Reportable:	*Yes/No*
Circulate to Judges:	*Yes/No*
Circulate to Magistrates:	*Yes/No*

IN THE HIGH COURT OF SOUTH AFRICA
(NORTHERN CAPE DIVISION, KIMBERLEY)

CASE NO.: 214/2017
Date heard: 13-09-2023
Date delivered: 17-01-2025

In the matter between:

SUSARA HENDRIKA VAN WYK **Plaintiff**

And

DR JAMES KHAVALETHU DUZE **1st Defendant**

MEDICLINIC LIMITED **2nd Defendant**

CORAM: WILLIAMS J

JUDGMENT

WILLIAMS J:

1. On 13 February 2015 the 1st defendant, Dr J K Duze performed a total hip replacement (THR) on the plaintiff, Ms S H Van Wyk, who was at the time 73 years old.

2. It is common cause that the surgery was performed with informed consent and that the post-operative care and management were acceptable. It is further common cause that the plaintiff suffered a permanent sciatic nerve

injury during or as a result of the surgery, which resulted in *inter alia* a permanent *"drop foot"*.

3. The only issue to be determined is whether the intra-operative damage done to the sciatic nerve was as a result of the negligence of the defendant. The plaintiff is not proceeding against the 2nd defendant, Mediclinic Ltd.

4. The nature of the negligence alleged by the plaintiff, as it transpired during the course of the trial, though not specifically pleaded in the particulars of claim, is the incorrect and careless placement of a retractor during the THR procedure.

5. The plaintiff called Dr MC Naude to testify as an orthopaedic expert in her case. The 1st defendant, herein-after referred to as the *"defendant"*, testified himself and called Dr JD Jordaan as an expert.

6. Drs Naude and Birrell were initially tasked with examining and assessing the plaintiff on 26 July 2016. They were of the opinion that due care had not been taken by the defendant during the hip replacement procedure. They were however also of the view that since two years had not transpired since the surgery and some improvements were theoretically possible, a follow-up assessment should be done during 2017.

7. On 13 March 2017 Dr Birrel carried out a follow-up examination of the plaintiff and after collaboration with Dr Naude agreed, in a report, that no improvement of note was shown by the plaintiff. She still had to wear the drop foot splint and had a limp on the left side. The doctors were still of the view that the defendant had not taken proper care during the procedure and that due to the damage to the sciatic nerve, the plaintiff had a claim for damages against the defendant.

8. Dr Jordaan who completed his report during March 2020 dealt much more comprehensively with the issues extant at the time of his report, such as

the indication for surgery, informed consent, intra-operative management, post-operative management of the complication and issues of causation.

9. The experts' attempt at compiling a joint minute was not successful, with no final joint minute having been signed. The sticking points being the cause of the injury and whether the defendant was negligent.

The Evidence

10. Dr Naude is a retired Orthopaedic/Arthroplasty surgeon and emeritus member of both the South African Orthopaedic Association and the South African Arthroplasty Society. Over the course of his career he has performed approximately 6000 hip replacements of which 4000 were primary hip replacements and 2000 were revision hip replacements.

11. Dr Naude had sight of all the relevant reports in this matter as well as the hospital notes and billing accounts of the defendant.

12. Dr Naude agreed with the report of the defendant's neurologist Dr L Smit that there was a direct relationship between the plaintiff's sciatic nerve injury and the surgery. He also agreed with Dr Smit that *"if the sciatic nerve is compressed it is both the lateral and medial parts of the nerve that is involved and the patient will have problems lifting the foot up, as well as stepping down and turning the foot inward and outward."* He also agreed with the schematic representation in Dr Smit's report of the close relation of the sciatic nerve with the hip joint.

13. Dr Naude agreed that the technical performance of the THR was good, i.e. that the hip replacement was in a good position, with no radiological evidence of complications, loosening or abnormalities, with a good acetabular angle.

14. Drs Naude and Birrel had attempted, with Dr Jordaan, through a process of elimination to find the most probable cause for the injury to the plaintiff's

sciatic nerve. During the course of this exercise, Dr Naude excluded thermal damage such as electrocautery, since no cement was used. He also excluded traction – the overstretching of the leg during surgery, as a cause of damage to the sciatic nerve since the plaintiff's leg length was found to be normal during examination by the experts. Dr Naude also found compression by haematoma pressure to have been unlikely since the amount of blood drained from the wound post-operative was only 20ml.

15. Dr Naude was of the view that the most likely cause of the injury to the sciatic nerve was due to incorrect retractor placement.

16. He explained that a retractor is the 5th hand during surgery. The surgeon's and his assistant's hands are not enough to keep the wound open to gain access to the joint. Because the sciatic nerve is so close to the hip joint, incorrect placement of the retractor can cause damage to the nerve. Though the sciatic nerve is not visible with the lateral approach to the hip joint, it is a big nerve, and the surgeon should know where it is. According to Dr Naude, the first thing you are taught as a registrar is to be aware of the sciatic nerve and to take the necessary care to protect it at all times during surgery – the so called *"golden rule"*. Placement of the retractor over the sciatic nerve could cause damage to the nerve with its sharp edges or could cause pressure on the nerve leading to ischemia, an inadequate blood supply.

17. Dr Naude was referred in this regard by Mr Williams SC for the plaintiff, to literature which emphasizes the importance of the careful placement of retractors around the acetabulum in order to prevent or reduce the incidence of nerve damage, with which he agreed.

18. Dr Naude testified that he had experienced three cases of drop foot over his career but that they all cleared up within 6 to 8 weeks. That he was therefor careful enough not to cause permanent damage.

19. During cross-examination by Mr De Waal SC for the defendant, Dr Naude conceded that he may not have been careful enough with the three THR's where complications were experienced and that he could only assume that he must have placed a retractor incorrectly in those instances, despite having exercised the utmost skill and care.

20. Interestingly enough, later during his cross-examination Dr Naude testified that it could have been retractor placement which caused the complication in one of his three drop foot cases, that it could also have been as a result of constriction and in one case it could have been over-manipulation. He stated that the incidents were not deliberate and that he had only with hindsight attempted to figure out what could have caused the complications. He later on disavowed retractor placement as the cause of his complications and suggested that those instances could have fallen within the 50% of unknown causes.

21. Dr Naude agreed that the cause of 50% of sciatic nerve injury associated with hip replacements is unknown.

22. Dr Naude also agreed with the literature that no single risk factor has been consistently reported as being significant and that many patients with no known risk factors incur neurological injuries.

23. Dr Naude was also referred to the literature in which it is stated that anatomical variations in the course of the sciatic nerve have also been implicated in iatrogenic (caused by the medical treatment) nerve injury during procedures such as total hip arthroplasty and arthroscopy. He was of the opinion however that since the variations in the course of the nerve occur either above or below the level of the hip joint, which is the area of surgery, any variation not expected by the surgeon would unlikely have led to injury of the nerve, especially where the lateral approach was used. He did however acknowledge that the course of the sciatic nerve through a muscle (the piriformis) is also a known variant.

24. Dr Naude did not dispute that sub-clinical nerve involvement during hip replacement surgery was inevitable as demonstrated by nerve, conduction studies done intra-operatively, although only a minority of it manifested post-operatively.

25. Dr Naude maintained that the reason for his opinion that a retractor most likely caused the damage to the plaintiff's sciatic nerve was that a retractor is always used during such an operation, close to the nerve, that it has sharp edges and that it is a dangerous instrument and is the usual cause of such an injury.

26. The defendant, Dr Duze testified. He qualified as an orthopaedic specialist in 2012. In 2013 he qualified as a super specialist in arthroplasty, specialising in joint replacement. He started working at the Kimberly Hospital in 2014. He had performed 150 to 200 hip replacements and had assisted in about 500 hip replacements.

27. During February 2015 the plaintiff consulted the defendant at the Kimberly Hospital, complaining of extreme pain in the left hip. By then she had already seen two private orthopaedic surgeons but because her medical aid benefits were limited she could not afford their rates. As a state doctor the defendant was allowed a certain number of hours to do private work. He then assisted the plaintiff with a reduced fee and by submitting a motivation for the THR to her medical aid and facilitating the performance of the procedure at the Medi-Clinic hospital, a private facility.

28. The defendant testified that although he had done private surgery on fingers and toes, this was to be his first private THR. He however used the same assistant that he used in the state hospital, the instruments including retractors, are universal and the prosthesis was ordered from his own provider.

29. The plaintiff was anatomically normal, her body mass index was within normal limits. According to the defendant the plaintiff was lean, with more muscle than fat, which made the procedure easier.

30. He performed the operation with due care and skill, he placed the retractors himself, only requiring his assistant to hold it in place. There was no force used to place the retractors in position. The retractors were used for less than 20 minutes and were rounded off at the ends so as to prevent serious injury to the nerve. The procedure was uncomplicated, there was no excessive manipulation or overstretching necessary. There was no excessive bleeding during the operation and the drain which he placed at the edge of the incision drained less than 20ml, an indication that there was no haematoma present.

31. The defendant also testified that by using the lateral approach, his operating area was far from the sciatic nerve. He did not palpate for it as there was no need to fiddle with the nerve. He was satisfied that the surgery had been a success.

32. The day after the operation, after the epidural had worn off, the defendant did a routine check that the sciatic nerve was in order. The plaintiff could move her left leg and there was no swelling.

33. On the second day after the operation, he was shocked to find that the plaintiff's whole left leg was swollen grossly. She could not move the leg and he was concerned that she had developed deep vein thrombosis although nothing showed up on an ultrasound.

34. It was only later that it was determined that the plaintiff had incurred a sciatic nerve injury. The defendant testified that he had thought about the cause of the injury many times – whether it had happened in theater or in the ward, but still does not know what the cause of the injury was. He disagreed that there was a direct relationship between the symptoms of the plaintiff and the surgery.

35. The defendant had billed the plaintiff's medical aid for a major neurolysis performed during the surgery. Dr Naude explained that a neurolysis is the dissection of tissue or an adhesion around the nerve to expose the nerve. It is never indicated in an uncomplicated primary hip replacement since it can damage the blood supply to the nerve and cause some other damage as well. A neurolysis would normally be done in a revision hip replacement or when the surgeon suspects that he had damaged the nerve in some way and needed to explore the nerve.

36. The defendant denied having performed a neurolysis since it was not necessary and he in any event did not come close to the sciatic nerve during the operation. He explained that as a state doctor he was paid a monthly salary and was not familiar with billing codes. He had only been doing private work for a year and as this was his first private THR he had asked a colleague to assist him with the billing codes. He was therefore unaware, at the time, that he had billed for a procedure which he had not performed. Although he got paid for the neurolysis, there were certain other legitimate items on his bill which were not paid for and which he did not pursue because he was too pre-occupied with the complication suffered by the plaintiff.

37. Dr Jordaan, the defendant's expert, is a specialist orthopaedic surgeon, specialising in arthroplasty. He is the head of the Arthroplasty Unit at the Tygerberg Hospital, attached to the University of Stellenbosch. He has worked in academic teaching and training facilities throughout his career and has performed about 4000 joint replacements of which 3000 were hip replacements. He has been a specialist orthopaedic surgeon for about 11 years.

38. A summary of the expert testimony of Dr Jordaan was filed during March 2020. As mentioned above the experts attempted to file a joint minute during February and March 2021 but failed to do so. It is however not in dispute between the experts that thermal damage, local anaesthetic

application or excessive traction appear unlikely to have caused the damage to the plaintiff's sciatic nerve.

39. Whereas Dr Naude favours direct retractor damage as the most likely cause of the injury to the nerve, Dr Jordaan disagrees with this opinion on the basis that it is not indicated. He is of the opinion that indirect compression of the sciatic nerve most likely caused the complication.

40. Dr Jordaan explained the reasons for his opinion as follows. Direct compression of the nerve would result from for instance a finger, a knife, a retractor or any hard object that is placed on the nerve and which then compresses it. Indirect injury of the nerve could be caused for example by the rotation of the leg during the operation (a normal part of the procedure) and the nerve gets caught between different anatomical structures around the hip such as muscles or a muscle and a bone. A haematoma formation in the nerve fibres can also cause indirect compression. A haematoma which has formed outside the nerve can compress upon the nerve and cause direct compression of the nerve. Direct compression caused by a haematoma has been excluded by both Drs Naude and Jordaan as a cause of the injury given the relatively small amount of blood which had collected in the drain inserted by the defendant.

41. Dr Jordaan testified that he had had sight of the plaintiff's x-rays, had read the surgical notes of the defendant and had listened to his evidence. There was nothing to indicate that the THR performed by the defendant was anything other than an uncomplicated procedure. The lateral approach used by the defendant has been shown to have a lower risk of sciatic nerve injury. The defendant had, according to his notes and evidence, taken all the reasonable steps to protect the soft tissue around the hip joint. He had placed the retractors used on the normal safe zones to prevent injury to the sciatic nerve. The injury to the plaintiffs sciatic nerve, affecting both the peroneal as well as the tibial parts of the nerve, as shown by the nerve conduction tests, is an atypical sciatic nerve injury.

Normal direct compression of the nerve would usually only impact on one area, commonly the peroneal nerve, because it is situated closer to the joint.

42. As a result of the above-mentioned, Dr Jordaan has excluded direct compression as the cause of the injury to the sciatic nerve.

43. Dr Jordaan could however not exclude indirect compression of the sciatic nerve which he states is difficult to pinpoint. He testified that there are two known causes of indirect compression to the sciatic nerve which have been widely published academically. The first could occur around the piriformis tendon where the variation of the sciatic nerve can be closer to the hip joint or can pass through the piriformis muscle. Should the leg then be rotated 90 degrees without releasing the piriformis muscle, the muscle fibres can sometimes compress the sciatic nerve, known as piriformis syndrome. The second common indirect compression occurs at the gluteus maximus sling, which is a narrow area. If the leg is turned 90 degrees during the THR the nerve is stressed at that area and can be pinched from both sides which would be atypical to a direct compression injury which would affect only one part of the nerve, usually the personal nerve.

44. In this regard Dr Jordaan referred to the article of Asmall *et all*, which Dr Naude was also referred to and which is a South African study dealing *inter alia* with the variation in the sciatic nerve, its relationship with the piriformis muscle, variation in the bifurcation level and gender. In 76.2% of the 42 cadavers examined the normal relationship between the sciatic nerve and the piriformis muscle existed i.e. with the sciatic nerve passing undivided below the piriformis muscle. In 15% of the cases the sciatic nerve divided in the pelvis with both the peroneal and tibial nerves emerging below the piriformis muscle. In 7.1% of the test cases the sciatic nerve divided in the pelvis with the peroneal nerve piercing the piriformis muscle and the tibial nerve emerging below the muscle. The

incidence of other variants are insignificant and not relevant to the matter *in casu*.

45. As I understand the evidence of Dr Jordaan, in the 7.1 % of the cases where the peroneal nerve passes through the piriformis muscle, the nerve is prone to be pinched by the muscle when rotated. In 22.% of the cases studied, the sciatic nerve split into the tibial and peroneal nerve in the hip area running closer to the posterior wall of the acetabulum. If a retractor is placed at the posterior wall of the acetabulum, which is the norm, the nerve would be closer to the operating area which would increase the risk of iatrogenic nerve injury simply because it would not be in the place where the surgeon would expect it to be.

46. Dr Jordaan was further of the opinion that the plaintiff's sex, body phenotype and anatomy could place her in a high-risk group to develop neurological compression injuries. The medical literature is consistent that females have a higher risk of developing sciatic nerve injuries. Furthermore, the plaintiff, being an older woman, with lean body mass and loss of muscle, will be of a higher risk of compression of a nerve around the body. Dr Naude held the opposite view, that patients with a higher body mass have a greater risk of nerve palsy because of the need to apply more forceful retraction during surgery. The issue of body mass index as a risk factor appears to be controversial in terms of the literature presented, but not much turns on this factor, in my view.

47. In any event, Dr Jordaan was of the opinion that the cause of the compression injury to the plaintiff remains unknown. He was also of the view that indirect compression of the sciatic nerve represents a true surgical complication of a THR and does not constitute unreasonable or unprofessional conduct by the surgeon.

48. During cross-examination Dr Jordaan was confronted with the summary of his evidence which states that a *"potential mechanism of indirect compression of the sciatic nerve could be from retractor placement or*

anatomical variants of the sciatic nerve . . ." It was put to him that he was batting for the defendant, by removing retractor placement during his evidence as a cause of the injury, whereas he had initially been of the view that retractor placement could be a possible cause for the injury.

49. Dr Jordaan explained that while he disagreed with Dr Naude and Dr Birrell that there was direct retractor injury to the nerve, since he could not find direct injury, he could not eliminate an indirect injury by way of a retractor or anatomical variant. If there is no anatomical variant then in 99% of the cases, placing the retractors at the normal position will not cause nerve injuries. In the 1% of cases which present with sciatic nerve injury there are risk factors such as female phenotype or anatomical variance, because the sciatic nerve is not where it is expected to be.

50. Although Dr Jordaan could not deny that retractors are always a possible cause in typical sciatic nerve injuries, he maintained that the injury *in casu* was atypical for any sciatic nerve presentation as well as for retractor compression because both the common peroneal as well as the tibial nerve were injured. Neither he nor Dr Naude could find a direct relationship with a specific retractor being placed at a specific point during the operation which was responsible for the injury. He could not find any evidence that a retractor has cause the sciatic nerve injury and cannot agree with Drs Naude and Birrell who in any event cannot give a reason for their opinion of retractor damage.

Discussion

51. The approach to expert evidence has been stated in *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA) as follows at 1200, 1201:

"*[34] In the course of the evidence counsel often asked the experts whether they thought this or that conduct was reasonable or unreasonable, or even negligent. The learned Judge was not misled by this into abdicating his decision-making duty. Nor, we are sure, did*

counsel intend that that should happen. However, it is perhaps as well to re-emphasize that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised.

[36] . . . what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of Bolitho v City and Hackney Health Authority [1997] UKHL 46; [1998] AC 232 (H.L.(E.)). With the relevant dicta in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.

[37] The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached "a defensible conclusion" (at 241 G - 242 B).

[38] If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242 H).

[39] A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are

conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed" (at 243 A-E)."

52. *In J.A obo D.M.A v Member of Executive Council for Health, Eastern Cape* [2022] 2 All SA 112 (ECB), Van Zyl DJP, writing for the Full Bench dealt with the evaluation of conflicting expert evidence with reference to the authorities at paragraphs 11 to 16, thereof and concludes as follows at paragraph 17 thereof:

[17] What is evident from the aforegoing is that the evaluation of expert opinion in determining its probative value and the considerations relevant thereto, are determined by the nature of the conflict in the opinion, and the context provided by all the evidence and the issues which the court is asked to determine. In general, it is important to bear in mind that it is ultimately the task of the court to determine the probative value of expert evidence placed before it and to make its own finding with regards to the issues raised. Faced with a conflict in the expert testimony of the opposing parties, the court is required to justify its preference for one opinion over another by a careful and critical evaluation thereof. Further, the primary function of an expert witness is to guide the court to a correct decision on questions, which fall within that expert's specialized field. To that extent, the expert witness has a duty to provide the court with abstract or general knowledge concerning his or her discipline, and the criteria necessary to enable the court to form its own independent judgment by the application of the criteria to the facts proved in evidence. Accordingly, the mere "... ***pitting of one hypothesis against another does not constitute the discharge of the functions of an expert."*** *Finally, it is not the function of the court to develop its own theory or thesis and to introduce on its own accord evidence that is otherwise founded on special knowledge and skill. Ex hypothesi, such evidence is outside the learning*

of the court. The function of the court is restricted to deciding a matter on the evidence placed before it by the parties, and to choose between conflicting expert evidence, or accepting or rejecting the proffered expert evidence."

53. In paragraph 7 of *J.A obo D.M.A supra,* it is stated that *"An expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance."*

54. The relevant common cause facts in this matter are as follows:

56.1 The plaintiff suffered an injury to the sciatic nerve on the left side following upon a THR performed by the defendant, which left her with a permanent drop foot.

56.2 Both the peroneal and tibial aspects of the sciatic nerve were injured.

56.3 It was an uncomplicated THR and the operation was technically successful.

56.4 The lateral approach employed by the defendant poses a lower risk of sciatic nerve injury.

56.5 Permanent sciatic nerve damages in an uncomplicated THR is rare (about 1% - 2%) but is a well-known complication.

56.6 In 50% of sciatic nerve damage following upon a THR, the etiology or cause thereof is unknown.

55. What then informs the opinion of Dr Naude that the injury to the sciatic nerve was caused by incorrect or careless placement of a retractor, despite the denial thereof by the defendant?

56. As mentioned herein, Dr Naude was, during his evidence in chief, referred to medical articles which appeared to postulate that incorrect retractor placement was one of the main causes of sciatic nerve damage. A closer reading of the review article by Unwin and Scott shows that it deals with not only sciatic nerve palsy after hip replacement, but also with damage to the femoral and obturator nerves. The article suggests that traction (which has been ruled out *in casu*) is probably the most common cause for sciatic nerve injury. Placement of a retractor over the anterior lip of the acetabulum is the principal cause of damage to the femoral nerve. Reliance by the plaintiff in this article for the contention that retractor placement is the most common or obvious cause of sciatic nerve injury is, in my view, unfounded. The same can be said of the other articles in the bundle provided.

57. That is of course not to say that incorrect or prolonged retractor placement should automatically be ruled out as a cause for the complaint. The experts agree that incorrect retractor placement can cause sciatic nerve damage, either temporarily or permanently. The issue is whether it is the most plausible cause of the plaintiff's injury, there being no factual evidence regarding the mechanism of the injury.

58. With all due respect to Dr Naude, his attempts at explaining the cause of his three drop foot cases, despite him taking the utmost care in those instances, does not assist the plaintiff. Neither does his proposition that because the plaintiff presented with a drop foot after the operation, the defendant must have been negligent, which is not only apparent from Dr Naude's evidence but also from the two reports compiled by him and Dr Birrell during 2016 and 2017, wherein the probable cause of the injury to

the plaintiff is not addressed at all, save to state that the defendant did not take due care during the procedure.

59. During argument by Mr Williams on behalf of the plaintiff, the defendant was criticized for this carelessness. Firstly in making the wrong diagnosis of avascular necrosis of the plaintiff's left hip (although it was conceded that a THR was indicated), secondly, of keeping shoddy surgical notes (although according to Dr Naude the defendant's notes were adequate), thirdly, in billing for a neurolysis which the defendant testified was not performed, neither indicated (although this is not the plaintiff's case), fourthly, for not being particularly concerned about the sciatic nerve during the procedure since he was far away from it, and lastly, for not palpating for the sciatic nerve prior to the placement of retractors. More needs to be said about this last criticism.

60. Mr Williams has in this regard referred to the matter of *Meyers v MEC, Department of Health, EC* 2020 (3) SA 337 (SCA). In the *Meyers* matter, the defendant's surgeon had, during the removal of a gallbladder injured the bile duct. The majority court held that both the opposing experts *"were at one on the need for a surgeon to properly identify the anatomy and structures. Both accepted that to dissect in the danger zone namely Calot's triangle, without having properly identified the structures would constitute negligence."* Further that when both expert's evidence is read together, no reasonable suggestion had been offered as to how the injury could have occurred, save for the negligence of the surgeon (at paragraphs 81 and 82 thereof).

61. Mr Williams argued that the finding in the Meyers case was consonant with the evidence of Dr Naude, that if the whereabouts of the sciatic nerve is identified/plotted (by palpation) then the retractors would not be placed too close to the sciatic nerve. In this regard the evidence of Dr Naude is as follows:

MR WILLIAMS: *In the middle of the page, there is a sentence ... the second sentence in paragraph 2.12 where it says:*

> *"The sciatic nerve is the largest nerve in the human body and it is unlikely to be inadvertently lacerated or transected."*

In other words you would not cut it ... what this expert is saying is that you would not cut it by accident.
DR NAUDÉ: Well, unless you ... unless you dissect in that area.
MR WILLIAMS: *Yes*
DR NAUDÉ: We are taught to avoid ... we know where the nerve lays round about. You cannot see it, you are not going to look for it, because once you start looking for the nerve, you are going to damage the nerve. So you must just be aware of where the nerve lays and what are the anatomical variations.
MR WILLIAMS: *But you agree, it is the largest nerve in the body?*

And further on:

MR WILLIAMS: *And if you could go page 75. It is another article. Well, let us go to page 69 first? Page 69 is also an article that the defendant relies upon. And on the right hand column, the word that starts with 'because'. Do you see that?*
DR NAUDÉ: Ja, ja?
MR WILLIAMS: *It says that:*
"Because most nerve ... [indistinct] is associate with total hip replacement involving the sciatic nerve, increased attention has been paid to localising and protecting the sciatic nerve in primary cases using either posterior or the lateral approach, localisation of the nerve can be formed routinely and easily by finger palpitation as the nerve cresses the ... [indistinct] and for the brain specific care be taken."(sic)
Do you agree with that sentiment?
DR NAUDÉ: Yes, I fully agree. You cannot see the nerve, but you can feel it. It is not easy to feel, because there is a muscle laying over him, but it is really very near to the posterior edge of the acetabulum.

62. In my view the evidence of Dr Naude, as encapsulated above, does not support a plotting or palpation of the sciatic nerve before placement of retractors, rather an awareness of the anatomy and where the nerve is situated.

63. The attitude of Dr Naudé in fact accords with that of the defendant in that it was an uncomplicated procedure, there was no need *"to fiddle"* with the sciatic nerve and that he was far from the nerve. Dr Jordaan confirms this.

64. The evidence, in my view does not indicate that it is normal practice to palpate for the sciatic nerve in a primary THR, unlike a revision hip replacement where palpation/identification and even a neurolysis would be indicated. The criticism of the defendant's evidence in this regard is unfounded.

65. Mr Williams sought to draw a parallel between the present matter and that of *Van Vollenhoven v Dr JCM Venter* 12314/2011) [2015] ZAGPPHC 39 (2 February 2015), in which the plaintiff incurred an injury to the peroneal aspect of the sciatic nerve during a THR, which left her with a drop foot. Louw J reiterated the golden rule which applies to THR procedures, i.e., that at all stages care has to be used to protect the sciatic nerve. The surgeon has to be aware of the location of the nerve, if not visually, then by palpation. Especially great care should be taken to position retractors to avoid injury to the sciatic nerve.

66. In the *Van Vollenhoven* matter the court held on the probabilities that the placement of the retractor caused the injury to the plaintiff's sciatic nerve. In that matter, as *in casu,* placement of the retractors was done by the defendant alone. The court held that the resultant damage showed that the defendant did not exercise proper skill and care in protecting the sciatic nerve. The court rejected the evidence of the defendant's expert that the defendant had performed the procedure with proper skill and care because it was based solely on the good reputation of the defendant and the fact that the defendant had demonstrated his excellent knowledge, skill and care in performing such an operation during a consultation with Prof Weber (defendant's expert) using a plastic model. The defendant's expert was found to be biased.

67. *Van Vollenhoven* can however also be distinguished from the present case in the following respects: (i) the mechanism of the injury was not in dispute – the defendant from the outset expressed his view to the plaintiff that a retractor pressed on the sciatic nerve during the operation. He confirmed during cross-examination that the most probable cause of the injury was that the retractor pushed too hard against the sciatic nerve; and (ii) there does not appear to have been any scientific evidence as to other possible causes or risk factors involved in such a procedure.

68. Dr Jordaan was criticized for not being objective, that he excluded retractor damage on the say so of the defendant, that he kicked up dust by postulating all kinds of possibilities, not probabilities, and that his opinion is rooted in a scientific approach. That a judicial measure of proof should be applied and not a scientific measure. Mr Williams referred in this regard to the *JA obo DMA* matter where it is stated at paragraph 50 thereof:

"[50] The burden of proof in a civil case requires a plaintiff to prove his case no higher than on a balance of probabilities. The probabilities are determined upon the facts and an element of experience and common sense. It calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course. Applying the standard of proof to the test for factual causation, the enquiry is directed at identifying the more plausible of any one cause against the backdrop of the negligent act found proved, including the available evidence as a whole, which in a matter such as the present, will include, but is not limited to, expert opinion. In Linksfield the court pointed to the fact that expert scientific witnesses tend to assess the likelihood of something in terms of scientific certainty, and stated that the ***"Essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of Dingley v The Chief Constable, Strathclyde Police 200 SC (HL) 77 and the warning given at 89 D-E that '(o)ne cannot entirely***

discount the risk that by immersing himself in every detail and by looking deeply into the minds of experts, a judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence."

69. But this is not a matter where one would be tempted to assess the evidence in terms of scientific certainty. A mere analysis of the cogency and underlying reasoning for the opinions of the experts suffices. Dr Jordaan's disregard of direct retractor compression as a cause for the injury is not just on the say-so of the defendant but because the injury was atypical of a retractor injury. This evidence was not contested by the plaintiff. The experts were *ad idem* that in 50% of sciatic nerve injuries the cause thereof was unknown. There is no factual evidence that the injury was caused by incorrect retractor placement. The explanation by Dr Jordaan of the impact of anatomical variance with regard to sciatic nerve injury is not only logical but is underpinned by the medical literature. Dr Naudé acknowledged these variants but disregarded it as a cause or a risk factor without giving any reasonable explanation for his dissent with the results of medical research.

70. Against the logical and well-reasoned testimony of Dr Jordaan, that the cause of the plaintiff's sciatic nerve injury falls within the 50% of cases which are unknown, Dr Naudé's bald opinion that the injury was most likely caused by a retractor because it is always used and is a dangerous instrument known to cause damage, cannot prevail.

71. The plaintiff has in my view failed to show on a balance of probabilities that incorrect and careless placement of a retractor had caused the injury to the plaintiff's sciatic nerve. As a result the claim should be dismissed. There is no reason why costs should not follow the result.

The following order is made:

1. **The plaintiffs claim is dismissed with costs.**
2. **The costs shall include the reasonable taxed party and party costs on the High Court scale for:**

   2.1 The reasonable full day fees of senior counsel;

   2.2 The reasonable costs of procuring medio-legal reports from Dr J D Jordaan and Dr L Smit; and

   2.3 The qualifying fees of Dr Jordaan.

[redacted]

CC WILLIAMS
JUDGE

For Plaintiff: Adv D Williams SC with
Adv CR Van Onselen
Engelman Magabane Inc

For Defendant: Adv W P De Waal SC
Elliot Maris Attorneys