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IN THE HIGH COURT OF SOUTH AFRICA

EASTERN CAPE LOCAL DIVISION, BHISHO

CASE NO: 140/2016

In the matter between:

A Z

Plaintiff

and

THE MEMBER OF THE EXECUTIVE

COUNCIL FOR HEALTH, EASTERN CAPE

Defendant

JUDGMENT

STRETCH J:

1. The plaintiff, who is alleged to have been born on 1 November 1997, has issued summons against the defendant for damages in the sum of R51 700 000,00 founded in contract, alternatively delict, arising from her hospitalisation at Frere Hospital and her treatment by the staff of this hospital during the period 2011 to 2013.
2. The trial proceeded on the issues of negligence and causation only.

3. The claim arises from a posterior fusion of the second to the seventh thoracic vertebrae (T2 to T7) with a posterior onlay bone graft performed on the plaintiff by one Dr Kaschula¹ at Frere Hospital on 5 February 2011 (hereinafter referred to as the first surgery or operation). She was 13 years old at the time.
4. The plaintiff claims that Dr Kaschula failed to obtain informed consent from her guardian before he performed the surgery, and that, whereas she was able to walk before the surgery, she was rendered paraplegic immediately thereafter.
5. On 9 December 2011 Dr Kaschula performed corrective spinal surgery on her by way of a posterior instrumented fusion of T3 to T8 (hereinafter referred to as the second surgery or operation). She had just turned 14. The plaintiff claims that she was paraplegic before and after the second surgery. It is not in dispute that the plaintiff was unable to walk immediately prior to the second surgery and that she presented with paraplegia after that surgery.² The plaintiff alleges that her paraplegia (and the sequelae associated therewith), was caused by the defendant's servants at the hospital, who were negligent in their treatment of her.
6. The defendant pleads that the plaintiff's disability was as a result of having contracted spinal tuberculosis (TB) prior to her admission to the hospital in January 2011. This caused a kyphosis³ and permanent damage to the vertebrae in her thoracic spine, with resultant atrophy of the spinal cord and paraplegia.⁴
7. The defendant's servants treated her for TB and performed the two operations on 5 February and 5 December 2011, in an attempt to "stop the damage from

¹ Dr Kaschula is a medically qualified specialist orthopaedic surgeon who qualified as a doctor in 1988, commenced his career in orthopaedic surgery in 1994 and commenced specialising in this field in 2009. Since then he has been the designated spinal surgeon at Frere Hospital.

² According to Dr Kaschula the plaintiff probably became unable to walk altogether around September/October 2011.

³ A forward rounding of the back commonly referred to as a hunchback.

⁴ A CT scan taken on 20 January 2011 depicts what is described in the report thereon as a kyphotic spine.

getting worse.” Differently put, the purpose of the first surgery was to “fix” the spine, or in layman’s terms, to “make it solid”. In the premises it is the defendant’s case that the plaintiff’s neurological fall-out is due to a progressive kyphotic deformity and not as a consequence of surgery.

8. The defendant denies that her servants were negligent, and contends that the aforesaid medical treatment was reasonable and appropriate. The defendant also disputes the allegation that informed consent was not obtained.

The plaintiff’s case

9. As a child, the plaintiff was cared for in Cofimvaba by one Mrs Z (a relative and teacher). Mrs Z told this court that at some stage she noticed the plaintiff limping with her right leg. She asked the plaintiff where she was experiencing pain. The plaintiff was unable to identify a particular spot. This caused Mrs Z to worry. She decided to seek medical attention. During January 2011 she took the plaintiff for medical attention and left her in the care of her daughter, P (an estate agent with a diploma in marketing) who was living in East London at the time.⁵
10. The plaintiff (who was 20 years old when she gave evidence) said that this was her first visit ever to Frere Hospital. This was confirmed by her relative P. The plaintiff testified that when she visited Frere Hospital on this first occasion (which appears to have been on 6 January 2011), she presented with a pain-free limp of the right leg. Dr Kaschula examined her and opined that a bone or bones in her back may have become loose or damaged as a result of a fall.⁶ He said that he would perform surgery on her back to “bring back the bone that might have become loose”.

⁵ According to the report of the plaintiff’s orthopaedic expert, Dr Schnaid, the plaintiff was transferred from Gateway Clinic to Frere Hospital on 6 January 2011. As there are no medical records which speak to this transfer, the probabilities are that this information came from the plaintiff and/or Phumza who accompanied her when she consulted with Dr Schnaid on 24 March 2016.

⁶ Phumza confirmed the plaintiff’s evidence to the effect that Dr Khashula had told them that he intended performing back surgery on the plaintiff because of a bone which may have moved. According to Dr Kaschula he had described this surgery to Phumza as a risk free bone graft procedure which may have been of assistance to the plaintiff, but probably would not be. Phumza agreed that the doctor had told her that

11. Subsequent to this, P phoned Mrs Z and told her that she needed to sign a consent form, as the plaintiff was going to require surgery.
12. On 10 January 2011 Mrs Z, as the plaintiff's guardian, signed a consent to medical procedure form which was counter-signed by one Dr Daniel. The form reflects the nature of the procedure as an "instrumented posterior fusion of the spine with bone graft." According to the form, an interpreter had been used to explain the procedure. The form also states that the doctor explained the nature, risks and possible consequences of the medical procedure to the patient or to a person legally competent to give consent. It further states that the doctors who perform the medical procedure may increase the reasonable scope thereof or carry out additional or alternative measures if considered necessary.⁷
13. The plaintiff testified that she was unable to stand or walk after the first surgery. She could not feel when she was urinating. She had to borrow a wheelchair from the hospital when she was discharged on 15 February 2011 to get from the hospital to the vehicle which was collecting her.⁸
14. She returned to the hospital for check-ups but Dr Kaschula did not pay attention to her. He did however suggest a second operation as "there might have been a mistake during the first operation and he wanted to rectify it". P signed consent for the second surgery.⁹ The plaintiff testified that Dr

the surgery would be risk free, but disputed that he had said that it probably would not assist the plaintiff. She said he advised her that the surgery would be helpful. She denied that Kaschula had explained anything to them about spinal TB.

⁷ Mrs Z explained that she signed the consent form because Dr Kaschula had told her that if the plaintiff's problem was not attended to, her condition would deteriorate. She said that according to Dr Kaschula, there was something causing the limping (a bone which seemed to have moved) which had to be fixed. The doctor said that if she wanted the plaintiff to "walk again" she must sign the consent form. The doctor did not tell her that the plaintiff had TB. According to Dr Kaschula, the plaintiff was mobile before the first operation, albeit with such difficulty that she was unable to mount the scale in order to be weighed. His evidence was that he could not, and would not have used terminology such as "walk again" in the circumstances.

⁸ Mrs Z and Phumza corroborated the plaintiff's evidence that she walked before the first surgery but was unable to do so immediately thereafter. According to Phumza they had to use an office chair with wheels to mobilise the plaintiff at home. When she enquired from Dr Khashula why the plaintiff could not walk, he told her that the operation was "still new, everything would be okay thereafter."

⁹ Phumza explained that Dr Khashula had told her that they had made a mistake during the first surgery because a bone in the plaintiff's back had moved and that they intended to rectify it. He said that they could

Kaschula did not tell her what procedure he was going to use but said that she would walk after the second operation. She did not. Indeed, according to the plaintiff, she was worse off than before. Her left arm had become very weak and she also relied on support in order to sit upright.

Medical records

15. A document dated 10 January 2011 and purporting to be part of the plaintiff's patient record, describes her medical diagnosis upon admission as "painful both legs". The plaintiff disputed that she was in any pain upon admission. It further appears from this document that the plaintiff was not weighed upon admission, as she was "ambulant" but "unable to stand". The plaintiff disputed that she was unable to stand upon admission. A document purporting to be the plaintiff's care plan, confirms that on 10 January 2011 the plaintiff was suffering from pain in both her legs. It also refers to weakness of the right leg. By 4 February 2011 (the eve of her first surgery), what purports to have been her progress note, refers to weakness of *both* legs.
16. A document purporting to be her in-patient medication management chart (which I am advised is a working document which would have been completed upon admission) states that she was diagnosed with a collapse of T5 and T6. She denied that this diagnosis was made upon her admission.
17. According to background history recorded in what purports to be her inter-departmental referral form dated 6 January 2011, she was previously treated at Frere Hospital during 2006 for a period of six months for TB in her left leg. The plaintiff denied this.¹⁰

do this because the plaintiff was still young. He promised her that the plaintiff would be able to walk thereafter. According to Phumza, the restoration of the plaintiff's status quo ante as described by the plaintiff and her witnesses, was a condition precedent to her consent to the second surgery.

¹⁰ The plaintiff's expert witness, Dr Mpotoane, testified that when he consulted with the plaintiff, the records she made available to him confirmed a history of right leg TB going back as far as 2006, and that a right knee abscess was drained during November 2010. Upon clinical examination Dr Mpotoane found multiple healed scars on both knees.

18. The same form reflects that on 9 October 2010 the plaintiff attended Frere Hospital presenting with an abscess in her left knee, which was drained and treated with oral antibiotics. This too, the plaintiff denied.
19. The form describes the plaintiff's present complaint (as at 6 January 2011) as that of pain in her right leg accompanied by a pins and needles sensation. The plaintiff denied that this was her complaint when she first visited Frere Hospital. She maintained that it was simply that of a pain-free limp.¹¹
20. A document which purports to be an extension of her patient record, and which is described as a "problem-orientated patient progress record", (which is also dated 10 January 2011), confirms a medical diagnosis of pain in both legs. It also confirms a history of TB and reads as follows under the heading "progress note":

'D: Presenting with painful legs. Had TB in 2006. Was treated for 6 months. Difficulty in walking.

I: Painful knees.

A: Admit to ward for further investigation and management. For strict bedrest.'

When this entry was put to the plaintiff her initial response was that when she visited the hospital in January 2011 she only had pain in her right leg. She then changed this answer and reverted to her initial stance (that she was pain free). She denied that she had any difficulty in walking. She stated that whoever had written this was lying. She added that the first time she heard that she had TB was towards the end of 2011 when she asked Dr Kaschula why she could not walk.

21. Two entries, purportedly made less than an hour later, repeat that the patient presented with pain in both legs and that she was complaining of pins and needles in her right leg. It appears from one of these that the plaintiff could

¹¹ In this regard Dr Christoffels confirmed that he was the author of the entries on this page of the inter-departmental referral form in the paediatric outpatients department. Although the doctor appears to have no independent recollection as to the identity of the patient he was dealing with or the source of the information which he had recorded, it is significant that the folder number, the names and the date admittedly relate to the plaintiff.

not be weighed because she was unable to stand, and that she was referred for a 3D scan. The plaintiff commented that whoever had stated that she was unable to stand was lying. She said that she was only referred for a 3D scan after the first surgery.¹²

22. A computer printout (described as the “patient information form”), reflecting the plaintiff’s names, gender, telephone number, address, folder number and the date of her admission on 6 January 2011 as well as the name, surname and telephone number of her mother, confirms that the plaintiff had been admitted to Frere Hospital for surgery on 9 November 2010.
23. The form reflects that on 6 January 2011 the plaintiff was complaining of pain and paraesthesia (pins and needles) in her right leg. The plaintiff disputed that she was suffering from this condition or that she had verbalised such a complaint.
24. According to these records she was seen by Dr Kaschula and his “team” at 09h00 on 11 January 2011. The note states that the plaintiff was to be booked for a “3D CT scan”, that she had to be kept on bed-rest and that her blood results were to be “chased”.¹³ In the interim she was to be managed conservatively and given TB treatment. The records further state that the patient’s limbs had improved with bed rest and that both lower limbs were moving with good sensation.
25. When the plaintiff was questioned about the CT scan, she denied that it was done before the first operation, despite a progress note dated 28 January 2011 confirming that doctors had seen the CT scan results. She said that the only thing that was done before the first operation was her blood tests. When the plaintiff was asked about these blood tests, she contradicted what she had

¹²This statement is obviously wrong. It is not in dispute that the first scan was done on 20 January 2011, before the first surgery.

¹³ Professional nurse Sister Tshengu who was working in the plaintiff’s ward (G5) at the time and who had made certain entries in what was submitted to have been her clinical records, testified that the entry referring to the chasing of bloods meant that the blood had already been taken and that the results were outstanding and needed to be expedited.

said before, and stated that her blood was not taken before the first operation. She added that whatever was reflected in these hospital records was “all lies”.

26. According to the same progress note the plaintiff was assessed as still presenting weakness of the lower limbs on 31 January 2011. On 4 February 2011 (the day prior to the first surgery) “weakness of legs” is noted. The plaintiff remained adamant that only her right leg was weak at that stage.
27. During cross examination it was put to the plaintiff that a progress note recorded by Sister Tshengu immediately after the first surgery reflects the following:

‘All four limbs warm, pink, moving with sensation present ... Nurse flat in bed and logroll as necessary.’¹⁴

28. The plaintiff insisted that she was unable to move her legs. She accused Tshengu of lying as well. The upshot of her evidence (corroborated by P and Mrs Z) was that all hospital records purporting to reflect that she was able to move her lower limbs after the first surgery, and any suggestions that she had verbalised the ability to move her legs, were false.
29. The plaintiff was adamant that when she was wheeled from the theatre to the ward after the first surgery, she could feel that she had urinated on the bed. When it was put to her however, that her catheter was only removed on 10 February 2011, she contradicted herself once more and agreed that a catheter had been inserted in the theatre. When I sought clarification from her, she changed her version once again. She said that she did not have a catheter *in situ* during the first surgery, or immediately after the first surgery,

¹⁴ According to Sister Tshengu these entries (which she said she had made contemporaneously) meant that the plaintiff was able to move her toes and her fingers. She said that she would have asked the patient to move the extremities of all four limbs and would have observed whether she was able to do so. She would not simply have relied on the patient’s say-so. She would also not have “lied” and documented something which she had not observed. If the patient failed this test she would have reported it to the doctor because it is an “abnormality”. She would also have made a note of it. Tshengu explained that what she had noted and testified about was standard post-operative care, and that they had been trained to do this. She said that “logrolling” was done with all spinal patients. This procedure was later confirmed by Prof. Vlok who was called as an orthopaedic expert on the defendant’s behalf.

which was why she had wet her bed. She said that the hospital staff only inserted a catheter after she had reported to them that she could not feel when she was urinating. She denied that her problem with incontinent urinating only presented itself after the second operation (in contrast with what P had said to Dr Mpotoane).¹⁵

30. When P testified she was referred to a consent to medical procedure form (for the second surgery). It is dated 5 December 2011 and is counter-signed by Dr Kaschula. It reflects that the procedure was explained to the consenting party personally and without the use of an interpreter. The nature of the procedure is described as a posterior instrumented fusion of T5 to T7 of the thoracic spine. It reflects the plaintiff's name and her folder number. P agreed that she had signed a consent form but denied that it was the one which had been shown to her.
31. She testified that one of the defendant's servants working at Frere Hospital at the time had given her the plaintiff's hospital file to copy at home.¹⁶ According to P, she proceeded to make copies of some of the contents of the file, but then became "tired" and did not copy everything. She claimed that she was unaware of signs at the hospital stating that patients' folders remained hospital property. She said that she did not know that it was wrong to remove hospital property because she did not study health care.

¹⁵ The report of Dr Mpotoane (the plaintiff's expert witness) reflects that when he consulted with the plaintiff and Phumza during November 2014, Phumza told him that the plaintiff did not suffer from urinary incontinence up until after the second surgery. According to Dr Kaschula permanent catheterisation was only recommended and performed three years post-operatively. This would accord with the patient information form, which reflects that the plaintiff was admitted to Frere Hospital on 14 and 19 May 2014 (ostensibly for this purpose).

¹⁶ The deputy director (general administration) of Frere Hospital was called to confirm that patients were not entitled to remove their folders from the hospital. In special cases lawyers were permitted to copy records and had to pay an access fee. Alternatively, the hospital manager could arrange for copies of records to be made available to a patient. She explained that there were notices posted in the hospital making it clear that the green folders were hospital property and that patients were not entitled to remove them from the premises. She testified that the plaintiff's entire folder had disappeared from the filing room, never to be seen again. It appears to be common cause that the clinical notes referred to at the trial by both parties were copied from the copies which Phumza had made when she took the plaintiff's file home.

The defendant's case

32. The defendant's case is based in the main on the evidence of Dr Kaschula. Dr Kaschula commenced his evidence by saying that he had made extensive notes when he dealt with the plaintiff, but that these had gone missing.¹⁷
33. He saw the plaintiff at paediatric outpatients when she visited Frere Hospital on 6 January 2011. Her central complaint was of paraparesis (difficulty walking). He made a clinical assessment and ordered X-rays. She presented with a collapse of the spine at T5 and T6 caused by spinal TB which he had diagnosed on 10 January 2011 from what he could assess from the X-rays. He said that he had an independent recollection of what he had seen when he looked at the X-ray imaging. He observed paravertebral abscess formation. However, he could see that the abscess formation was not contributing to the plaintiff's condition and her mechanical instability. This he could see from both the X-ray images and the subsequent CT scans. His working diagnosis was that of mechanical instability of the spine.
34. On that same day Dr Kaschula decided to admit the plaintiff (whom he regarded as an "emergency patient" requiring emergency intervention)¹⁸ and commenced anti-TB medication as a precaution even though it appeared to him that the spinal TB had healed.¹⁹ He ordered a three dimensional

¹⁷ In this regard much of the trial was devoted to accusations and counter accusations with respect to the absence of certain records. It is the plaintiff's case that the defendant's staff failed to keep accurate and full records. It is the defendant's case that relevant portions of the hospital records had gone missing and that it was suspected that they were removed from the plaintiff's folder when Phumza was given the file to take home. It is neither necessary nor appropriate at this stage to rule on this thorny and sensitive issue. The fact is that certain records which may well have been of some assistance to this court, were no longer available at trial stage.

¹⁸ In this regard Kaschula explained that at that stage, he was consulting with an average of 60 patients per day. He regarded the plaintiff as an emergency with respect to intervention rather than time. Differently put, his words were that the necessity to operate was an "imperative".

¹⁹ During cross-examination Dr Kaschula added that even if the plaintiff was suffering from active TB, his approach would have been no different. In such circumstances he would have aggressively determined the presence or otherwise of an intra-dural abscess in the spinal canal. If the plaintiff was suffering from active

computed axial tomography scan (a “3D CT scan”) and blood tests including a sedimentary erythrocyte rate (ESR) test.²⁰ According to Kaschula he had already decided that the first surgery was necessary when he called for the CT scan.²¹ He would, in any event, only have obtained the results of the CT scan some two weeks later. He testified that he would not have operated without having seen the blood results as he abides by the Hippocratic principle of “giving the biggest benefit with the least harm”.

35. The scan (which was done on 20 January 2011) had no impact on this decision. He diagnosed the collapse of the spine and made the decision to perform the first surgery based on the X-ray imaging. He said that he was able to diagnose the collapse from the X-rays alone. However, at Frere Hospital it is mandatory for X-ray imaging to be followed by a CT scan. All the CT scan really did was to assist him in deciding how many levels of the spine would be involved in the fusion. He added that it was also evident from the CT scan that there was no abscess or puss present in the area of the proposed surgery. This served to fortify his view that the plaintiff was presenting with a mechanical instability.
36. He went on to explain that the purpose of the blood tests was to show the plaintiff’s haemoglobin level, and the ESR test would confirm whether the TB was active or quiescent. During cross-examination he stated that blood tests are the most conclusive way of determining TB activity. In the plaintiff’s case the ESR showed that the TB was dormant (and “subsidiary and almost irrelevant”) as he had suspected. His primary diagnosis was “mechanical instability of the thoracic spine caused by TB destruction of T5 and T6”. He described this as a “mechanical urgent problem”. He said that a magnetic

TB and presented with an intra-dural abscess he would also have performed a vertebral cross-vasectomy (draining of the abscess) during the first surgery, because determination of the presence of an intra-dural abscess independently is an aggressive procedure which further destabilises the spine. He further mentioned that active TB in itself could also result in paraplegia.

²⁰ A consent form for a 3D scan dated 13 January 2011 purports to have been signed by one Phumza Z (described as the patient’s sister) on behalf of one A Simayile.

²¹ According to Dr Kaschula a posterior fusion was aimed at preventing the spine from collapsing further by “creating a bony block posteriorly that braces the spine as it were.” TB spine is the only condition that indicates this type of surgery. It is not done for any other reason and he himself had never done it for any other reason.

resonance imaging (MRI) scan would not have provided him with any useful information in this regard.²² Nor would there have been any point in obtaining a histology specimen. The TB had healed. There was accordingly nothing to biopsy. According to the doctor, the criterion at Frere Hospital is, in any event, radiological. Even patients with active TB were not subjected to biopsies.

37. He decided to perform an on-lay posterior fusion of the spine in the area between T4 and T8 in order to provide the plaintiff with a solid continuum of bone block in order to arrest further collapse of the spine. It entailed “minor” surgery.
38. He discussed this with the plaintiff’s guardian. He advised her that the plaintiff had a serious problem with a collapse of the spinal cord. He told her that the plaintiff had had spinal TB. In making this assessment he was guided by the X-ray and by the fact that she had a history of TB in her left knee. He told her guardian that surgery may or may not help because the problem was very serious. Dr Kaschula testified that he would not have told anyone that the plaintiff may have fallen. Nor would he have said that she would walk again. He said that the plaintiff’s version in this regard was “complete nonsense”. He said that this was an exceptional case. He devoted a tremendous amount of time explaining things to the plaintiff’s family. He said that he could not remember what he had said before the second operation because that consent was less controversial and more standard. However, the situation before the first surgery was unique. It was important for him “not to promise too much”. In the circumstances he informed the plaintiff’s guardian that surgery was not a cure but that it was “benefit versus risk favourable”. Consent to perform this surgery was accordingly given.
39. He performed the surgery on 5 February 2011. He confirmed that longhand entries in the patient progress record which he was referred to for that period

²² Dr Kaschula testified that during 2011 Frere Hospital did not have scanning facilities. Scans were done by private radiologists with rooms at St Dominics Hospital. Hospital patients did not pay for these scans. They are expensive, ranging between R15 000 and R20 000 per scan.

appeared to be an accurate contemporaneous reflection of the plaintiff's condition, symptoms and conduct.

40. The plaintiff was received back from theatre at 10.30am after a 40 minute operation. At 7pm that same day the following is recorded:

'Patient crying, screaming restless complaining of having pains like burning needles start from the waist down to both legs.'

According to Dr Kaschula this description was consistent with what he would have expected on the same day as the surgery.

41. On 11 February (six days post surgery) an entry is recorded stating that the patient's catheter had to be removed. According to Dr Kaschula, the catheter would not have been removed then, but would have had to remain *in situ*, if the plaintiff was indeed paraplegic immediately after the surgery, as suggested on the plaintiff's behalf.
42. The plaintiff was discharged on 15 February 2011.²³
43. When it was suggested to him that the plaintiff was discharged ten days post-operatively in a paraplegic state with no wheelchair, he disputed this. He said that he and the hospital staff take great pride in attending to patients post-operatively. He added that a patient would sometimes occupy a hospital bed for up to six weeks just waiting for a wheelchair. He mentioned that he presently had a Zimbabwean patient who had been occupying a bed for seven months because he had no support structure on the outside. He dismissed the suggestion with apparent indignation and with the comment:

'I take offence to that. It's a disgraceful thing to say.'

²³ Dr Kaschula explained that the plaintiff was detained at the hospital for ten days post-operatively as he was concerned about her spinal stability. Her procedure had been elective and he wanted her to have strict bed rest.

44. When the plaintiff attended physiotherapy in March 2011, she was assessed and found not to be ready for a wheelchair yet.²⁴ According to Dr Kaschula, the plaintiff's neurological functioning gradually deteriorated after the first operation. She could still walk with difficulty for about two weeks post-surgery, but by September 2011 she was no longer ambulant and required a wheelchair, which was obtained for her that same month. He admitted her for five days while she was waiting for the wheelchair to be made available.²⁵
45. On 17 October 2011, and because of the change in her neurological functioning, he requested a MRI scan of her spine. During his evidence, he was referred to this report.
46. Dr Kaschula testified that this MRI report confirmed his suspicion that the plaintiff's spinal deformity (as a result of an inactive TB spine) was "too great to have held". Upon assessment, his primary concern was that the severe nature of her thoracic deformity would compromise her breathing, which, in turn, could lead to *cor pulmonale* (a form of heart failure) if the spine collapsed resulting in compression which would compromise her respiration.
47. The status quo accordingly necessitated a posterior fusion of the plaintiff's thoracic spine to prevent this from happening, because the first non-instrumented fusion did not achieve the anticipated results.²⁶

²⁴ The patient information form confirms that the plaintiff attended Frere Hospital on 1 March 2011 for medical reasons.

²⁵ This evidence coincides with an entry in the patient information form, which reflects that the plaintiff was indeed hospitalised in the orthopaedic section from 19 to 23 September 2011.

²⁶ Dr Kaschula, who maintained that he had an independent recollection of this case, described it as an unusual, exceptional and significant one, which lends itself to recall. The plaintiff was the oldest patient that he had ever performed this type of fusion on. This type of fusion is typically performed on very young children, usually between the ages of two and seven. The reason for this is that fusion in young children will allow for the vertebrae to grow. By the time the patient has reached the age of 11 the surgeon is on his "last legs with surgical options". The patient only has about three years of growth remaining. He attributed the failure of the first operation to achieve the results which he was hoping for, to the plaintiff's advanced age and not to any particular difficulties experienced during the surgery. Indeed, he described the operation as one of the easiest procedures in spinal surgery ("nothing can go wrong"). He said that he had performed about 30 similar but successful operations on children between the ages of two and seven. The plaintiff on the other hand, was in her early teens at the time. She was also the only patient on whom he had performed this type of surgery, who presented with a pre-existing neurological deficit. Because of this and her advanced age, he regarded her as an emergency patient.

48. Dr Kaschula testified that he proceeded with the second operation on 9 December 2011. He described the outcome thereof as “a very good fix”.
49. According to a patient information form the plaintiff was discharged on 22 December 2011.
50. I asked Dr Kaschula whether, with hindsight, he would have done anything differently. This is what he said in response:

‘Certainly not as far as my clinical decision making was concerned. Looking back in hindsight, I would be much more inclined to photostat my clinical notes – to have my own copies in all cases where there is potential controversy, but it is very difficult to work out which cases are going to be controversial and which are not. I consider my clinical decision making in this case to be faultless ...’

The radiological evidence

51. A number of radiological reports and scans were referred to in evidence. For the sake of completeness, and because I refer to them from time to time, I list them chronologically in order of scanning rather than reporting. They are:
 - a. A CT scan ordered by Dr Kaschula which was done on 20 January 2011 and reported on by Dr Counihan on 24 August 2017. The scan itself was found after this trial had already commenced. The report could not be traced. Radiologist Dr Counihan studied the scan and prepared a report for the purposes of this trial. It reads as follows:²⁷

‘Radiology Report: A Z / G / S

CT CHEST

Comparison is made with the CT scan performed on 23rd May 2014.

The scan confirms a sharp gibbus²⁸ at the T6 level with destruction of T6 and partial destruction of the inferior portion of the body of T5 and superior portion of the body of T7.

The residual disc margins are slightly immature when compared to the scan of 2014 as one would expect.

The AP diameter of the sac at the level of the gibbus is 3.8mm. There is no evidence of an epidural soft tissue mass (collection or cold abscess). This would imply inactivity, however, the consolidation at various bony components is not as mature as noted in May 2014.

The associated calcified hilar nodes and features typical of previous TB are present, as noted in May 2014.

COMMENTS

In summary, the current CT scan confirms post-tuberculous bone destruction with a gibbus in the mid dorsal region in a slightly less mature state than in May 2014 as one would expect. Although there is no evidence of associated abscess or activity, this cannot be totally excluded on a CT scan, particularly when compared to an MRI.

There is marked narrowing of the sac which is draped over the gibbus. It is not possible to separate the sac from the cord, as can be done on MRI. The narrowing of the sac is consistent with extreme flattening and atrophy of the cord observed in the MRI report of 2011-11-23.

²⁸ A gibbus deformity is a form of structural kyphosis typically found in the upper lumbar and lower thoracic vertebrae, where one or more adjacent vertebrae have become wedged. Gibbus deformity most often develops in young children as a result of spinal TB and is the result of collapse of vertebral bodies (see Kasper D.L. et al *Harrisons principles of internal medicine* 16ed 2005 958; Garg, Ravindra Kumar, Somvanshi, Dilip Singh (2011-09-01) *Spinal tuberculosis. A review: The Journal of Spinal Cord Medicine* 34 (5): 440-454). This can in turn lead to spinal cord compression causing paraplegia (see Ghandi, Aycock, Ryan, Berwald and Hahn (2015): *Gibbus Deformity: The Journal of Emergency Medicine* 49 (3) 340-341). The gibbus deformity is marked by an especially sharp angle. Viewed from behind, the resulting hunchback is more easily seen when bending forward. A kyphosis of more than 70 degrees can be an indication of the need for surgery and these surgeries can be necessary for children as young as two years old, with a reported average of eight years of age (see *Kyphosis: Description and Diagnosis: Spine Universe*. Retrieved 2017-11-15).

Scan done 20/01/11. Reported on 24/08/17.

Dr T C COUNIHAN

MB ChB (UCT 1976) FF Rad (D) (SA) 1990'

- b. A MRI scan report of the spine requested by Dr Kaschula on 17 October 2011 and reported on by Dr Counihan on 23 November 2011. The scan has never been found. The report reads as follows:

'MRI OF THE SPINE

CLINICAL PROBLEM: Mid thoracic TB with kyphosis and complete paraplegia. Has had 10 months TB treatment. Stabilised with bone graft in February 2011.

TECHNICAL FACTORS: Sagittal T1, T2 and STIR. Focal sagittal STIR and T1 with Gadolinium. Axial T1 and T2.

FINDINGS: There is a sharp gibbus centered on T6 which has disintegrated. The counting was performed from the bottom up and the top down. The patient is noted on plain films to have 13 pairs of ribs which makes things contentious. At this point there is pseudo-arthritis between T5 and T7. This is hypointense with no STIR hyperintensity or enhancement to suggest active inflammation. No epidural collection or abnormal enhancement in the epidural space. No significant scoliosis is seen associated with this sharp gibbus. At this point the cord is extremely flattened and atrophic with some T2 hyperintensity extending a couple of centimeters superiorly and inferiorly.

The actual bony canal is not stenotic at this point with copious posterior epidural fat noted.

The remainder of the end plates and discs are intact.

More peripherally the nerve roots exit normally. No incidental abnormality.

COMMENTS

No active disease seen at the gibbus. This was presumably confirmed to be TB at surgery. There are no features to suggest otherwise. No other abnormal levels.'

- c. A MRI scan requested on 23 June 2017 and reported on by Dr Strydom on 27 June 2017. The report reads as follows:

‘MRI DORSAL SPINE

Comparison was made with a previous MRI report of 2011.

CLINICAL HISTORY

Mid thoracic TB with kyphosis and complete paraplegia. The patient received treatment for the TB. There was stabilization with a bone graft in February 2011.

FINDINGS

There is a slight rotational scoliosis convex to the left in the mid dorsal region. The alignment of the dorsal spine shows a sharp kyphosis centred at the level T6 which is shown to be completely disintegrated. There is wedging with partial destruction of the inferior endplate of T5. There is bony union between the inferior endplate of T5 and the superior endplate of T7.

Hardware is in place with a fusion done from the level T3 to T8. No significant bony spinal canal stenosis seen. There is no abnormal signal on the STIR sequences to indicate active inflammation.

The spinal cord is seen to be atrophied with a raised T2 signal at the level T6 as its course along the sharp kyphosis. All of these changes were already reported on the MRI done on 17.10.2011. There does not appear to be an interval change.

No epi- or subdural fluid collections noted.

The rest of the disc spaces as well as the vertebral bodies are normal in appearance.

COMMENTS

There is a gibbus formation at the level T6 with bony union of the T5 and T7 vertebra. There is a sharp kyphosis due to the gibbus formation without evidence of a spinal stenosis. There is focal atrophy of the cord at the level T6 with a raised T2 signal which was already mentioned on a previous MRI report.

DR WESSEL STRYDOM'

- d. A supplementary radiological report compiled by Dr Counihan on 26 July 2017 reads as follows:

'Radiology Report A Z / G / S

MRI 17/10/11 reported by me

CT 23/5/14

MRI 23/6/17

26 July 2017

Reference in records to a CT scan in January or early February 2011 noted. This scan has not been seen.

All the scans demonstrate typical healed mid-dorsal TB Spine. T6 is destroyed as is the inferior half of the T5 body and the superior portion of the body of T7. Mature bony union between the remains of T5 and T7 was noted on all scans, with a sharp gibbus / kyphosis.

CT does not visualize the cord.

On both MRI studies severe focal cord atrophy is present limited to the gibbus. The bony canal is capacious. This would account for her paraplegia with no interval change noted between October 2011 and June 2017. Instrumentation was present on the second MRI and the CT. I concur with Dr Strydom's findings/report.

No cord pathology/damage noted above or below the gibbus, a typical picture of TB damage.

My report of October 2011 refers to complete motor paraplegia in the history. This is consistent with the radiology findings, although some right leg sensory sparing is noted clinically.

DR T C COUNIHAN

MB ChB (UCT 1976), FF Rad (D) (SA) 1990.'

- e. An amended supplementary radiological report by Dr Counihan dated 8 August 2017 reads as follows:

'8 August 2017

Reference in records to a CT scan in January or early February 2011 noted. This scan has not been seen.

All the scans demonstrate typical healed mid-dorsal TB Spine. T6 is destroyed as is the inferior half of the T5 body and the superior portion of the body of T7. Mature bony union between the remains of T5 and T7 was noted on all scans, with a sharp gibbus / kyphosis.

CT does not visualize the cord. However on appropriate settings there is evidence of healed pulmonary TB.

On both MRI studies severe focal cord atrophy is present limited to the gibbus. The bony canal is capacious. This would account for her paraplegia with no interval change noted between October 2011 and June 2017. Instrumentation was present on the second MRI and the CT. I concur with Dr Strydom's findings/report.

No cord pathology/damage noted above or below the gibbus, a typical picture of TB damage.

My report of October 2011 refers to complete motor paraplegia in the history. This is consistent with the radiology findings, although some right leg sensory sparing is noted clinically.'

The experts

- **Radiologist Dr Counihan²⁹**

52. The defendant called Dr Counihan as a witness. Counihan explained that Frere Hospital had no MRI facilities or CT scan facilities for the best part of 2011. MRI scans were outsourced to a private practice in East London. The hospital was supplied with its first CT scanner on 11 October 2011. Before that CT scans were outsourced to Cecilia Makiwane Hospital.
53. He stated that he did not even think that it was necessary for Dr Kaschula to treat the plaintiff for TB before the first operation, because it had cleared after having been there in 2006. He referred to Dr Kaschula's conservative treatment in this regard as a "belts and braces" approach. In his view, if the hospital had the facilities then to do a MRI scan, the results would have confirmed that TB treatment was not called for. Dr Counihan stated with confidence that if one were to take an X-ray of the plaintiff's knee as it presented currently, there would be a 98 per cent chance that it would confirm that she had had TB of the knee.
54. Dr Counihan, in commenting on the recently discovered CT scan which was performed pre-operatively at the request of Dr Kaschula, confirmed that the state of the bone in the CT scan suggested healed as opposed to active TB.

²⁹ Dr Counihan was the radiology registrar at Groote Schuur Hospital and Cape Town University from 1987 to 1991. In 1990 he passed the FF Rad (Diagnostic) S.A. of the College of Medicine of South Africa. He worked as a full-time radiologist at Frere Hospital (as well as in private practice in a partnership in East London) from 1991 to 2015 (24 years). He retired from private practice in 2015. He claims to be extensively experienced in the field of spinal TB.

In his oral evidence he confirmed and elaborated on his report on the 20 January 2011 CT scan. In this regard he confirmed that the scan showed the sac and the cord “coming around” and being pulled tightly over the apex of the gibbus/kyphosis and narrowing markedly. He also repeated his view that there was no abscess visible, and explained this conclusion in the following terms:

- a. The sac is wrapped anteriorly around the vertebrae at the gibbus. If there was an abscess (normally caused by infection of the vertebrae or bone) it would have pushed the sac further back and it would not have been positioned in the front as was evident from the scan.
- b. An abscess would have taken up space in the canal, displacing the fat.
- c. Such displacement was not evident from the scan.
- d. If there was active TB one would more than likely have seen “moth-eaten bone destruction”. However the bone visible on the scan was “already maturing, it is corticated, it is healing, it is classic resolved TB”.

- 55. When asked about his comment in the report to the effect that TB cannot be totally excluded on a CT scan (as opposed to a MRI scan) he explained that what he meant was that one could not with 100 per cent certainty exclude the presence of active TB *bacteria*.
- 56. In commenting on the MRI scan of 23 November 2011 he stated that at the site of the gibbus, fat in the spinal cord had been replaced. The bony canal presented as wide. The bone destruction was very severe reflective of a classical case of TB. He said that there was no active inflammation however. If there was, it would “shine up” on the MRI scan.
- 57. He was asked to comment on the MRI report completed by Dr Strydom on 26 June 2017 (forming part of the defendant’s expert bundle) with respect to a scan which had been done three days previously. He agreed with the facts, findings and opinions reflected therein, with the reservation that he would not have used the word “significant” in the sentence which states “no significant bony spinal canal stenosis seen”.

58. Dr Counihan said that atrophy as a result of the gibbus could have been caused in one of two ways:

- a. The vertebral bodies collapsed and as the plaintiff grew the gibbus continued increasing until the spinal cord could no longer accommodate it.
- b. The vertebrae simply collapsed which is the tragedy of spinal TB in children.

59. Finally, Dr Counihan was asked to compare the CT scan of 20 January 2011 (pre first surgery) with his report on the MRI scan of 23 November 2011 (pre second surgery), the CT scan of 23 May 2014 (post surgery), and the more recent MRI performed on 23 June 2017 for trial purposes. He noted that there was extremely little “interval change” between the various images.³⁰ The only slight change was that in 2014 the residual disc margins were slightly more mature than in 2011, as one would expect. He pointed out in particular that the narrowing of the sac visible on the 20 January 2011 scan (pre first surgery) was consistent with the extreme flattening and atrophy of the cord which was noted in the MRI report of 23 November 2011 (some ten months post first surgery).

60. In this regard he confirmed that the severe focal cord atrophy was limited to the gibbus and would account for the plaintiff’s paraplegia, as stated in his final comparative report dated 8 August 2017. In this respect his interaction with the plaintiff’s counsel reads as follows:

‘What caused that, could you identify that?

....

MR STRYDOM: Severe focal cord atrophy is present limited to the gibbus. --- Do you want to know what caused the atrophy or the gibbus?

No the atrophy. --- The atrophy is caused by the gibbus.

³⁰ Dr Strydom’s report (which compared the MRI of 23 June 2017 with Dr Counihan’s MRI report of 23 November 2011) materially corroborates this finding. It also states that “there does not appear to be interval change”.

And how did the gibbus cause the atrophy? --- Two ways, the vertebral bodies in the front collapsed, bending the spine forwards and as she grew the posterior elements got bigger, so it increases the gibbus until the cord could not take it and then she went to see the doctors.'

61. The doctor confirmed that he had checked the entire spinal cord as reflected in the MRI scan of 23 June 2017. There was no other site apart from the one at the gibbus where there was wasting away or damage to the spinal cord.
62. Dr Counihan expressed no reservations regarding his determined view that the plaintiff had suffered from active TB before the first surgery. He could see this clearly from the various radiological images and scans. He could also see that the TB had been treated. His final comments were: "She must have been helluva sick once upon a time".

- **Neurosurgeon Dr Mpotoane**

63. The plaintiff called Dr Mpotoane as a witness.³¹ He consulted with the plaintiff and with P on 3 November 2014 and prepared a medico-legal report which was handed in as an exhibit at this trial. In a nutshell, the report states that it appears that the plaintiff was walking prior to the first surgery and that she was rendered paraplegic thereafter.³² The doctor's comment on this is the following:

'One may only assume that something negative happened during the procedure resulting with spinal cord injury.'

The doctor conceded however, that there was no evidence before him to suggest that something untoward had happened during the operation.

64. Below a heading referring to progress and ongoing problems however, the following is recorded:

³¹ Dr Mpotoane is a medically qualified specialist neurosurgeon with a special interest in spine and pain pathology. He has been in practice since 2008.

'Spasticity both legs: She was well prior to the operation even though she had a problem with the knee, following the operation she started developing this spasticity.'³³

65. When it was pointed out to the doctor that there is a difference between spasticity and paraplegia, he said (in commenting on his note regarding the development of spasticity after the first operation) the following:

'Yes and the patient was telling me and this is what I was recording from what the patient was telling me.'

66. At the commencement of his evidence, Dr Mpotoane was somewhat critical of the fact that the issue of consent had not been revisited by the defendant's servants after the CT scan results had been obtained. He said that the plaintiff was entitled to an informed and comprehensive consent with proper clarification of the fusion process. He agreed however, that the defendant's pro forma used when consent was obtained for both surgeries was adequate. He also, coincidentally, agreed that Dr Kaschula's post-operative follow up, insofar as it purports to have been documented in her patient information form, was reasonable.
67. He said that if instrumentation is used during surgery, there is no need to log-roll a patient. There is also no need for a patient to sit in a wheelchair. That patient must "stand up and walk and go".
68. Dr Mpotoane was of the view that various other steps ought to have been taken before a final decision was made whether to surgically intervene or not. According to the doctor one cannot, when a CT scan shows a kyphotic deformity, conclusively decide on the cause of thereof³⁴. A biopsy should be taken. The surgeon should consider whether the condition is life threatening

³³ It is common cause that 'the operation' refers to the first surgery.

³⁴ However, later on in his evidence he conceded that a kyphosis is evidence that the TB has been there for several months, and that, on a balance of probabilities, what one is dealing with here is spinal TB.

or whether he can buy time by proceeding with conservative treatment such as lying the patient down flat for observation. Facilities allowing, a MRI should be considered.³⁵ So should decompression in order to allow the spine to breathe before removing what should not be there such as a TB abscess. The other option would be to leave the abscess and administer anti-TB medication.

69. In summary, according to Dr Mpotoane, the proper way to deal with spinal kyphosis is to obtain MRI, decompress, follow with anterior debridement and posterior column shortening, and then conclude with instrumentation. The doctor conceded however, that there was no guarantee that any of this treatment would prevent paraplegia and even quadriplegia (in the case of cervical spine TB). He agreed that the spine is the most common skeletal site affected by TB, followed by the hip and the knee. He agreed that within the spine the thoracic and lumbar spine are the most commonly affected. He agreed that in developing countries spinal TB is more common in children and young adults. He agreed that TB is an insidious disease.³⁶ He conceded that the development of the condition is progressive³⁷, particularly in children, who are more vulnerable because their spines are growing. He agreed that spinal deformity is a hallmark feature of spinal TB.³⁸ He also agreed that TB in the leg could be accompanied by TB in other parts of the body. He conceded that a posterior bone graft procedure is more conservative than instrumentation. He testified that hypothetically, surgery would be considered appropriate where there was a progressive neurological deficit including

³⁵ Much later on in his evidence however Dr Mpotoane said the following: '... it does not necessarily mean that if I happen to do an MRI I am wrong, or if he happens not to have done it, he is wrong. It is an opinion, his line of thinking.' He agreed that it was not unreasonable for Dr Kaschula not to have obtained a MRI scan, particularly in the light of the fact that at the time there were no MRI facilities available at both Frere Hospital and at Cecilia Makiwane Hospital (its sister hospital in the area of East London).

³⁶ In other words one does not necessarily know that it is working its way through the system. It is because of this that persons suffering from the disease and its consequences only present for treatment when the disease is at an advanced stage. Because of its slow development the disease could have been there for months to a year without a person being aware of it. One may for example be aware of TB in the leg but unaware that it is present in another part of the body as well.

³⁷ In other words the symptoms become progressively worse over time.

³⁸ This is manifested by disc collapse, destruction of the disc space between adjacent vertebrae, destruction of the vertebral body where the thoracic vertebrae are affected, and anterior wedging of adjacent thoracic vertebrae resulting in a gibbus deformity or kyphosis (an unnatural sharp bend in the spine) because of the transmission of weight, creating a hunchback appearance.

mechanical failure of the spine caused by a significant kyphosis, because without surgical intervention, the kyphosis and the mechanical failure would become more severe over time due to an increased stretching or flattening of the spinal cord.

70. Dr Mpotoane was referred to the CT scan which was done on 20 January 2011 and reported on by Dr Counihan on 24 August 2017.³⁹ He agreed that the scan itself presented a clear picture of the point of kyphosis and of disc collapse with destruction of actual vertebral body.⁴⁰ He agreed that all the radiological reports (presented by both sides) described a very severe kyphosis or a sharp gibbus situated at an acute angle. He also agreed that on comparison of the scan done before the first surgery with one which was done on 24 May 2014 (after the second surgery), the structure of the vertebrae are practically identical.⁴¹
71. Dr Mpotoane agreed that spinal TB often leads to neurological deficit or damage.⁴² He further agreed that spinal TB may develop into paraplegia and even quadriplegia if it is present in the cervical spine. Spinal TB can either be in the form of early onset paraplegia (which develops when the disease is still active) or late onset paraplegia which develops in a patient with healed TB and the resultant kyphotic deformity.⁴³
72. Dr Mpotoane also agreed that the symptoms and conditions described in the hospital records relating to the period between 6 January 2011 and 5

³⁹ Supra. It is not in dispute that the scan was only located after the trial had commenced, but sans the report. Dr Counihan was accordingly asked to report on the scan during the course of the trial.

⁴⁰ It is clear from the scan itself that T6 has disintegrated completely leaving a union of T5 and T7. On the left side of the spine anterior wedging (caused by the weight on the damaged tissue of the vertebrae) with a loss of disc space is evident. Dr Mpotoane agreed that all of these are typical consequences of spinal TB, and that as a differential diagnosis spinal TB would have been “number one” on his list.

⁴¹ In this regard Dr Mpotoane agreed that both scans showed features typical of previous TB in the abdominal area (such as calcified hilar nodes). He could not however assume that because lung images showed healed TB, that TB had healed in the spine by the time the first operation took place. This was because, in his words “... every black man in this country, at one stage or another, has had TB, not knowing.”

⁴² In other words, it affects the spinal cord which in turn affects the motor and sensory functions of the limbs.

⁴³ It is common cause that late onset paraplegia is associated with marked spinal deformities and that there is no guarantee that treatment (whether it be in the form of chemotherapy or surgery) will prevent paraplegia.

February 2011 (prior to the first surgery) point to significant neurological problems.⁴⁴

73. It was put to Dr Mpotoane during cross-examination, that prior to the first operation, Dr Kaschula was faced with three conditions, which individually and particularly in co-existence, called for and justified surgery:
- a. a progressive neurological deficit in a child characteristic of spinal TB;
 - b. mechanical failure of the spine;
 - c. severe kyphosis.

74. Dr Mpotoane's response was that he agreed that surgery was justified in such circumstances. What he did not agree with, was that the neurology was caused by TB. He said that "this was basically an assumption, because we are not sure as to exactly if it was TB or not". Later on in his evidence, and during questioning by the court, Dr Mpotoane stated that the joint opinion of Dr Schnaid and Prof. Vlok⁴⁵ (that the plaintiff was suffering from an incomplete paraplegia as a result of spinal TB) was a reasonable one and added the following:

'What basically I am saying is that I am not blaming the TB in its entirety as responsible for her paralysis.'

75. Dr Mpotoane was asked to comment on the fact that Dr Kaschula initially performed the least invasive surgery in the form of a posterior bone graft, and that it was only when the bone graft failed to arrest the neurological decline that the less conservative fusion was employed. Dr Mpotoane agreed in principle that this approach ought to have been followed. He also agreed that the steps which Kaschula took before the second surgery (to keep the plaintiff on TB medication and to order a MRI scan) were reasonable forms of investigation before the second operation. He agreed that, given the fact that

⁴⁴ These being previous TB in the left leg, an abscess in the left knee, pain in the right leg, paraesthesia, weakness of the lower limbs, difficulty in walking and standing and limping.

⁴⁵ This opinion is documented in the joint minutes of Dr Schnaid (an orthopaedic surgeon identified as the plaintiff's expert) and Prof. Vlok (an orthopaedic surgeon identified as the defendant's expert) dated 27 November 2017.

it was common cause that the plaintiff was motor paraplegic after the first operation and before the second one, that the second surgery was not the cause of her paraplegia. In perusing the clinical notes, he said that a patient cannot be “ambulant” when the spinal cord has been injured. He added that, if the plaintiff was walking after the first operation, and at a later stage she progressively deteriorated until she ended up in a wheelchair, then he would not “blame” the first surgery for her paraplegia. In this regard he added the following comment:

‘Everyone knows that kyphosis is one of the causes. Especially in children, is that they will end up with paraplegia. That is a known fact. No one can run away from that.’

76. He also agreed that, on a balance of probabilities the kyphosis (caused by spinal TB or a congenital defect for that matter) in turn caused the atrophy which was present on 20 January 2017, when the CT scan was done.
77. Dr Mpotoane’s point of departure from what was suggested to him by the defendant’s counsel was on the point of whether the kyphosis was at that time, the cause of the plaintiff’s paraplegia. When asked to explain why he did not agree with this proposition, he replied as follows:

‘My reasons for not agreeing is that especially I would refer in particular to this patient and not to a hypothetical situation. In the case of this patient, she went into the hospital *okay* (emphasis added). She gets operated. She develops paraplegia. We are not treating the images. We are talking about human beings. You may still get that image like that, but then still find somebody else with that kyphosis, but still find somebody else who is still working with the images having that kyphosis. So in reference to this particular patient I do not agree ... If there is evidence beyond any reasonable doubt that this patient was wheeled into the hospital and got operated and wheeled out of the hospital, then I would then say yes, it isn’t anything that has to do with the hospital, because the patient came in that particular condition. However, a patient who comes without, who comes into the hospital walking and having those images, I will not assume that because the patient is having those images so it is automatic that it is the pathology that has resulted in the paraplegia.

No, I would *examine what actually happened* (my emphasis) also whilst the patient was in the hospital and from that particular examination I would then be able to draw a conclusion ... if you look at the clinical records, the entries when the patient came into the hospital preoperatively, I don't think that there is anywhere that we saw paraplegia. There is no paraplegia pre-operatively. It is only post-operatively that we have a patient who is paraplegic. I would agree with you if pre-operatively on the clinical records there is mention of paraplegia, however, there isn't.'

78. When the doctor was asked to comment directly on the proposition that the plaintiff's 3D CT scan (taken in January 2011) showed a case of spinal TB which had probably healed, he said the following:

'I think every doctor has a right to make his opinion when confronted by the images of any situation in front of him, and whichever thinking at that particular time that one may think or may take, that line might be either correct or that line might be either wrong, however one has to make a decision if you have the X-rays and you have the scans and when you look at them and you think that it has healed that is your opinion, but however it may not necessarily be the opinion of the other person, because the other person might say you know I need to think a little bit further, let me probably pursue these and confirm and make sure that everything is healed and how would one then arrive at that? One would then want to say, look, if it has healed, when was it treated.'

79. Hypothetically however, Dr Mpotoane was in agreement with the following modus operandi when surgery is indicated in a growing child:

- a. Stabilisation of the spine in order to arrest further collapse by arresting the kyphosis posteriorly, so that the growth of the child will result in an anterior elongation resulting (long term) in a decompression of the pressure on the spinal cord as the spine straightens.
- b. This can be done conservatively with a posterior bone graft (packing bone onto the spine to solidify and stabilise it), and it can also be done by way of instrumentation (inserting screws into the vertebrae to support metal struts that fix the spine).
- c. If done properly a posterior bone graft would present no significant risk to the patient, because it does not go near the spinal canal, or the dural sac

or the spinal cord. On the other hand, when inserting screws, one has to be particularly cautious not to enter the spinal canal and risk damaging the spinal cord.

80. He said that Prof. Vlok's opinion on the following aspects was reasonable and that he would not question it:

- a. Whilst it would have been of value to obtain a MRI scan before the first operation, one may rely on a CT scan and X-rays to evaluate the spinal column. The status of the spinal cord is a clinical evaluation.
- b. Spinal TB can be confirmed by X-rays and serological examinations (such as the blood tests done in the plaintiff's case). Specimen results (such as a biopsy) will confirm TB histologically in the acute phase, but not after it has healed.
- c. It was reasonable for Dr Kaschula to perform a posterior spinal fusion with on-lay bone graft on the basis of X-rays and the CT scan of 20 January 2011.
- d. The CT scan of 20 January 2011, taken together with the earlier X-rays, provided a sufficient basis to conclude that the plaintiff's neurological complications were attributable to the compression of the spinal cord that would necessarily have followed from the kyphotic deformity at T6 level.
- e. A diagnosis of spinal TB on the basis of an X-ray and a CT scan is permissible and reasonable.
- f. Spinal surgery was indicated on account of the kyphotic deformity, even if the cause had been something other than spinal TB.

81. In short, Dr Mpotoane testified that he was in agreement with Prof. Vlok's opinion as set forth in his two reports.⁴⁶ However, when it was put to him in re-examination that Dr Schnaid (who was not called as a witness) had indicated in writing that he was of the opinion that the paraplegia was related to the surgery, he agreed with this "sentiment" as well. He also then found himself in agreement with a view ostensibly expressed by Dr Schnaid that the

⁴⁶ Dr Vlok's evidence and reports will be dealt with in more detail in due course.

indication for the first surgery was debatable. Notwithstanding the concessions made previously, Dr Mpotoane was also heard to agree with an unconfirmed statement, that surgical consent for the first operation was inadequate. In this regard he stated that if he had been presented with the clinical picture on which the defendant relies, he would prior to the first surgery, have explained to the plaintiff and/or her guardian that:

- a. She has spinal TB.
- b. The complications of spinal TB in children.
- c. Chances of complications with the growing spine in growing children are high with TB in progression.
- d. Possible complications with any intended procedure to try and arrest the progression of the deformity that she was presenting with, for example where there is a chance that the bone graft may not hold and/or that infection may set in which may necessitate further surgery. There are chances that the cord may be damaged or that she may develop a blood clot which could compress the cord resulting in further neurology, or the need for a blood transfusion. Depending on what is found intra-surgery, further surgery may be indicated and performed.
- e. That there was no guarantee that the surgery would do away with the deformity or ensure that she will be normal again like other children.
- f. She had options, for example to continue with chemotherapy instead of opting for surgical intervention, and that she would then be invited to return after four to six weeks for the doctor to assess whether the treatment was working.⁴⁷
- g. A decision regarding surgery must be made with the aforesaid in mind. Should the patient opt for surgery she must be informed regarding the two possible types of surgery and the pros and cons of each.⁴⁸

⁴⁷ Dr Mpotoane opined that upon re-visits he would expect no deterioration in the clinical picture and that he would then want to do imaging to see whether what he was dealing with was increasing in size or disappearing.

⁴⁸ That is opening up the back and packing the bones as opposed to cutting the bones back, shortening them, opening the chest, removing the abnormal piece of bone, turning her back and putting in screws.

82. During re-examination Dr Mpotoane was permitted to traverse the surgical steps he would have taken when addressing healed as opposed to acute TB. He said that if the TB was healed there would have been no need to continue with anti-TB medication because the child was already presenting with a deformity. Instead he would have discussed with the guardian the risks of progression of the deformity and the neurological risk of the weakness getting worse resulting in paraplegia as opposed to trying to correct the deformity with no guarantee that correction of the deformity would heal the weakness resulting in a “normal” child.⁴⁹
83. He said that urgent surgical intervention would normally be indicated if the patient was presenting with a deformity accompanied by progressing weakness of the leg. If the patient was already in a wheelchair he would not intervene surgically or decompress as the damage would already have been done and surgery would not improve the condition. It would be of “cosmetic” value only. He would leave the patient and “see what will happen”.
84. During questioning by the court he said that the “hump” caused by the kyphosis would progress, making the chest smaller, which may result in breathing problems and people thinking that the patient is asthmatic when she is not, because “the lungs are squashed in a small container”. He said that without surgery the hump would become more “concaved” until the back is bent forwards. However, surgery could arrest the hump and prevent it from getting worse. He said that the atrophy visible on the MRI scan taken just before the second surgery is indicative of a chronic, long standing problem. He added that the plaintiff’s description of starting to limp out of the blue was consistent with spinal TB.
85. In summary Dr Mpotoane stated that the chances were that neither medical nor surgical intervention were likely to arrest the deterioration of the plaintiff’s condition.

⁴⁹ In this regard Dr Mpotoane explained that once a child presents with TB of the spine the chances are that the deformity would still progress (whether addressed medically or surgically) resulting in the development of further neurological problems, because growing of the spine may cause the deformity to get worse.

- **Orthopaedic surgeon Professor Vlok⁵⁰**

86. Professor Vlok consulted with the plaintiff on 19 April 2017 in the presence of her attorney (who also interpreted) and orthopaedic surgeon Dr Schnaid. He delivered his report on 5 May 2017.
87. According to the report, the plaintiff told him that she presented herself at Frere Hospital on 6 January 2011 with pain in her right knee and leg as well as weakness and paresthesia. She was limping. Dr Kaschula evaluated her and said that the weakness in her right leg originated from her back.
88. Dr Kaschula suggested a 3D CT scan which was done on 1 February 2011. On 4 February it was noticed that she had weakness and pain in both legs. Dr Kaschula performed an on-lay posterior fusion at T4 to T8 on 5 February 2011. Post-operatively it was reflected in the nursing notes that she had severe burning sensation in both legs. The next day pain was also reported and on 7 February, after management, it was noted that the pain had subsided. On 13 February 2011 the nursing notes stated that she was “on the go”. She was discharge on 15 February 2011.
89. The plaintiff told Prof. Vlok that all she experienced after the first surgery was a burning feeling. She could not move her legs. She said that she could not walk and had no control of her bladder after she was discharged. When she

⁵⁰ Prof. Vlok is a practising orthopaedic surgeon. He qualified with a MB ChB degree at Stellenbosch University in 1970. He obtained his MMed (Orth) in 1976. During 1977 and 1978 he specialised in orthopaedic surgery at Tygerberg Hospital. During 1978 he was also associated with the scoliosis clinic in the department of orthopaedic surgery attached to the HF Verwoerd Hospital in Pretoria. During 1980 he worked at the Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry (UK) in its department of spinal disorders. During 1981 he returned to Tygerberg Hospital as principle specialist in the department of orthopaedic surgery. From 1984 to 2012 he served as a professor at the University of Stellenbosch and also as head of the department of orthopaedic surgery at Tygerberg Hospital. At the time of giving evidence he had been in private practice in association with a neurosurgeon specialising in spinal surgery since 1991 (a period of 26 years).

was discharged she was not given a wheelchair and had to be carried. She attended physiotherapy post discharge.

90. Follow up revealed that she had progressive weakness in her legs. Dr Kaschula requested a MRI study which was done on 17 October 2011. It indicated that the spinal cord was flattened and atrophic and that the bony canal was not stenotic, but that there was a gibbus⁵¹ and a possible non-union. Kaschula revised the posterior surgery on 5 December 2011 with instrumentation from T4 to T8.
91. According to the plaintiff she still could not move her legs after the second surgery. In 2015 she was issued with a wheelchair. She told Prof. Vlok that the “hump” in her thoracic area was slowly increasing.
92. After a clinical evaluation, and having viewed the X-ray material available, Prof. Vlok made the following diagnosis:
 - ‘1. Vertebral collapse T6 with kyphotic deformity.
 2. Progressive neurological deficit; pre-operative date.
 3. Probable previous spinal TB⁵² treated and healed.
 4. Incomplete neurology with sensation sparing on the right leg.
 5. Well rehabilitated in a wheelchair.’
93. Prof. Vlok stated in his report that although the plaintiff was in denial regarding any previous form of TB, the clinical notes clearly indicated that she had TB when she was nine years old. Upon examination he found that she was not completely paraplegic. She had sensory sparing in her right leg but was motor complete with spasticity. He expressed the view that the fact that she was incomplete indicated that there was some spinal cord activity and that further anterior decompression could have been of value to prevent further

⁵² Prof. Vlok explained that TB is very common in the anterior part of the vertebral bodies. It affects adjacent disc spaces which become rotten and collapse. The TB forms a lot of puss (soft tissue mass) which pours out causing a collapse. When the front pillar of the vertebral column collapses a kyphosis forms. He added that a patient would normally suffer from more pain when the spine collapses from trauma or tumours. TB does not result in that much pain.

deterioration and give her a chance for possible improvement although very minute.⁵³

94. Prof. Vlok stated that he could not fault the technique followed and the result of the posterior on-lay fusion (the first operation) performed by Dr Kaschula.
95. For the sake of completeness and for the purposes of this judgment, it is necessary to repeat Professor Vlok's opinion and his summary as reflected in his report (and repeated in his evidence). It reads as follows:

'MY OPINION

She was 9 years old when she was treated for TB which cleared. We do not have the extent and involvement of the TB at that time. It was noted that in 2011 she presented with weakness of her legs. She was evaluated and according to the notes she was still mobile, but weaker in both legs before the first operation. She then had an operation, according to her she could not move her legs, but according to the notes she was up and about and mobile.⁵⁴ She progressively got weaker and the MRI indicated that there was cord compression and non-union, resulting in another operation. Currently she is not complete; she has sensory sparing on the right hand side, some bowel control, but no urinary control. With the information available I am of the opinion that she had neurology prior to the operations and progressively became worse due to the kyphosis. The current diagnosis is that of a kyphus, the precise origin of that is not clear to me, but the most probable is that it was TB in origin. In a growing child a kyphus tends to be progressive and with that in a critical thoracic area progressive neurology as we see here. I am therefore of the opinion that Dr Kaschula's operations did not cause her paraplegia and that it was the natural history of the kyphosis in a growing child. The upper extra-vertebral screws are not the cause of the neurology, because they are not in the canal, but lateral in the bony structure.

SUMMARY

⁵³ According to Dr Kaschula this was suggested to the plaintiff and her family, but they refused further intervention.

⁵⁴ Prof. Vlok explained that both the clinical notes and her blood pressure recordings belied the suggestion that the plaintiff was completely paraplegic immediately after the first operation. The blood pressure recordings showed that there was no insult to the spinal cord during the first operation.

Dr Kaschula did operations on the patient which was growing, had progressive neurology from before the operations. Given the history of TB the diagnosis of a TB kyphosis is the most probable. Overall consensus is that it is a progressive kyphotic deformity with neurology and that the operation did not contribute to the paraplegia which is incomplete.'

96. I have already referred to what Prof. Vlok stated in his addendum report after he was given the benefit of viewing the CT scan done on 20 January 2011. Briefly, the addendum fortifies his original opinion and the reasons therefor. In particular, Prof. Vlok testified that he could see from the CT scan that the TB was healed or in a healing phase because the air in the lungs was visible, there was no soft tissue mass or swelling, and the bone was already consolidating and the same colour as the rest of the bone which was indicative of a healing process.

97. Professor Vlok testified that he requested the MRI dated 23 June 2017 in order to see what the cause of the paraplegia was. The MRI showed cord atrophy over the kyphosis with a spacious canal and no cord trauma. It was consistent with stretching over the gibbus and confirmed that there was no surgical damage. He said that an onlay posterior bone graft does not involve spinal cord entry. It does not interfere with the spinal cord dural sac. It is a very simple and quick procedure. In his words:

'Yes, it does not involve any entry. It is a very simple and quick procedure especially in children. You just roughen it, you pack the bone on and you bail out. And we can see in Dr Kaschula's operation it only took him 40 minutes.'

98. Professor Vlok referred to the assessment recorded by the nursing staff immediately after the first surgery (that all four limbs were warm, pink and moving with sensation present) and said that if there had been an accident intra-surgery the plaintiff's legs would have been flaccid and she would not have been able to move them. He stated that all patients are logrolled every day – not only paraplegic ones. He said that complaints of burning sensations in the legs and feet were common post surgery. He added that a posterior onlay fusion (as performed by Dr Kaschula) is the "way to go" with a

progressive kyphosis. Medication cannot heal a kyphotic deformity. If the deformity is not attended to, it may stabilise but if there is a neurological deficit it has to be attended to again. In the plaintiff's case the need for surgery was indicated because there had been a mechanical failure and progressive neurology. The fact that there was no abscess evident from the CT scan of 20 January 2011, was confirmation that the TB had healed. Acute TB would also have been evident from the ESR results.

99. Professor Vlok stood by the joint minutes of the meeting between himself and the plaintiff's orthopaedic expert, Dr Schnaid, who was not called as a witness. The meeting was held on 8 November 2017 and a final draft of the minutes was recorded on 27 November 2017. For purposes of this judgment, the upshot of these minutes is that the orthopaedic experts (Dr Schnaid and Prof. Vlok) agreed on the following:
 - a. The plaintiff has incomplete paraplegia as a result of spinal TB.
 - b. At Frere Hospital, her family were told that she had a thoracic problem, and that a thoracic surgical procedure needed to be performed. Dr Kaschula was the treating surgeon.
 - c. After a radiological evaluation a posterior spinal procedure was performed by Dr Kaschula on 5 February 2011.
 - d. Dr Schnaid was told by the family that the plaintiff could not move her toes post-operatively and had bladder and bowel incontinence. They said that this subsided and she was carried out of hospital.
 - e. A second surgical procedure was performed by Dr Kaschula on 9 December 2011. At that stage the plaintiff was partially paraplegic with bladder incontinence.
 - f. There is now permanent incomplete paraplegia, with bladder dysfunction.
100. The crisp issue between the orthopaedic experts (as is evident from the minutes) is whether the neurological fallout was due to a progressive kyphotic deformity, or whether it was caused by the first surgery. For the reasons which I have already mentioned, Professor Vlok is of the opinion that there were neurological complications before and after the first surgery, and that this neurological fallout progressed between the two surgeries. The professor

expressed the view that the fallout had nothing to do with the surgery, but was due to a “progressive kyphotic deformity” (which he believed to have been caused by TB destroying the vertebrae at that level). Dr Schnaid on the other hand, is recorded in the minutes to have been of the opinion that the paraplegia was related to the first surgery, for two reasons:

- a. because dysfunction was noted immediately after the first surgery;
- b. because the dysfunction was progressive.

101. No reasons are given in the minutes or in the doctor’s medico-legal report for such an opinion. Nor was Dr Schnaid called as a witness to amplify thereon. What is significant however, is that this report (which purports to have been prepared after Dr Schnaid’s consultation with the plaintiff and P 17 months before they testified), tells a story which is at odds with the plaintiff’s version at this trial on a number of significant issues. I mention but a few:

- a. The report states that when the plaintiff was transferred from Gateway Clinic to Frere Hospital on 6 January 2011, she was, and had been experiencing *pain* in her right knee for a period of two weeks. In the absence of any medical records identifying the source and the duration of this pain, I accept that this is what the plaintiff and/or P told the doctor. The plaintiff and her witnesses however, have been persistent in their denial of the existence of any pain at this time.
- b. The report states that after X-rays were done, Dr Kaschula told the plaintiff and her family that there was a “thoracic spinal problem” and a “thoracic” operation needed to be performed. This information could also not have been gleaned from the available medical records (unless the plaintiff furnished Dr Schnaid with hospital records which were not subsequently discovered in terms of the rules, which has been denied). I accept that this information also came from the plaintiff and/or P. With specific reference to the issue of informed consent, the plaintiff and her witnesses would have this court believe that Dr Kaschula only made vague reference to a bone or bones which may have become loose in her back as a result of a fall. No mention was ever made in their

evidence that the doctor explained anything which involved the *thoracic* spine specifically.

- c. The report states that post-operatively, the plaintiff was unable to move her *toes* and had bladder and bowel problems, but that these appeared to subside and that she was discharged without the assistance of *crutches*. The plaintiff and her witnesses however, testified that she was unable to move her *legs*, and, having been rendered paraplegic post-operatively, she had to borrow a *wheelchair* to get from the hospital to the car that was taking her home. Reference to crutches (in March 2016) which are normally used to assist an ambulant person, as opposed to a wheelchair (in August 2017) which would be needed when the patient cannot walk, to my mind creates the impression that the plaintiff and her witnesses have been particularly selective and significantly inconsistent in the presentation of their versions.
- d. In his report Dr Schnaid states that the plaintiff returned a month after she was discharged and informed Dr Kaschula that she had lost control of her bladder and that she had lost *sensation* in her legs. According to the plaintiff she was told by Dr Kaschula that these symptoms and dysfunctions would subside. During her evidence the plaintiff and her witnesses conveyed the impression that she suffered from complete paralysis and urinary incontinence from the time that she was wheeled out of the operating theatre, and that her condition simply deteriorated from there on. She also made no mention of bowel problems post-operatively. She testified that Dr Kaschula simply ignored her when she returned. It is however evident from the patient information record that the plaintiff returned to Frere Hospital on at least two occasions during the month following upon her initial discharge on 15 February 2011.

- 102. Prof. Vlok testified that he does not know Dr Kaschula and that he did not consult with him. He arrived at the conclusions which I have mentioned based on the scans and the clinical records. He said that whilst it would have been of value to have obtained a MRI scan before the first surgery it was

permissible to rely on a CT scan and X-rays to clinically⁵⁵ evaluate the spinal column. During cross examination he consulted the contemporaneous notes which he had taken when he consulted with the plaintiff, and confirmed that she had told him that when she first visited Frere Hospital in January 2011, she had *pain* in her right knee and her right leg. She said that she had spent a week in hospital suffering from paresthesia in her leg, went home and returned for the first surgery (which she did not consent to). She said that when she awoke from the first operation she could not move or feel her legs and experienced a burning sensation.

103. Prof. Vlok expressed the view that the issue of whether the TB was active or healed, did not need to play a role in the surgeon's decision to perform the first surgery. The indication for surgery had been to stabilise the spine with an onlay graft. He added that if active TB was present he would have placed the plaintiff on anti-TB treatment to kill the micro bacteria.⁵⁶ He would also have expected the surgeon to have discussed the presence of active TB with the patient. He said that if there was an abscess it could have been addressed simultaneously with the onlay fusion by entering the operation site from the side. He would have got rid of the puss from the abscess first because if one does not, it takes a longer time for the patient to heal. Failure to get rid of puss from an abscess could result in paraplegia.⁵⁷
104. When it was put to Prof. Vlok during cross-examination, that the only way to have conclusively determined that the TB was active would have been through blood results, and that one cannot tell from the CT scan alone whether there was TB, his response was the following:

'I can tell yes. I can tell you that it is most possibly tuberculosis, it is not a congenital deformity, and I can tell you that there is destruction which is typical of tuberculosis.'

⁵⁵ Prof. Vlok explained that a "clinical" evaluation means that in order to examine a patient's legs, one examines the nervous system to see whether it is intact or not. That was why spinal TB could be confirmed by X-rays and serological examinations. Specimen results would only confirm TB in the acute phase, not after it has healed.

⁵⁶ According to Prof. Vlok anti-TB treatment would kill the micro bacteria (which caused the disease to be contagious) within 24 hours after which it would be safe to operate.

⁵⁷ This is consistent with what Dr Kaschula said he would have done if presented with an abscess.

105. During cross-examination the professor was asked how he was able to conclude that the TB had healed when he deposed to his report on 5 May 2017. His response was that he based his conclusion on the clinical history from the plaintiff when he saw her during April 2017, the CT scan of 23 May 2014 and the fact that she was in an advanced healing phase.
106. During re-examination Professor Vlok confirmed that he had inter alia considered the following documents before he prepared his report:
- a. An in-patient medication management chart reflecting that a female patient by the name of A S (folder no. 27413673) was admitted to ward G5 on 10 January 2011 with a confirmed working diagnosis of a collapse of T5 and T6.
 - b. An in-patient medication management chart reflecting that the same person (aged 13), having been admitted with the same working diagnosis, had a posterior fusion bonegraft of T2 to T7 on 5 February 2011 (the date of the plaintiff's first operation).
 - c. Dr Counihan's MRI report dated 23 November 2011 (before the second surgery).
 - d. The CT scan and report of 23 May 2014.
 - e. The MRI report and scan of 23 June 2017.
107. He confirmed that the same images were reflected in the two MRI scans.

Factual and expert witnesses – discussion on the applicable law

108. It is trite that in a claim founded on contract and/or delict, the plaintiff must prove, on a balance of probabilities:
- a. negligence on the part of the defendant's servants (in the form of an act or omission);
 - b. that the negligent act or omission caused the harm suffered by the plaintiff.

109. Only causal negligence can give rise to legal responsibility.⁵⁸
110. The plaintiff has pleaded that the defendant's servants (and in particular Dr Kaschula) were negligent in one or more of the following respects:
- a. They failed to examine her properly and thoroughly.
 - b. They failed to properly evaluate her complaints of "pain" in her lower limbs and knees.
 - c. They failed to prudently refer her for necessary and additional X-rays and MRI scans.
 - d. They performed a spinal fusion operation without giving care and consideration to the "applicable standards", thus rendering her paraplegic.
 - e. They failed to ensure that the fusion was done in a "current and proper" way.
 - f. They failed to take "precautions" and they failed to exercise proper "skill, diligence and care" in identifying, diagnosing and treating her so as to avoid rendering her paraplegic.
111. In the alternative to these claims, the plaintiff pleads that the defendant's servants were negligent in that they failed to obtain informed consent for the two operations. In this regard it is pleaded that they, and Dr Kaschula specifically, failed to:
- a. Disclose Dr Kaschula's diagnosis of spinal TB to her or to her relatives;
 - b. Comprehensively discuss all the material advantages and the disadvantages of the operations with her guardians.
 - c. Comprehensively discuss the advantages and disadvantages of other forms of treatment with her guardians.
112. It is apparent from these pleadings that the only averments which have been made with respect to causation (and I intend attaching to the pleadings a wide interpretation for the plaintiff's benefit) is that the defendant's servants:

⁵⁸ See *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC) par. 37

- a. Failed to properly “identify”, diagnose and treat the plaintiff.
- b. Performed the first operation carelessly, improperly and without giving thought to the current “standards applicable”.

113. At the conclusion of the trial, it was contended on the plaintiff’s behalf that:

- a. Dr Kaschula negligently failed to obtain the plaintiff’s guardian’s informed consent to perform the first surgery;
- b. Dr Kaschula’s negligence (as referred to in paragraph 110 above) “resulted in the plaintiff’s paraplegia caused by the first surgery”.

114. The plaintiff’s heads of argument set forth the final issue for determination as follows:

‘The issue is whether the defendant incurred liability for negligence as a result of Dr Kaschula’s failure to warn the plaintiff (P and/or Mrs Z) of the material risks and complications which might flow –

- From a failure to obtain an MRI and blood test results in respect of the plaintiff’s suspected spinal TB;
- From a failure to first implement conservative anti-TB treatment for a period of 6 to 9 months.’

115. To my understanding, it is ultimately contended that Dr Kaschula’s failure to obtain MRI scans and blood test results, together with his failure to first implement conservative anti-TB treatment, amounts to negligence which caused the plaintiff to be rendered paraplegic.

116. Plaintiff’s counsel has prevailed upon me to arrive at this conclusion by relying on the “factual version” or the “first-hand factual evidence” presented by the plaintiff, P and Mrs Z as “coherent and reliable”. In so doing, it is contended that I ought to reject:

- a. the evidence of Prof. Vlok and Dr Counihan as subjective and unreliable;
- b. Dr Kaschula's version of the events, particularly in respect of material issues, as highly improbable;
- c. any recordings in the medical and clinical records in respect of which the authors were not called, as inadmissible hearsay in terms of the Law of Evidence Amendment Act ("the Evidence Act").⁵⁹

117. It is rare, in claims of this nature, that this court has the benefit of listening to the testimony of the plaintiff and the medical practitioner who has been accused of negligent conduct. In my experience, prosecution of medical negligence claims are more often than not, the subjects of inordinate delay. Factual witnesses and records are no longer available. The parties rely on expert witnesses who sometimes have to base their opinions on the physical presentation of the plaintiff alone, many years post the alleged morbid intervention, with very little else to go by.

118. In the matter before me, the plaintiff's counsel has advocated reliance on the factual witnesses only (and then only those called by the plaintiff), and the rejection of at least the evidence of Prof. Vlok and Dr Counihan. These witnesses have been described as subjective and unreliable, and in the context of "hired guns" for the defendant.⁶⁰

119. With respect to the value to be attached to the evidence of factual witnesses, I cannot agree more. I have listened very carefully to the testimony of the factual witnesses for that very reason. I am not inclined however, to simply ignore the evidence of the experts, particularly where they make common cause with the factual witnesses or with each other for that matter.⁶¹ In this regard, Dr Mpotoane agreed with the plaintiff's case with respect to, inter alia, the following:

⁵⁹ In terms of section 3(1) of the Law of Evidence Amendment Act 45 of 1988

⁶⁰ See *Schneider NO and Others v AA and Another* 2010 (5) SA 203 (WCC) at 211

⁶¹ By way of example, Dr Mpotoane who was called by the plaintiff agrees that Dr Kaschula's surgical decision making and treatment of the plaintiff was reasonable.

- a. TB could cause damage to the spinal cord in various ways including TB that changes the shape of the spine so that the misshapen spine impacts on the cord.
- b. For surgery to cause paraplegia the surgeon must either cause trauma directly to the spinal cord or the dural sac around the cord or by severing a blood vessel or vessels that supply the cord (it is not disputed that there is no evidence that any of this happened).
- c. It is appropriate to adopt a conservative approach to treatment of spinal TB in a child, firstly in terms of deciding whether surgery is indicated and secondly, once indicated, to select that form of surgery which is likely to impose the least threat to the spinal cord.
- d. Spinal TB is often accompanied by or preceded by pulmonary TB.
- e. More than one vertebra will be affected by spinal TB because segmental arteries bifurcate to supply two vertebrae (as found by Dr Kaschula and Dr Counihan).
- f. The spinal deformity is a hallmark feature of spinal TB.
- g. Spinal TB is manifested by disc collapse, destruction of the disc space between adjacent vertebrae, destruction of the vertebral body where the thoracic vertebrae are affected, and anterior wedging of adjacent thoracic vertebrae. The result is a gibbus deformity or kyphosis.
- h. The reason why a patient with spinal TB develops an unnatural sharp bend in the spine in the form of a khyphosis is because of the transmission of weight anteriorly which compacts on the infected vertebra more anteriorly than posteriorly and hence the collapse and forward bend.
- i. The vulnerability within the vertebrae which gives rise to the anterior wedging and deformity in the spine is created by the presence of TB in the vertebrae.
- j. With respect to the CT scan performed pre-operatively, he agreed that the point of angulation of the spine in the scan was the point of the kyphosis. He also agreed that the scan showed a clear instance of disc collapse with the discs having disappeared and the vertebrae having been fused, along with destruction of vertebral body.

- k. He agreed with the opinion of Dr Counihan that the T6 vertebra had in fact disintegrated completely so that what one sees on this CT scan is a union of T5 and T7.
- l. He agreed that this CT scan manifested the phenomenon of anterior wedging caused by the weight on the damaged bone tissue in the vertebrae.
- m. When it was put to him that what was visible from the first CT scan were the typical consequences of spinal TB, he said "that will be number one on my list".
- n. He agreed that damage to the spinal cord can also cause spasticity (which was his description of the plaintiff's presentation immediately after the first surgery) and often the first sign of neurological deficit and spasticity would be an abnormal gait and weakness of the legs.
- o. He agreed that it is well established that in spinal TB cases the neurological deficit may develop into paraplegia.
- p. In particular, he agreed that there are two types of paraplegia which can be caused by spinal TB. The first is early onset paraplegia which develops when the disease is still active. The second is late onset paraplegia which develops in a patient with healed TB and kyphotic deformity (in line with the defendant's case).
- q. There is no guarantee that treatment, whether chemotherapy or surgery, will prevent paraplegia.
- r. The development of paraplegia in spinal TB cases is progressive, especially in children (progressive meaning that the symptoms become progressively worse over time), and that children are much more vulnerable because their spines are growing.
- s. He agreed that the symptoms described in the plaintiff's medical records prior to the first operation point to serious neurological problems.
- t. He ultimately conceded that the kyphosis (whatever its cause) was the cause of the corresponding atrophy in the spinal cord.
- u. He significantly agreed that in the CT scan of 20 January 2011, the area in the spinal canal surrounding the dural sac is completely black and that this would exclude the presence of an abscess (in line with the evidence of Dr Kaschula, Dr Counihan and Prof. Vlok).

- v. He stated that chemotherapy is the main form of TB treatment, but that in some cases surgery (and not just chemotherapy on its own) would be appropriate particularly where there is a progressive neurological deficit and where there is mechanical failure of the spine and a significant khyphosis because the khyphosis and the mechanical failure would become more severe over time.
- w. It was put to Dr Mpotoane that the object of the surgery performed by Dr Kaschula was firstly to stabilise the spine and stop it from collapsing further and (as in the case with the plaintiff who was a child), arresting the khyphosis posteriorly which would result in elongation of the spine anteriorly, tending to result in a decompression of the pressure on the spinal cord as the spine straightens. Dr Mpotoane accepted the correctness of these propositions although qualifying it to the extent that decompression would take place in the long term.
- x. He agreed that a posterior bone graft (as performed by Dr Kaschula) is a conservative form of surgery which would not present a significant risk to the patient because it does not go near the spinal canal, the dural sac or the spinal cord.
- y. Finally, Dr Mpotoane was asked to comment on the following extract from a letter addressed by Dr Schnaid to Prof Vlok:

'The patient has an incomplete paraplegia as a result of spinal tuberculosis'.

His response was that this was Schnaid's opinion. When I attempted to clarify this response, he said that, due to the information at his disposal, he could not conclusively blame the TB entirely for the paralysis, that he could not say whether the opinion was wrong or right, and that, at the end of the day, Dr Schnaid's conclusion was a reasonable one.

- 120. The defendant has been criticised for not calling orthopaedic surgeon Dr Mwangalawa, whose report forms part of the defendant's expert bundle. It appears that the plaintiff wishes to emphasise and rely on the following statements made in the report:

- a. That chemotherapy is the gold standard of TB treatment;
- b. That amongst others, the principles of surgery for TB spine are a decompression of the spinal cord and stabilising the spine to prevent or correct the deformity.

121. The plaintiff's contention appears to be that Dr Kaschula was negligent because he did not follow these suggestions. It is trite however that this is not the test for negligence. The proper approach is to consider each case upon its own facts, and to be guided by the principles set forth in matters such as *Van Wyk v Lewis* where Wessels JA said the following:

'We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted, or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent.'⁶²

122. The plaintiff, having raised the discussion set forth in Dr Mwangalawa's report, is constrained to take the good with the bad. The bad part for the plaintiff is that Dr Mwangalawa, in his conclusion, supports the course of conduct followed by Dr Kaschula in more fervent terms perhaps, than any of the other experts. His conclusion (in the absence of the benefit of the first CT scan) reads thus:

'The diagnosis of TB spine was correct and appropriate treatment was given to A G.

The pain in the legs and the limping was due to pathology in the spine. Her spinal cord was compromised by the disease process.

The development of complete paraplegia of A G cannot be attributed to negligence of the surgical team or nursing staff at Frere Hospital (emphasis added).'

⁶² 1924 AD 438 at 461

123. To my mind, facts agreed by the experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference. Litigants are not at liberty, as a matter of principle, to repudiate opinion agreements which have been reached in the joint minutes of experts. In my view then, concessions made by experts called by one party in favour of the views of the experts for the opposing side, should enjoy the same status. Whilst it is always so that the evidence of expert witnesses cannot be allowed to usurp the function of the trial court, the circumstances in which a trial court will find itself bound to reject agreements of experts from opposite sides, are rare.⁶³

The factual witnesses

124. It is with this approach in mind that I turn to the contention that (based on the evidence of the plaintiff and her two relatives), negligence causing paraplegia has been proved on a balance of probabilities.
125. Dr Counihan concluded that his comparative study between the CT scan before the first surgery and the MRI scan thereafter shows that the plaintiff did not present with active spinal TB before the first operation. I have some difficulty in understanding the contention on the plaintiff's behalf, that this conclusion is unconvincing and militates against the "factual version" presented by the plaintiff, P and Mrs Z. I say so because none of the plaintiff's factual witnesses suggested that the plaintiff presented with active spinal TB before the first surgery. On the contrary, I gained the distinct impression that these witnesses were making their best endeavours to distance themselves as far as possible from any suggestions that the plaintiff suffered from (or was treated for) any form of TB both before and after the first operation, or at all for that matter. I have been invited on the plaintiff's behalf to disregard Dr Counihan's evidence "in consequence of the first-hand factual evidence" presented by the plaintiff and her relatives. The effect of this is that I must:

⁶³ The approach to be adopted was fully canvassed by Rogers AJA (delivering judgment for the majority) in *BEE v RAF* 2018 (4) SA 366 SCA383 I to 384 F.

- a. Accept the plaintiff's version that she did not suffer from and was not treated for TB before the first surgery (because this is what she says);
 - b. Alongside this acceptance, find as a fact (without taking into account the expert evidence or radiological evidence) that the plaintiff was suffering from active TB just before, and presumably during the first operation (despite the fact that this was not pleaded).
126. In my view this type of approbative and reprobative reasoning is void of any logic and has no basis in law. Indeed, I prefer the plaintiff's contention, that in medical actions, where the reasonableness of a defendant's conduct has to be decided on the basis of expert medical evidence, the court should attempt to determine whether the opinions are founded on logical reasoning.⁶⁴
127. The onus is on the plaintiff to prove her case on a preponderance of probabilities. In her *pleadings* she avers that she:
- a. Approached the hospital with *painful knees* and a limp on 10 January 2011;
 - b. Was told that she should undergo spinal surgery as the preferred treatment for her condition;
 - c. On 5 February 2011 a posterior fusion of T2 to T7 with onlay bone graft chromos and skin clips for closure was performed on her by Dr Kaschula.
 - d. This surgery was negligent and rendered her paraplegic.
128. The plaintiff and her two relatives (on whom it is contended I should rely exclusively, reject the evidence of the medical staff who dealt with her at the time and any contemporaneous recordings, and ignore any comments made on her condition by experts who were granted the opportunity to consider hospital records from before, during and after the first operation), were not entirely candid with this court. I have already dealt with their evidence fully. I will highlight a few instances of concern to me:

⁶⁴ *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA); *Medi-Clinic Ltd v Vermeulen* 2015 (1) SA 241 (SCA) paras 4-8.

- a. The plaintiff and her witnesses have denied in the strongest possible terms that she suffered from any pain whatsoever when she was admitted. This denial is persisted with, notwithstanding that the existence of pain is mentioned in her pleadings, is recorded to have been mentioned by her in her consultations with experts on both sides⁶⁵, and is recorded to have been mentioned by her in copies of contemporaneous hospital records (which I am invited to exclude as inadmissible hearsay) which the plaintiff has had at her disposal since the time she removed her own folder from the hospital (at the time of the surgery).⁶⁶
- b. The plaintiff and her relatives disown any direct or indirect knowledge of or treatment for TB either before, during or after the surgery. They also insist in their evidence that the plaintiff was wheeled from the first surgery in a completely paraplegic state. This, despite the fact that the report of the plaintiff's orthopaedic surgeon (dated March 2016) states that (a) a surgical procedure was performed on her left leg in 2006 and a diagnosis of TB was made; (b) when she was transferred to Frere Hospital she had been experiencing right knee *pain which had been present for two weeks*; (c) post operatively she could not move her toes and had bladder and bowel problems which appeared to subside; (d) she was not given crutches and had to be carried to the car by her sister (this could only have come from the plaintiff and her relatives but is contradicted by their oral evidence where they say that the plaintiff had to be wheeled in a wheelchair to the car that was taking her home)⁶⁷; (e) only a month later she told Dr Kaschula that she had lost *sensation* in her legs and was suffering from urinary incontinence (in her evidence the plaintiff claimed

⁶⁵ See the reports of Dr Schnaid and Professor Vlok

⁶⁶ On the plaintiff's version, Phumza removed the plaintiff's personal medical folder from the hospital at the time of the surgery, took it home and made copies of some of its contents, and then returned it. On the defendant's version, the folder was empty. This resulted in the plaintiff discovering medical and clinical records which would otherwise have been in the possession of the defendant.

⁶⁷ This is particularly significant when viewed in the light of the evidence given by the plaintiff's expert Dr Mpotoane whose version is that if the patient walked into the surgery with no pain and she came out as a paraplegic in a wheelchair, one can "assume" that something went wrong during that surgery. This assumption is not based on the defendant's version. Indeed, when it was put to the doctor that the plaintiff's unfortunate condition was caused by a progressive kyphosis, he said "If she was walking after the operation and deteriorated, that is different. But if she is in a wheelchair immediately after the operation, that is a problem."

urinary incontinence at the time that she was wheeled from the first surgery); (f) it was only after the *second* surgery on 9 December 2011, that she was rendered completely incontinent and paraplegic.⁶⁸ Indeed the report of orthopaedic surgeon Dr Mwangalawa categorically states the following:

‘In her past medical history, A was treated for tuberculosis of the left leg in 2006, and in November 2010 she had an abscess of the left leg, which was treated with debridement and antibiotics.’

- c. It is significant that Dr Mpotoane (who was the only expert called by the plaintiff), when he consulted with the plaintiff and her family in November 2014 and had the copies of the medical records which she took from her file at his disposal, records that the plaintiff and her family told him that the plaintiff had no history of spinal disease, meningitis, mental illness or epilepsy prior to her admission in 2011. His report is silent on what the plaintiff and her relatives had to say about TB, which is something which I would have expected the good doctor to have canvassed with her, particularly in the light of his disconcerting evidence “*that every black man in this country, at one stage or another, has had TB, not knowing*”, and more particularly in the light of the fact that the medical records which the plaintiff gave him stated clearly that she was seen and admitted as “a follow up” who had previously been seen with TB of the *left* leg in 2006 and was treated at Frere Hospital for six months.⁶⁹ The notes further state that she was also seen with a new abscess on 9 November 2010 which was drained and treated with oral antibiotics and that when she visited the hospital in January 2011, she complained of a *painful right leg, pins and needles and a limping gait*. It is furthermore significant that Dr Mpotoane’s report refers to spasticity in both legs (as opposed to paraplegia) after the first surgery. It is with this information at his disposal

⁶⁸ This is entirely consistent with Dr Khashula’s evidence, the hospital and clinical records, the report and evidence of Professor Vlok and the reports and evidence of Dr Counihan.

⁶⁹ In this regard the doctor’s clinical examination revealed multiple healed scars on both the left and the right knees. Despite these multiple healed scars it appears that the plaintiff told her urologist, Dr Steyn, that she could not recall any injury to the leg.

that Dr Mpotoane commented in his report that one *may only assume* that something negative happened during the procedure resulting in spinal cord injury.

- d. It is contended on the defendant's behalf that in truth, the testimony of Dr Mpotoane served only to confirm the absence of any prima facie case on the part of the plaintiff, and to lend support to the defendant's defence that the plaintiff's paraplegia was caused by the acute khyphotic deformity of her spine brought about by spinal TB. During cross-examination Dr Mpotoane was challenged about his assumption that something had gone wrong during the surgery. In response, he was constrained to concede that there was no evidence to suggest that something negative had transpired during the first procedure resulting in spinal cord injury.

129. I am inclined to agree that having made that concession, there was nothing left of the plaintiff's case that the operation, or something which happened during the course thereof, caused the paraplegia.

130. As stated on the defendant's behalf, the adoption of this approach of making assumptions would at best for the plaintiff mean that she is attempting to apply the *res ipsa loquitur* (the thing speaks for itself) maxim to the facts of her case. With respect to the application of this maxim, Ponnann J said the following:

'Thus, in every case, including one where the maxim *res ipsa loquitur* is applicable, the enquiry at the end of the case is whether the plaintiff has discharged the onus resting upon her in connection with the issue of negligence ... That being so, and given what Holmes JA described as the "evolved mystique of the maxim", the time may well have come for us to heed the call of Lord Justice Hobhouse to jettison it from our legal lexicon. In that regard he stated in *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998):

"In my judgment the leading cases already give sufficient guidance to litigators and judges about the proper approach to the drawing of inferences and if I were to say anything further it would be confined to suggesting that the expression *res ipsa loquitur* should be dropped from

the litigator's vocabulary and replaced by the phrase a *prima facie* case. *Res ipsa loquitur* is not a principle in law: it does not relate to or raise any presumption. It is merely a guide to help to identify when a *prima facie* case is being made out. Where expert and factual evidence has been called on both sides at a trial its usefulness will normally have long since been exhausted."⁷⁰

131. It is trite that to hold a surgeon negligent simply because something had gone wrong during the course of surgery would be to impermissibly reason backwards from effect to cause. But in any event, this is not the plaintiff's case. The plaintiff is seeking an order in her favour because it is *assumed* (based on the aforesaid maxim) that something *must have* gone wrong during the course of the surgery.
132. Broadly stated, the maxim is nothing more than a convenient Latin phrase used to describe the proof of facts which are sufficient to support an inference that a defendant was negligent and thereby to establish a *prima facie* case against him. The maxim is no magic formula. Nor is it a presumption of law. It is merely a permissible inference which the court may employ if upon all the facts it appears to be justified. The maxim alters neither the incidence of the onus, nor the rules of pleading, it being trite that the onus resting upon a plaintiff does not shift.⁷¹
133. It is therefore necessary for the plaintiff, if she were to succeed, to have produced positive *prima facie* evidence of both causation and negligent conduct, neither of which she has thus far been able to do.
134. It is not in dispute that Dr Christoffels completed the plaintiff's inter departmental referral form on 6 January 2011 when she was admitted. The point taken on the plaintiff's behalf is rather that Dr Christoffels, by his own admission, had no independent recollection of the plaintiff and could not remember where he had obtained the information which he recorded. This may well be so. However, in the light of the fact that a copy of this document was discovered by the plaintiff, and due regard being had to the contention

⁷⁰ *Goliath v MEC for Health* 2015 (2) SA 97 SCA 104H-105A

⁷¹ *Goliath* supra 103F-I

that it was not returned to the defendant's servants post removal, the only possible inference in the circumstances is that the historical information which is recorded here either emanated from the plaintiff and/or her relatives and/or from historical records kept by the hospital. A further compelling inference is that the contemporaneous information (stating that the plaintiff is now complaining of right leg pain and paraesthesia) could only have come from the plaintiff and/or her guardians.

135. Sister Tshengu testified regarding her own progress notes made four days after Dr Christoffels admitted the plaintiff. Once again reference is made to pins and needles of the right leg (paraesthesia). This time the plaintiff is recorded to have been complaining of pain to both her legs. Sr Tshengu confirmed (from her contemporaneous notes) that by 28 January the CT scan results had been seen by the "doctors" and were tabled for discussion with Dr Kaschula the following week. I have already discussed what Sr Tshengu meant when she recorded the words "warm, pink, moving with sensation present".
136. As I have said, all this information was rejected outright by the plaintiff and her witnesses as a pack of lies. It is perhaps convenient at this juncture to traverse why I have already referred to the clinical records which the plaintiff contends ought to be ruled inadmissible.

Hearsay

137. The defendant has applied for those portions of the medical records in connection with which the authors of the entries were not called to testify and which were not formally admitted as the truth, to be received as admissible hearsay in terms of section 3(1)(c) of the Evidence Act.
138. The relevant section provides as follows:

'Subject to the provisions of any other law, hearsay evidence shall not be admitted as evidence at criminal or civil proceedings, unless –

....

(c) the court having regard to -

- (i) the nature of the proceedings;
- (ii) the nature of the evidence;
- (iii) the purpose for which the evidence is tendered;
- (iv) the probative value of the evidence;
- (v) the reason why the evidence is not given by the person upon whose credibility the probative value of such evidence depends;
- (vi) any prejudice to a party which the admission of such evidence might entail;
- and
- (vii) any other factor which should in the opinion of the court be taken into account,

is of the opinion that such evidence should be admitted in the interests of justice.'

139. These are civil proceedings. Apart from Dr Kaschula, none of the factual witnesses which were called appeared to have an independent recollection of the plaintiff. *Aide memoires* such as these can turn out to be invaluable particularly when witnesses are expected to cast their minds back to what may have transpired in a very busy hospital close on seven years previously, when litigation was not in contemplation. As stated by the defendant's counsel, given the contemporaneous nature of such notes and records, they are not susceptible to the vagaries of the frailty of human memory. It has also been contended on the defendant's behalf that contemporaneous notes allow little room for *ex post facto* adjustment or tailoring of the evidence to suit the defendant's case. I agree. This is particularly so when copies of the notes are produced by the plaintiff and not the defendant. It has also, importantly in my view, been contended that the notes are predominantly made by nurses in a claim where the accusation of negligence is made against the operating surgeon rather than the nurses involved. It is in any event so that all the expert witnesses have to a greater or lesser extent relied on these medical records (or their absence for that matter) in arriving at their conclusions, including the three expert witnesses who prepared reports on the plaintiff's behalf. Reference was made to these notes by both counsel during the course of the trial before me. As I understand the position in any event, the main

purpose of tendering this evidence is to corroborate the cogent radiological evidence obtained at the time.

140. As I have said, when Dr Christoffels and Sr Tshengu were called to testify regarding some of their notes, they were challenged in the main regarding whether they were in a position to confirm that that which is recorded in the folder pertains to the plaintiff before me. They were not seriously challenged with respect to issues such as credibility and accuracy. In the premises I am inclined to agree that for the defendant to have called each and every person who made an entry in the plaintiff's folder, only for those persons (in all probability) to confirm their entries by rote, would amount to an inordinate waste of time and resources.
141. As I have said before, the plaintiff has displayed a tendency to both approbate and reprobate. Her resistance to the admission of that which she herself sourced from her own hospital file is an example of this. The plaintiff cannot be seen to have her cake and eat it. Whilst I am of the view that the plaintiff already faces an insurmountable challenge in proving her claim, admitting this medical evidence would have the effect of "completing the mosaic of the defendant's case"⁷². In my view then, the interests of justice dictate the admission of the evidence reflected in the medical records (referred to at the beginning of this judgment) where such evidence has not been orally confirmed by the authors thereof, or where such evidence has not been tendered by consent, and the evidence is so admitted.
142. Having said that, I am inclined to view the argument about the admission of this evidence as a bit of a storm in a teacup. The records which have either been admitted or confirmed by *viva voce* evidence, have, in my view in any event sufficiently established the "pattern of the mosaic", which is simply this:
 - a. That the plaintiff had visited Frere Hospital before and that she was treated for TB;
 - b. That the plaintiff was in pain and suffering from paraesthesia when she was admitted;

⁷² Extracted from *S v Ndhlovu and others* 2002 (2) SACR 325 (SCA) at para 44

- c. That within four days of her admission (and before the first surgery), the pain had progressed from her right leg to her left leg as well;
 - d. That some three weeks post her admission, a CT scan had been done and had been studied by doctors to be discussed the following week with Dr Kaschula;
 - e. That immediately after her surgery the plaintiff's vitals were normal and she was able to feel and move her limbs.
143. The documents which have been ruled admissible simply corroborate that which I have set forth above, and in particular Dr Kaschula's version that the plaintiff would only have degenerated into a definitive state of paraplegia some time after she was discharged from the first operation, and shortly before the second one.
144. It has further been contended on the defendant's behalf that the patient information computer printout from the hospital's computer system or database complies with the definition of a data message as referred to in section 15 of the Electronic Communications and Transactions Act 25 of 2002 ("ECTA"), and is accordingly admissible in evidence and proof (albeit rebuttable) of the facts contained in the record. Ms Nxelewa⁷³ spent some time in the witness box explaining the status of hospital folders and how data is captured and stored. She described the patient information form as a computer printout which explains the "in- and out-goings" of the patient. This evidence was not significantly challenged. As I have said before, it is in any event abundantly clear from the printout that it relates to the plaintiff. It reflects the same folder number reflected in all the hospital records and reports before this court. It correctly reflects her name, surname, gender, address, status, occupation and the particulars of her mother. Significantly, it confirms the clinical records that the plaintiff was admitted to the casualty ward of Frere Hospital during the previous year for surgical purposes. It also reflects that between the first and second surgery, the plaintiff visited the hospital on no less than ten occasions.

⁷³ The deputy director of general administration at Frere Hospital

145. As I have said, the plaintiff and her relatives did not impress me as witnesses. On the other hand, Dr Kaschula made a favourable impression on me as a factual witness who was required to recall what happened almost seven years ago in a particularly busy public hospital.⁷⁴ He struck me as a conservative, dedicated and hard-working medical practitioner, who had been rendered both vulnerable and devastated by claims impacting on his work ethic and his conduct. He was careful not to blame the plaintiff for the disappearance of the medical records and his notes. When I asked him if he would, with hindsight, have operated differently, his spontaneous response was the following:

‘Certainly not as far as my clinical decision making was concerned. Looking back in hindsight, I would be much more inclined to photostat my clinical notes - to have my own copies in all cases where there is a potential controversy. But it is very difficult to work out which cases are going to be controversial and which are not ... I consider my clinical decision making in this case to be faultless. It was - in this context it was unfortunate that the patient disappeared for follow up after the second operation, because I would certainly have considered sending her down to Cape Town for a second opinion, but was unable to do so, because she simply was not available to me. ... There are more extensive surgical procedures that can be done ... to certainly correct the kyphotic deformity ... So there is certainly scope to consider a third procedure, but as I say this would have been a highly sophisticated spinal operation, which only three or four surgeons in the country could have done.’

146. Dr Kaschula explained that the plaintiff was kept in hospital pre-operatively for a long time because they were, amongst other reasons, waiting for the results of the CT scan. They did not want to send her home in the interim because they were concerned about the stability of her spine and deemed it appropriate that she should be kept on strict bed rest, which is very difficult at home, particularly with a young child. Of particular significance in my view, was Dr Kaschula’s concern that if he did not perform the first operation timeously, the plaintiff would develop *cor pulmonale*. He explained that the clinical problem of *cor pulmonale* in the context of this case is that when the

⁷⁴ Dr Kaschula testified that the outpatients clinic alone dealt with on average, 200 patients a day, of which he would deal with more than 60.

spine collapses further and further it compresses the space available for the patient to breath. This can sometimes lead to heart failure.⁷⁵

147. I have already dealt in detail with Dr Kaschula's testimony. As the doctor who performed the impugned surgery, his evidence regarding the issue of causation is important. To my mind he provided a far more credible factual version of the events than that provided by the plaintiff and her guardians. Notwithstanding the absence of his notes, it is significant that his evidence was corroborated in every material respect by that which is reflected in the nursing records and the radiology reports and images. By contrast, the evidence of the plaintiff and her witnesses was contradicted in material respects by the medical records and images.
148. Mr Dodson for the defendant has set forth a list of the features of Dr Kaschula's evidence which bear emphasis. I agree with the list and repeat it in shortened form with some additions:⁷⁶
 - a. His description of the seriousness of the plaintiff's condition upon admission is supported by the medical records and the images.
 - b. His diagnosis of healed spinal TB (as opposed to a bone which had become loose in her back as suggested by the plaintiff) is supported by all the expert evidence and the radiological images, particularly by the CT scan of 20 January 2011 ("the first scan").
 - c. His acknowledgment of TB is supported by his prescription of Rifafour⁷⁷ as reflected in the medical records.
 - d. His explanation for doing this as a precautionary measure, despite his view that the TB had healed, has not been criticised by the experts.
 - e. His denial of having promised the plaintiff that she would walk again, is borne out by the very clear and compelling evidence of the extent of the compromise of her spine from before the first operation.

⁷⁵ Dr Mpotoane in his evidence gave a similar description. In the circumstances of this case it seems that Dr Kaschula's intervention may well have been life preserving in the long term.

⁷⁶ The heads of argument submitted by counsel on both sides have been of invaluable assistance and I am indebted to them.

⁷⁷ Rifafour is a combination of four drugs commonly used to treat and cure TB.

- f. Dr Kaschula gave a lucid account of the first surgery and confirmed that there were no complications. He did not enter the spinal canal, the dural sac or the spinal cord. He did not interfere with the blood vessels supplying the spinal cord. The post-operative records reflect that there were no complications and that all the plaintiff's vital signs were normal.
- g. He confirmed that all patients are catheterised prior to surgery. This is standard practice. The plaintiff's version that she was not catheterised (which version vasculated to some extent) is highly improbable and is belied by the nurses' notes. His evidence, that if the plaintiff was paraplegic her catheter would not have been removed (as per the medical records) is logical and sensible in the circumstances.
- h. This applies too, to his evidence that it is unlikely that the plaintiff would have been able to master a wheelchair four to five days after having been rendered acutely paraplegic.⁷⁸ This process would have taken two to three weeks if she was paraplegic, and would have been further delayed by interaction with the family and lessons on how to master the wheelchair which would have taken several weeks.
- i. Kaschula explained that the plaintiff's discharge was delayed because she had a massive spinal deformity before the surgery, resulting in decreased neurological function causing paraparesis. There is nothing improbable, unreasonable or illogical about this explanation.
- j. Dr Kaschula explained that he was responsible for the Monday clinics which the plaintiff attended after the first operation (this is confirmed by the medical records and the computer printout). The records and his evidence contradict the plaintiff's version that he simply ignored her and that she was shoved from pillar to post.
- k. Dr Kaschula himself testified to her gradual deterioration from having been able to walk with difficulty initially to not being able to walk by September 2011 when she was provided with a wheelchair.⁷⁹
- l. There is no criticism of his evidence regarding the decision making process around and the conduct of the second surgery.

⁷⁸ The plaintiff's version is that she was placed in and used a wheelchair immediately after the first surgery.

⁷⁹ The computer printout confirms that the plaintiff was admitted to the orthopaedic section of the hospital from 19 to 23 September 2011.

- m. He disputed having told the plaintiff and her witnesses that there was a mistake in the first operation which necessitated a second operation which would make her walk again.
- n. His version, that there was no abscess in the spinal canal when he operated (as suggested by the plaintiff's counsel) is confirmed by the medical records, the radiological records, and the expert witnesses on both sides.⁸⁰
- o. In the light of Prof. Vlok's evidence (that in the absence of an abscess the activity or otherwise of TB plays no role provided that TB medication had been taken for 24 hours), the course of conduct followed by Dr Kaschula cannot and did not attract any criticism.
- p. Much was made of Dr Kaschula's alleged failure to determine finally and conclusively whether or not there was active TB before he proceeded with the surgery. I accept that the steps which he did take were sufficient to reasonably exclude such a possibility. But even if I am not correct, in my view it made no difference to his surgical decision making. I say so because it is clear from his evidence (and his reasoning is supported in this regard) that the main thrust of the surgery was to address the abundantly clear mechanical failure of the spine, regardless of its cause. This was a manifestly reasonable approach to adopt. Doctor Mpotoane conceded that much.

149. In view of what I have already said, I am inclined to prefer the evidence of Dr Kaschula, and in particular where it conflicts with that of the plaintiff and her lay witnesses.

150. In the premises I agree with the defendant's counsel. Despite the wealth of lay and expert evidence and the detailed written argument filed, the solution to this tragic case is largely revealed by a single item of evidence. That is the CT scan of the plaintiff's spine taken on 20 January 2011. It is not disputed that this CT scan reveals, pre-operatively, the plaintiff's severely kyphotic spine showing all the hallmarks of the catastrophic damage caused to the vertebrae

⁸⁰ Dr Kaschula testified that he could see that there was no active TB in the bone due to the absence of a "salt and pepper appearance" on the original X-ray and the first scan.

by extra-pulmonary or disseminated spinal TB. It is not in dispute that the disease it depicts the plaintiff to be suffering from is one of the highest causes of paraplegia in South Africa. It has for centuries been recognised as the highest cause of paraplegia.

151. This being the case, and in the light of my views on the evidence as a whole, the plaintiff has failed to establish a prima facie case against the defendant. Even if I am not correct in this regard, it is abundantly clear that any testimony from the plaintiff which may be suggested to have established a prima facie case, has been successfully rebutted by the clear, concise, credible and persuasive evidence of Dr Kaschula, materially corroborated by members of the Frere Hospital staff, and their notes, and most importantly extensively corroborated by the independent radiological evidence of Dr Counihan and the independent views of Prof. Vlok. There is no indication that these witnesses, with their wealth of experience and expertise, were in any way biased or that they unduly favoured the defendant's case.

Informed consent

152. The plaintiff amended her particulars of claim to introduce as an "alternative" ground of negligence, an alleged failure to obtain the requisite informed consent for the surgery. Having found that the operations did not cause the plaintiff's paraplegia, the issue of informed consent becomes academic. Even if the evidence were to show that the consent was somewhat wanting, no damages flow from the surgery. The plaintiff must demonstrate that she was not only inadequately or improperly informed of all the possible consequences, side effects, risks and sequelae of the surgery, but also that one or more of the things that could possibly have gone wrong, did go wrong. This is not the case before me. Negligence in the air is insufficient. Differently stated, the defendant has placed no reliance in her plea or in the evidence tendered on a notion that the plaintiff consented to a risky operation, which risk then materialised. The defendant's case, as pleaded and presented throughout (which evidence has been accepted by this court) is that the

plaintiff's paraplegia was caused by her kyphotic spine (which developed as a consequence of her having contracted spinal TB).

Conclusion

153. The plaintiff's story is a tragic one. The position she finds herself in is most unfortunate. That goes without saying. However, it has not been shown that the defendant's servants are accountable. On the contrary, the probabilities are that this tragedy befell her when she contracted TB at a much earlier stage, and long before she reported to Frere Hospital in January 2011.

154. Counsel for the defendant has referred me to a portion of the judgment of Denning LJ in *Roe v Ministry of Health*, which merits repetition:

'But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.'

155. I make the following order:

Order

1. The plaintiff's claim is dismissed with costs.
2. These costs include the costs of:
 - (a) two counsel;
 - (b) the costs of the expert witnesses Professor Vlok and Doctor Counihan, including their reasonable qualifying, consultation, preparation and appearance fees, and their reasonable travelling and accommodation expenses.

I.T. STRETCH
Judge of the High Court

14 August 2018

Date handed down: 14 August 2018

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