IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

2/02/2015.

Case number: 12314/2011

DELETE WHICHEVER IS NOT APPLICABLE
(1) REPORTABLE: ~~YES~~/NO
(2) OF INTEREST TO OTHER JUDGES: ~~YES~~/NO
(3) REVISED

28/1/2015 .....
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In the matter between:

SARAH SUSANNA VAN VOLLENHOVEN **Plaintiff**

and

DR JCM VENTER **Defendant**

Heard: **23 APRIL 2014**

Delivered

JUDGMENT

A.A.LOUW J

Introduction

[1] This is a case about alleged medical negligence. On 29 February 2008 the defendant performed a total hip replacement (THR) on the plaintiff. She was at that stage 72 years of age.

[2] It is common cause that during the operation the plaintiff sustained an injury to the sciatic nerve. The theatre time is recorded as 08h26 to 11h09.

[3] The sciatic nerve is the major nerve of the leg and is the nerve with the largest diameter. In evidence it was described as being as thick as a man's pinkie. This nerve runs down behind the thigh from the lower end of the spine. Above the knee joint it divides into two main branches namely the tibial and common peroneal nerves.

[4] It is further common cause that the injury to the peroneal component of the sciatic nerve left the plaintiff with a left sided foot drop. The drop foot means that both the sensory and motor nerves to the foot are absent. This kind of injury to a nerve is known as axonotmesis which is defined in the medical literature contained in bundle E as follows:

> *"Neural supportive sheaths are preserved but nerve fibres disintegrate. Motor and sensory loss is complete. Recovery is complete unless regenerating nerve fibres must travel a long distance. Causes are compression, traction, friction or ischaemia (fracture, intraneural injections, freezing)."*

[5] This is confirmed by nerve conduction studies by Dr Schultz a neurophysiologist. The report of Dr Schultz dated 30 September 2008 comes to the following conclusion:

> *"1. The current electro-diagnostic picture is one of a chronic and severe left sided proximal sciatic neuropathy affecting the peroneal components of the sciatic nerve maximally. No re-innervation or MUAP's from the peroneal innervated components from the proximal sciatic nerve could be recorded.*
>
> *2. The lesion was localized as follows: There is minor active denervation in the medial gastrocnemius with intact MUAP recruitment. The short head of biceps femoris (only true peroneal innervated muscle above the knee) and anterior tibial muscle showed absent MUAP recruitment noted. This indicates a partial proximal sciatic lesion affecting the peroneal components maximally.*
>
> *3. There has been excellent re-innervation in the posterior tibial nerve component, with some residual axonal loss demonstrated due to reduced posterior tibial CMAP amplitude and reduced recruitment pattern.*
>
> *4. The functional prognosis for recovery of the peroneal nerve component of the sciatic nerve is poor and there is*

electrophysiologically at 8 months post injury complete denervation."

[6] The defendant discussed these findings with the plaintiff on 13 October 2008. He expressed his view that a Charnley retractor (about which more later) pressed on the sciatic nerve during the operation. According to his file notes the plaintiff was also advised that the prognosis was not good. Possible treatment was an arthrodesis to the foot which means that the foot would permanently be fixed at a right angle to the lower leg. The plaintiff testified that this option was not acceptable to her. Another possibility to her was to continue walking with a splint. In any event it is not in dispute that the damage is permanent.

[7] In the particulars of claim the plaintiff relied on seven grounds of negligence. At the end of the trial the plaintiff only persisted with the allegation in para 7.7 of the particulars which avers that the defendant caused permanent and irreversible damage to the plaintiff's sciatic nerve during the performance of the operation.

[8] The plaintiff is claiming damages in the amount of R700 000.

[9] By agreement between the parties I was asked to first determine the liability of the defendant with the quantum of damages to stand over. I made such an order in terms of rule 33(4).

Hip replacement : generally

[10] There are two major approaches to a THR. These are the anterior and posterior approaches. In the case of the anterior access to the hip is gained through an incision above the femur, whilst in the posterior case it will be below the femur. The posterolateral approach is a variation of the posterior approach.

[11] The defendant used the posterolateral approach. The incision that is made in such a case is described and illustrated in exhibit "I" p1. It is not necessary to describe the operation in detail. Suffice it to say that to gain access to the femur, cuts have to be made through the skin, muscle and other tissues. During this process various retractors are used. A retractor is a surgical instrument used to expose the operation site by drawing aside the cut edges of skin, muscle and other tissues. Once there is proper access to the femur the hip is dislocated through a combination of flexion, abduction and internal rotation. Thereafter the femur head is cut off and the prosthesis is inserted into the femur. This prosthesis or "artificial femur head" was shown to the court during the evidence of Prof Weber. It is an artificial femur head designed to fit into the sockets of the hip bone with a tapering point which is the part going into the femur.

[12] Once this has been done the femur has to be reduced i.e. placed back into its proper possession. From there on the operation entails only the

removal of the retractors which were in place and suturing the various layers of muscle, tissue and skin.

[13] The "golden rule" is that at all stages caution has to be used to protect the sciatic nerve. Thus the surgeons at all stages have to be aware of the location of this nerve. As already mentioned it is the largest nerve in the body and its location can be easily established, if not visually, by palpation. Especially great care should be taken to position the retractors to avoid injury to the sciatic nerve.

The evidence

[14] The plaintiff testified and on her behalf two expert witnesses namely Drs Naude and Birrell. The defendant testified and Prof Weber was called as an expert on behalf of the defendant.

[15] Dr Naude, now retired, was in private practice as an orthopaedic surgeon for decades. He specialised in hip replacements and had done approximately 6000 such operations. His expertise is not in dispute. Neither is that of Prof Weber who has a very impressive curriculum vitae and had performed approximately 10000 hip replacements. During these thousands of operations neither of them caused damage to the sciatic nerve resulting in axonotmesis. The present case is also the first case with such damage amongst the 600 hip replacements that the defendant had performed.

[16] The evidence of Drs Naude and Birrell was quite simply to the effect that utmost care must be taken not to injure the sciatic nerve, that in this case

such damage was done resulting in the drop foot and that this means that due care was not taken to protect the sciatic nerve. I quote the following passage of the evidence of Dr Naude:

> *"MR WILLIAMS: [plaintiff's counsel] We know that there is a lesion and everybody talks about a lesion even Dr Weber talks about a lesion. He also surmises that it was the instrumentation? --- That is correct, M'Lord.*
> *Is that the most probable cause? --- That is what I think M'Lord Everybody says that. Now, during the operation what are the duties of the surgeon* vis-á-vis *the sciatic nerve. Especially in regard to the instrumentation? --- The surgeon must at all times make sure that he does not damage the nerve because he knows where the nerve is although he cannot see it always you know where it is. You are supposed to know where it is and you must avoid any instruments touching the nerve."*[1]

Evidence of the defendant

[17] He did not have an independent memory of this operation. The intra-operative notes leave much to be desired. Prof Weber also agreed that these notes are insufficient. I quote the defendant's note relating to this operation:

> *"29/02/2008 Narkotiseur: G. Tsesmellis 8h25 – 11h09*
> *Assistant: R v/d Berg*

[1] Record 61

Debridement linker heup. Ope spierloslating en primere sementlose THV (totale heup vervanging) links.

Sien oorspronklike notas vir inligting aangaande komponente gebruik."[2]

[18] The defendant could therefore just testify about how he generally performs these operations. Of importance is the following passage in his evidence:

"*Dit is waar nerveus iskiaties toe loop. Die nerveus iskiaties betas jy maklik daar met jou vingerpunte elke keer. Die nerveus iskiaties is 'n groot senuwees nie so dik soos jou voorvinger nie, so dik soos jou pinkie. Ek betas dit ten minste een keer 'n week. Dit is ook baie belangrik."*[3]

[19] In regard to the different retractors he used his evidence in regard to the Charnley retractors is to be found in his evidence in chief. [4] It is also set out in the detailed instructions he gave to his instructing attorneys during March 2011, which version he confirmed during his evidence.[5]

[20] Para 11.5 of exhibit "J" reads as follows:

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[2] Exhibit "F" p 2
[3] Record p189-190
[4] Record P193-199
[5] Exhibit "J"

"All retractors used during the procedure were placed by myself and also taken care of by myself. The assistant just hold to these retractors where it was manually necessary."

[21] In para 11.6 of this same letter he stated the following regarding the Charnley retractors:

"The Charnley retractor was now placed in the wound. Also placed was the Charnley pin retractor that stayed in position for +/- 25 minutes. The Charnley pin retractor was removed after debridement of the acetabulum and preparation of the acetabulum. The Charnley retractor stayed in position in the wound during the preparation of the proximal femur. However, the Charnley retractor is replaced from time to time and is not putting pressure on the same soft tissue all the time. The Charnley retractor was removed at the end of the procedure after the hip was reduced and was then in the position for +/- 50 minutes."

[22] Under cross-examination the defendant confirmed that the most probable cause of the injury was that the Charnley retractor pushed too hard against to the sciatic nerve.[6]

[23] In answer to my question he said:

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[6] Record p252-253

"Dit is die mees waarskynlike moontlikheid soos wat ek al die tyd gesê het en waarom ek dit voorgestel het aan die pasiënt omdat ek al die ander moontlike oorsake nie kon identifiseer nie."[7]

Professor Weber's evidence

[24] The crux of Prof Weber's evidence is in para 4.5 of his expert summary. There he states the following:

"Sciatic nerve injury following the performance of a total hip replacement procedure is a rare, but a well recognised and described complication of the procedure. It is an unfortunate complication that occurs in 1% or less of total hip replacement cases. The injury to the plaintiff's sciatic nerve was probably a traction or an instrument injury which occurred during surgery."

[25] In the following subparagraphs he details the different kinds of retractors which were used and the approximate time that such retractors were used. Of course, this is all based on a reconstruction by the defendant as he did not keep proper notes.

[26] He then comes to the following conclusion in para 4.5.5:

"The choice of retractors and the duration of their application in the plaintiff's case represent the standard described use and duration of use of those retractors. The retractors were placed

[7] See also para 6 above regarding his consultation with the plaintiff on 13 October 2008

by the defendant personally. There is no evidence to suggest that the retractors were incorrectly placed, or that the retractors were left in situ *for unacceptably long periods of time without release. The occurrence of the sciatic nerve injury in the plaintiff's case thus occurred despite reasonable and proper measures by the defendant to prevent its occurrence."*

[27] However, regrettably, despite his eminence I find that his evidence was not objective. I shall quote a number of passages from the record from which it appears that he was biased. Many of his conclusions are based on his view of the excellent reputation of the defendant as well as the defendant's experience.

> "Mr Delport: [defendant's counsel]. It is the most successful mayor (sic) procedure improving the quality of life that we know and prolonging patients productive lives. So I would not say that it is acceptable but it happens and sometimes the explanation is difficult.
> Would you say that this complication that this injury can occur without any negligence on the part of the surgeon? --- It can, I know Dr Venter's work..."[8]

> "Court: Yes? --- The size of the incision was large and big enough and he did a precision operation. I think one should see the operation he did like preparing a watch not like shoeing a horse. It is a precision operation he would have known if anything had gone wrong. It is not a wrestling match to try to get the instrumentation in there. You need adequate exposure to do it and adequate retraction and in my view that is what he did."[9]

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[8] Record p264
[9] Record p265

"I think that is the explanation that I would offer for non negligent damage to the relaxation which is not always predictable especially the woman the soft tissues and then also the manipulations of the operation field and pelvis that might bring the nerve to the retractor but not negligent. The retractor to the nerve."[10]

"MR DELPORT: Dr Venter's description today of a technique usually used by him and the manner in which he did this particular operation. Do you have any criticism on it? --- No, if fact in my notes previously I wrote on it exemplary. It is the same today I would like to see him teach young orthopaedic surgeon in the way that he demonstrated..."[11]

"Yes? --- I would like to point out that the biggest complication or the most common complication of the posterior approach is dislocation of the hip joint. He is not known to have dislocations of the hip joint because of the size of the head that he uses. Therefore it is an indication of a very meticulous technique that in his practice posterior dislocation are a very low incident and that is what you would have expected if he was not doing proper surgery.?"[12]

"COURT: But I do not think you really answered the question, professor. You were simply asked whether the intra operative notes were sufficient. --- I would say no.
Then you, without being exhorted to do so you added the tail as he explained, et cetera and what was now put to you by Mr Williams is that you seem to be defensive of the defendant, you did not just answer the question. What do you say about that? -

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[10] Record p266
[11] Record p266
[12] Record p273

-- I am defensive of the doctor, because after I read all the information I had I felt it was very similar to two other cases M'Lord, so I became defensive because I felt that this is a not uncommon problem we see."[13]

"Mr Williams: (plaintiff's counsel) Then you find it necessary to add again 'the actions of a careful, experienced orthopaedic surgeon'. --- That is correct.
Batting for the defence on a routine matter, correct? --- Well, that to me M'Lord, it is such an important point because many surgeons unfortunately do not have preoperative evaluations and then the patients has to be cancelled the night before, the patients has not been to the physician, so the moment I see that part of the work has been done by a physician I regard that as careful work up of an experienced orthopaedic surgeon.
No, no, no professor, we were talking about a routine thing..."[14]

"Alright, so you now not, you now leave that in the air and then what troubles the plaintiff is the following paragraphs, which is again a shocking, I may put it to you , endorsement. Doctor Venter is an experienced orthopaedic surgeon, this is your reason, and with many years of practice and therefore what happened here is interpreted as an unfortunate complication, that is the case. --- Well, that is correct. I know Doctor Venter and he does good work and from my point of view he did an operation the way he did it always and therefore I had to support him, because I could find nothing wrong in the number of meetings that I had with him that anything out of the ordinary happened, in fact there are precautions he took or circumstances at surgery that were actually better in even what he put there and we will come to that later on."[15]

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[13] Record p286
[14] Record p288
[15] Record p293

"But you say here there are complications that happen with this type of surgery and because he is experienced and because he has many years of practice you assume what happened here is an unfortunate complication, that is your reason. --- I took ... [intervenes].
At that stages that is your reason. --- Absolutely. I took his, I accepted his bona fides M'Lord, that what he did is what he always does and I accepted that he did a good operation."[16]

"Court: When do you make up your mind as to his reputation? --- I have a very peculiar practice M'Lord, and a lot of problem cases get referred to me and although I will not say it, because I did not get many referrals, problems from him, we have done one or two cases together which he felt we should operate together, so the reason or the fact that he felt that we should operate together made me feel that he is, or made me interpret that he is a very respectable colleague and there were five or six orthopaedic surgeons working at that hospital and I certainly have not heard a downside from him, but I ... [intervenes]."[17]

"COURT: Ja, it is definitely not a neuropraxia doctor, professor. --- It turned out not to be. In the beginning one does not know, but after the nerve conduction studies we know and it is not only a simple traction legion that recovers in time.
Okay, but what Mr Williams is questioning you about is at that consultation after the nerve conduction studies did he still have any reason to think it was neuropraxia? --- I do not think so. I think after these two nerve conduction studies it was evident that it was an axotmesis that second... [intervenes]

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[16] Record p294
[17] Record p295

> Alright, so it was a glaring error on behalf of the defendant on a matter which there could be no doubt about at that stage not so? --- Ja, that is how I interpret it, M'Lord."[18]
>
> "Scientific proof, so why let us not just forget about the 1year? There is scientific proof. --- Ja."[19] (the emphases are mine).

Evaluation

[28] In *Buthelezi v Ndaba*[20] the SCA recently again confirmed that the maxim *res ipsa loquitur* does not apply to medical negligence cases. In order to hold the defendant liable the plaintiff simply has to prove on a balance of probabilities that the defendant did not exercise the required skill and care of a reasonably competent specialist in his field. In regard to the conflicting views of expert witnesses *Buthelezi* states as follows:

> *"[14] I have said at the beginning that the outcome of the dispute as to whether or not the appellant's performance of the surgery, which led to the respondent's injury, could be described as negligent, ultimately turns on an election between the opposing views of two expert witnesses. It is true, of course, as the court a quo accentuated in its judgment, that the determination of negligence ultimately rests with the court and not with expert witnesses. Yet that determination is bound to be informed by the opinions of experts in the field which are often in conflict, as has happened in this case. In that event the court's determination must depend on an analysis of the cogency of the*

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[18] Record p305
[19] Record p306
[20] 2013(5) SA 437 (SCA)

underlying reasoning which led the experts to their conflicting opinions."

[29] It has been established beyond reasonable doubt that the damage to the nerve resulted from the improper use of the Charnley retractor. This resulted in either a partial lesion or a pressure injury to the sciatic nerve. From the passages quoted above it is clear that Prof Weber's view that the operation was performed with proper skill and care is based only on the following: Firstly, the good reputation of the defendant and secondly that the defendant demonstrated his excellent knowledge, skill and care in doing such an operation during a consultation with Prof Weber in his Sandton chambers where a plastic model was used for the purposes of such demonstration.

[30] I do not regard these as good reasons. On the other hand, the evidence of the plaintiff's experts, amount to a simple but in my view a good reason for holding the defendant liable. This is that it is probably the Charnley retractor which caused the injury, that all retractors were placed and adjusted by the defendant only and that the resultant damage shows that he did not exercise proper skill and care in protecting the sciatic nerve.

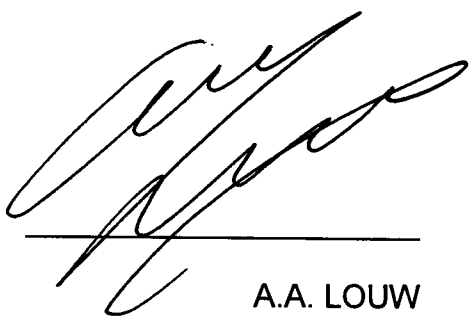
[31] This case therefore differs from *Buthelezi* in which case the cause of the patient's urine incontinence after the operation was unknown. The combined total of hip replacement operations performed by the experts and the defendant is 16 600. Out of all these cases this is the only one which resulted in axonotmesis and a drop foot. Pure logic therefore shows that in

this exceptional case the defendant must have made a negligent mistake in causing the injury. I therefore find that the defendant was negligent and that the plaintiff is entitled to the relief sought.

Order:

[32] I make the following order:

1. It is declared that the defendant is liable for all damages resulting from damage to the sciatic nerve during the operation performed on 29 February 2008.
2. The defendant is ordered to pay the costs of the trial on the merits.
3. The costs are to include the costs of senior counsel as well as the costs of the reports and preparation of Drs Birrell and Naude.



A.A. LOUW

Judge of the High Court