2, and at page 13, under Observations on the Mother, the midwife must:

1. Check daily temperature and pulse.
2. Check height of fundus and emptying of bladder.
3. Check lochia; colour, amount, smell.
4. Check lactation and state of breasts.

It is said at page 14 that accurate records must be kept. The plaintiff was not contradicted in her evidence when she said that when she was in Ward 1A the nurses, who are also midwives, did not check her fundal height, lochia and lactation. The nurses/midwives did not check these things although she told them that on the fourth day she had a sudden cessation of lochia. It was the evidence of Dr Ndovi that when he became in charge of Ward 1A on 30 and 31 March 1985, no nurse told him the plaintiff had bled heavily. When he looked at

the nurses' records, there was no record of the plaintiff bleeding heavily, no record of lochia and no record of fundal height. Dr Ndovi told the court that heavy bleeding is an indicator of infection and yet he was not told and it was not recorded.

On the evidence before me, I am satisfied that the nurses/midwives in Ward 1A did not carry out post-natal examinations and since no examinations were done, nothing could have been recorded. The nurses/midwives were required to exercise a reasonable degree of care and skill. Their standard of skill and care is that of an ordinary practitioner. Their duty was not as high as that of a specialist. My finding is that the nurses/midwives were in breach of their duty to the plaintiff. The plaintiff had entrusted herself to them and it was, therefore, their duty to exercise such care as was reasonable in the circumstances to protect her from dangers arising from the caesarian section. Put briefly, they were negligent. By reason of the breach, they were unable to diagnose the plaintiff's medical problem and thereby detect and arrest the infection with the result that the placental tissue began to rot and the uterus went necrotic necessitating its removal. Had the presence and infection of the placental tissue been detected at an early stage, it would not have been necessary to remove the uterus.

Even if it became necessary to remove the uterus at an early stage because it was damaged, infection which was a direct result of the rotting of the placental tissue imbedded in the uterus, would not have occurred. The plaintiff would have been spared much pain and suffering, anxiety and psychological trauma. She might not have undergone the multiple and painful operations at the Adventist Health Centre, in South Africa and at Makwasa.

However, I do not think that the nurses/midwives' failure to carry out post-natal examinations constituted statutory breach. The Rules and Regulations – Exhibit P2 – may have been based on the Nurses and Midwifes Act, but they are not subsidiary legislation. They are a mere administrative instruction. Their breach would only call for disciplinary action and a civil suit where the breach amounts to negligence in law, as is the case here.

The plaintiff was discharged on 4 April 1985 by Dr Patel. At that time, the plaintiff had low grade fever. It is in evidence that the doctor wondered why she was having persistent low grade fever. On 31 March 1985 she was tested for malaria, because she had fever, which means that from that date up to the date of discharge, she had fever. Nothing was done to investigate the cause of the fever, although Dr Ndovi told the Court that fever was one of the symptoms of infection. All this shows negligence on the part of the defendant. It is evident, therefore, that from the moment she was put in Ward 1A up to the moment of her discharge, nothing was done to prevent or diagnose infection, although the plaintiff had all the symptoms of infection.

Was it proper law for Dr Chiphangwi not to tell the plaintiff of the placenta accreta? He said he wanted to save her from anxiety. Generally, a doctor is not obliged to disclose to the patient all the information as to risks attending the operation. The doctor would have to take into account such factors as the patient's age, soundness of mind, patient's true wishes and whether the patient's rational choice would be imposed if certain information were not withheld from

him: see the case of Sidaway v Bethlehem Royal Hospital Governors [1984] 1 All ER 1018. So, a doctor has to consider a number of factors before deciding whether to disclose or not. However, Sir John Danulosen MR observed that:

“In an appropriate case a judge would be entitled to reject a unanimous medical view as to the duty of a doctor to disclose information to his patients if he was satisfied that it was manifestly wrong and that the doctors had been misdirecting themselves as to their duty in law.”

In what case would a judge find that a doctor’s withholding of information was wrong in law? In the present case it came out clearly in the evidence that in view of the high risk of infection, the doctors and nurses would have to give the case close attention and watch-out for symptoms of infection. It was important that if infection was to set in, it had to be arrested at an early stage. It is clear, therefore, that watching out for symptoms formed part of the treatment. And those symptoms could only come from the patient. It was necessary, therefore, that the patient should know her true position, because it was only then that she could properly assist the doctors in watching out for the symptoms of infection. It all means that the plaintiff had a part to play in her own treatment and the doctors had no choice, but to rely on the information she gave them relating to symptoms. The doctors would then diagnose for infection. I think that this is a proper case in which the plaintiff should have been informed. Perhaps I should seek assistance from the South African case of Dube v Administrator of Transvaal (1963) 4 SA where at 268 the judge observed as follows:

“In many cases it is reasonable or even necessary for the medical man to make the patient himself responsible for the performance of some part of the treatment which the medical man has undertaken to give. Where, as often

happens, the medical man's course of action depends upon a report by the patient as to his condition or symptoms or as to the progress of the treatment the medical man has no choice in the matter; he must rely upon the patient for the necessary information by which to determine what action should be taken, and must therefore in a sense, delegate to the patient part of his own duties. Frequently also, it would be quite unreasonable to expect the medical man to be in constant attendance upon the patient or exercise supervision over every detail of the treatment; he is compelled therefore to delegate to the patient the performance of some part of the treatment or cure."

The observations made by the judge are fully applicable to this case. It must be remembered that Dr Mataya told the Court that if he was faced with a placenta accreta like Dr Chiphangwi, he would have followed the same method, but then he would tell the patient so that she must appreciate the danger. It is significant that Dr Ndovi also told the Court that upon discharge, he would tell the patient. In this particular case, there were instructions from Dr Chiphangwi that the patient should not be told. It is my finding upon the evidence that the withholding of information was unreasonable and constituted a breach of duty to the patient. It must be remembered that the plaintiff is well-educated and a well qualified nurse and midwife and she was quite capable of appreciating the dangers in which she was.

Did this failure to disclose result in any injury at all? It did enhance the plaintiff's pain and suffering and caused her anxiety. Had she been told of the placenta accreta, it would have made her task with the nurses much easier. She had an uphill task to try and convince the nurses that her condition was serious. If she

had told them that her caesarian section was associated with a placenta accreta, perhaps their attitude and reaction to her complaints would have been different. For example, Mrs Chikopa told the court that had she known that Mrs Kalea had a placenta accreta, she would have called a doctor. Upon her discharge, all she was told was to go back to hospital for check-up after four weeks. This gave her the wrong impression that her case was a normal one, when in fact her life was in danger.

I now come to the last phase. When she was discharged, on 4 April 1985, she still had the low-grade fever. She had abdominal pains and general body pains. On 5 April she expelled a blood clot. It was her evidence that she was alarmed. Then she started feeling something coming out of her vagina. On two occasions she went to the labour ward where she met Mrs Chikopa and Mrs Hara. These nurses did not attend to her with all due diligence.

The defendant tried to make a mountain out of a molehill by saying the plaintiff went to the wrong ward. It was submitted that she should have gone either to Ward 1A or to OPD2. That may be so, but certainly the nurses would have done much more than they did. They could have done proper examinations and recorded their findings and then called a doctor. It is surprising that both nurses said they were busy delivering mothers and Mr Kambiya said he was rushing to the theatre for an operation. What coincidences these were! In my finding, this was nothing but a perpetuation of negligence on the part of the defendant.

On a balance of probability, I find that the plaintiff has succeeded in proving the allegations of negligence by the defendant and that by reason of those various acts of negligence, she suffered injury and damage as set out in the re-amended statement of claim.

Since I have already found that the various servants and/or agents of the defendant were negligent, I do not find it necessary to consider the alternative claim in which the plaintiff merely alleged acts of negligence without identifying the individual servants and/or agents of the defendant. Suffice to say that, on the evidence before me, the alternative claim would also succeed. A hospital authority is responsible for the negligent acts of its servants and/or agents. All the plaintiff must do is to prove the acts of negligence. She does not have to particularise the negligent persons: see the cases of Roe v Minister of Health [1954] 2 WLR 915 and Cassidy v Ministry of Health [1951] 1 All ER 574.

In her submissions the plaintiff also seeks to rely on the doctrine of res ipsa loquitur. This maxim applies where:

1. the happening of an occurrence has not been explained or the cause is not known;

2. when the occurrence is one which would not have happened in the ordinary course of things without negligence on the part of somebody other than the plaintiff;

and Page 186 of [1993] 16(1) MLR 152 (HC)

3. the circumstances point to the negligence in question being that of the defendant rather than that of any other person.

In the instant case, the plaintiff has succeeded in proving that her uterus got damaged and rotten; subsequently it got removed. In the normal course of events, a uterus does not get rotten. It was in evidence that caesarian sections are frequently performed without disastrous results. The uterus could not have been damaged and got rotten without the incidence of negligence on the part of the defendant. The res raises a prima facie case of negligence and it would then be upon the defendant to rebut by proving that even without negligence the uterus would have been damaged and got rotten. On the facts before me, this would have been an impossible task for the defendant.

In the case of Cassidy v Ministry of Health [1951] 1 All ER 574, the plaintiff went to hospital with two stiff fingers to be cured. After surgery, four fingers got stiff and the entire hand was rendered useless. The evidence showed that the operation itself was properly done, but it was the post-operative care that was in want. At 533, Denning LJ, observes that all the plaintiff was saying was:

“I went into the hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. That should not have happened if due care had been used. Explain it, if you can.”

The plaintiff succeeded because the defendants failed to explain that the injuries were consistent with due care on the part of all members of their staff. Similarly,

in the instant case the plaintiff would say:

“I went into the hospital to have my baby delivered, but I have come out with a damaged and rotten uterus which was subsequently removed. That should not have happened had due care been used. Explain it if you can.”

None of the defendant’s witnesses told the court that the perforated and rotten uterus is consistent with due care on the part of the defendant’s staff. In the case of Cox v Saskatoon (1942) 1 DLR 74, a summary which can be found in the English and Empire Digest, Volume 33 at 528, a woman sustained a severe and prolonged injury to her arm as the result of a blood transfusion operation. Several allegations of negligence were made in the citation, but none was established. The operation was one which was frequently performed without disastrous results and the defendant failed to explain how the injuries could have happened without negligence. The doctrine of res ipsa loquitur came into place and the plaintiff recovered damages.

In the instant case, however, the doctrine cannot apply, because the plaintiff has succeeded in proving the allegations of negligence. The doctrine applies only where the cause of the injury is not known. I have, therefore, not gone into details of the doctrine, since it has no application to the present case. If, however, the plaintiff were to fail in proving the allegations of negligence, the doctrine would then be fully applicable and it would succeed.

Finally, I come to the thorny issue of damages. It is pleaded that by reason of the defendant's negligence, the plaintiff suffered the following injuries:

1. Severe infection of the uterus resulting in the abdomen being distended.
2. Swelling of the cervix.
3. Painful seropurulent discharge.
4. Epigastic pain.
5. Sisytemic candidiasis (infection of the whole body).
6. Persistent fever.
7. Excessive loss of blood.
8. Urinary tract infection.
9. Abdominal colic pain (pain resulting from adhesion of intestines following operations).
10. Stress incontinence.
11. Pruritis vulvae and vaginal discharge.
12. Tenderness of the right illiac fossa.
13. Severe vaginitis (vaginal discharges).
14. Loss of the uterus.
15. Inflammation of the bladder.
16. Vaginal vault prolapse.

It is not denied that the plaintiff suffered the various injuries as cited above. It has, however, been submitted on behalf of the defendant that the injuries suffered are remote, in the sense that they did not come about as a result of the negligent acts of the defendant's servants and/or agents. It was also submitted that it was not reasonably foreseeable that nucrosis would set in as a result of the placenta accreta having been conservatively managed. The defendant's submissions are utterly misconceived and cannot be sustained.

It is abundantly clear that the injuries suffered by the plaintiff directly arose from the defendant's servants and/or agents' negligence. It was also foreseeable that if proper attention was not paid, infection would set in. One has only to read the referral letter written by Dr Chiphangwi when the plaintiff was leaving for South Africa. This letter was tendered as Exhibit P10, paragraph 2 of which reads:

"A caesarian section was performed at our hospital in March this year but this, too was complicated by infection and nucrosis of the uterine fundus. She then underwent a hysterectomy at a neighbouring hospital in April. Post-operatively she required various antibiotics because of the infection."

The letter goes on to detail the plaintiff's problems. It is clear, therefore, that what the plaintiff went through was a direct consequence of the caesarian section. The referral letter does not mention that the plaintiff had a placenta accreta, but had the placenta accreta been properly managed, a hysterectomy and the trip to South Africa would not have been necessary. The defendant must bear the consequences of its servants' and/or agents' negligence.

I start with special damages. These must be strictly proved. I award her the K2 112-80, being the bill at Adventist Health Centre, as evidenced by Exhibit P9. For the airfares to South Africa – K1 174-00 plus K20-00 airport fees as per air tickets which were Exhibit P14. For the treatment in South Africa, there is a receipt – Exhibit P15 – for R725-00 – and receipts for taxi amounting to R21-00. I award her these amounts. In all, I award her K3 306-80 and R745-00. The other expenses allegedly incurred in South Africa are not receipted and so I disallow them.

I now move on to general damages. It is clear in my mind that the plaintiff must be properly compensated. It is evident from Dr Chiphangwi's letter – Exhibit P10, from the letter she got from South Africa – Exhibit P13 – and what has been pleaded that the plaintiff went through hell. Even after her return from South Africa, her health had not improved drastically.

Apart from the various medical problems that arose from the caesarian section, it is clear that she also developed psychological problems and I think that is why in his letter, Professor GS Fehrsen concluded by saying that it was far more important to give her time to recover as a person.

I am, however, disadvantaged, in that local authorities in this area are scarce. The only local case that was cited to me was that of Nyambalo v Malawi Railways Ltd Civil Cause No. 483 of 1986 (unreported). In that case, the plaintiff underwent an operation in which she lost her uterus. The learned judge assessed damages at K12 000-00. However, the injuries the plaintiff suffered in the

present case are a lot more serious. The Nyambalo case is no comparison. She went through a series of operations and the pain and suffering and mental torment she went through must be enormous. She must have lost all hopes of living and it is in fact in evidence that she almost died during the operation at the Adventist Health Centre. I think that an award of K100 000-00 would be a fair assessment, considering the inflationary trends, and I so order.

The defendant is condemned in the costs of these proceedings.