



**IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)**

Case number: 9528/2022

In the matter between:

TASNEEM HASSIEM

Plaintiff

and

**THE MEC FOR HEALTH, WESTERN CAPE
PROVINCIAL HEALTH DEPARTMENT**

Defendant

Coram: Van Zyl, AJ
Heard on: 18-19 March 2025, 6 May 2025; 24-25 June 2025; 5 and
23 September 2025; 27 January 2026
Judgment: : 28 August 2026

Summary: Medical negligence – issues of liability and *quantum* separated – determination of liability – total hip replacement – partial sciatic nerve injury post-surgery - cause of injury and causation in issue - conflicting expert evidence – not possible to determine cause of injury – unable to determine whether revision surgery of further investigation would have yielded any result – factual causation not proved – action dismissed

ORDER

The plaintiff's claim is dismissed, with costs, including counsel's fees taxed on Scale B. All costs that stood over for later determination are costs in the cause.

JUDGMENT

VAN ZYL, J:

Introduction

1. Sometimes one suffers injury, and has to bear it.¹ No-one is at fault. This is the case in the present matter.
2. The plaintiff claims damages from the defendant on the basis of the alleged negligence of the staff at Tygerberg Hospital² in the treatment she received after she had undergone a total hip replacement ("THR") of her left hip in October 2019.³ She alleges that the defendant, through its orthopaedic surgeon, Dr Jordaan, could have prevented permanent damage to the plaintiff's sciatic nerve⁴ if he had further investigated (shortly after the THR surgery) the cause for an injury to the nerve, and had he performed revision surgery.
3. The defence, in summary, is that there was improvement in and no worsening of the plaintiff's condition after the surgery. She did not experience extra-ordinary pain that could not be medicated with analgesics. Dr Jordaan's approach in treating her conservatively was appropriate prior to her discharge from hospital on 23 October 2019, and thereafter. This is

¹ *Res perit domino, or casum sentit dominus.*

² A provincial academic hospital falling under the defendant's management.

³ Merits and *quantum* were separated in the course of pre-trial management, and this court is therefore to determine the merits only.

⁴ In layman's terms, the sciatic nerve is the longest and widest single nerve in the human body, running alongside the hip joint towards the back of the foot. It provides the connection to the nervous system for the skin of the lateral leg and the whole foot, the muscles of the back of the thigh, and those of the leg and foot.

especially the case given the pitfalls of revision surgery after the THR, and the absence of any guarantee that the plaintiff's condition would improve. In fact, more harm could have been done to the nerve in the revision surgery process.⁵

4. I refer to the relevant principles underlying claims such as the plaintiff's, before turning to the fact of this matter.

The relevant legal principles

5. On the ordinary principles applicable to claims of this nature, and on the framing of the plaintiff's case as discussed below, the plaintiff must prove, firstly, that the employees at the hospital wrongfully and negligently breached their legal duty, and, secondly, that there was a causal connection between the negligent breach of those duties and the damage suffered by the plaintiff.⁶
6. As to the first requirement, the question whether a legal duty exists in a particular case is essentially a value judgment based on considerations of public policy. It is a conclusion of law and depends on considering various circumstances:⁷

"[9] Our common law employs the element of wrongfulness (in addition to the requirements of fault, causation and harm) to determine liability for delictual damages caused by an omission. ... An omission is wrongful if the defendant is under a legal duty to act positively to prevent the harm suffered by the plaintiff. The test is one of reasonableness. A defendant is under a legal duty to act positively to prevent harm to the plaintiff if it is reasonable to expect of the defendant to have taken positive measures to prevent the harm. The court determines whether it is reasonable to have expected of the defendant to have done so by making a value judgment, based inter alia upon its perception of the legal convictions of the community and on considerations of policy. The question whether a legal duty exists

⁵ The argument is thus that the conservative approach adopted by the defendant accorded with the maxim of "first do no harm".

⁶ *Carmichele v Minister of Safety and Security and another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) para 25.

⁷ See *Van Eeden v Minister of Safety and Security* 2003 (1) SA 389 (SCA) para 9.

in a particular case is thus a conclusion of law depending on a consideration of all the circumstances of the case and on the interplay of the many factors which have to be considered. ...”

7. In *Minister of Safety and Security v Van Duivenboden*⁸ the Supreme Court of Appeal held that:

“... Where the law recognises the existence of a legal duty it does not follow that an omission will necessarily attract liability – it will attract liability only if the omission was also culpable as determined by the application of the separate test that has consistently been applied by this court in Kruger v Coetzee, namely, whether a reasonable person in the position of the defendant would not only have foreseen the harm but would also have acted to avert it.”

8. *Van Duivenboden* confirms⁹ that:

“... recognition of a duty of care is the outcome of a value judgment, that the plaintiff’s invaded interest is deemed worthy of legal protection against negligent interference by conduct of the kind alleged against the defendant. In the decision whether or not there is a duty, many factors interplay: the hand of history, our ideas of morals and justice, the convenience of administering the rule and our social ideas as to where the loss should fall. Hence, the incidence and extent of duties are liable to adjustment in the light of the constant shifts and changes in community attitudes.”

9. Negligent omissions will attract liability only if they are wrongful. The question must always be whether the defendant ought reasonably and practically to have prevented harm to the plaintiff.¹⁰
10. The failure of a professional person to adhere to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which he or she belongs would normally

⁸ 2002 (6) SA 431 (SCA) para 12.

⁹ At para 13.

¹⁰ *Minister of Correctional Services v Lee* 2012 (3) SA 617 (SCA) para 34.

constitute negligence.¹¹ A medical practitioner is in no different position to any other professional person, and is not expected to bring to bear upon the case entrusted to him or her the highest possible degree of professional skill. He or she must, however, employ reasonable skill and care.¹² Things sometimes go wrong in surgical procedures and medical treatment even where the greatest care had been taken. A medical practitioner cannot be held to be negligent simply because something was missed. The test remains always whether the medical practitioner exercised reasonable skill and care, that is whether or not his conduct fell below the standard of a reasonably competent medical practitioner in his field.¹³

11. As to the second requirement for liability for the breach of a legal duty, causation involves two distinct enquiries, and must be established on a balance of probabilities. The first enquiry is whether there is factual causation (the “but for” test), and the second enquiry involves legal causation, which relates to foreseeability.¹⁴
12. The court in *NKM (obo BM) v Member of the Executive Council for Health: Eastern Cape*¹⁵ stated the following in relation to factual causation, which is relevant for present purposes:

“It is a trite principle that a successful delictual claim entails the proof of a causal link between a defendant’s claimed culpable actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand. This is in accordance with the flexible “but-for” test. As is indicated by the authorities, in order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the alleged wrongful conduct of the defendant. Sometimes however this enquiry involves the mental elimination of the claimed wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such hypothesis the plaintiff’s loss would have ensued or not.”

¹¹ *Van Wyk v Lewis* 1924 AD 438 at 444.

¹² *Mitchell v Dickson* 1914 AD 519 at 525.

¹³ *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) para 15.

¹⁴ *Lee v Minister of Correctional Services* 2013 (4) SA 144 (CC) para 39.

¹⁵ [2024] ZAECBHC 10 (15 March 2024) para 134.

13. The court held further,¹⁶ in relation to negligence, as follows:

“[190] Concerning the approach to be adopted in determining the issue of negligence the court in Goliath v MEC for Health noted with reference to Lord Justice Hobhouse’s dictum in Ratcliffe that:

‘At the end of the trial, after all the evidence relied upon by either side has been called and tested, the judge has simply to decide whether as a matter of inference or otherwise he concludes on the balance or probabilities that the defendant was negligent and that such negligence caused the plaintiff’s injury. That is the long and short of it.’

[191] The court noted further in this connection that:

‘... it is important to bear in mind that in a civil case it is not necessary for a plaintiff to prove that the inference that she asked the court to draw is the only reasonable inference. It suffices for her to convince the court that the inference that she advocates is the most readily apparent and acceptable inference from a number of possible inferences ...’”

14. The facts of the present matter will be assessed in this context.

The pleadings, and the issues that arise for determination

15. It is trite that a party is bound by their pleadings.¹⁷ I set out the content of the pleadings in relation to merits of the action.

The plaintiff’s particulars of claim

16. The plaintiff pleads that on 9 October 2019 she was admitted to the hospital for a left THR, which she underwent on 15 October 2019.
17. By 17 October 2019, the plaintiff was experiencing a lack of sensation in the first and second toes of her left foot. She was unable to dorsiflex, and she had pins and needles in her left lower limb. The plaintiff received

¹⁶ At paras 190-191.

¹⁷ *Minister of Police v Gqamane* [2023] ZASCA 61 (3 May 2023) para 13.

physiotherapy *inter alia* to address these issues, and wore a splint. She was discharged from the hospital on 23 October 2019.

18. The plaintiff contends that the defendant's legal duty towards the plaintiff was breached because the defendant's employees wrongfully, unlawfully and negligently:

- 18.1 performed surgery in such a way as to cause "*over lengthening*" of the left limb;
- 18.2 failed to advise that further surgery was necessary to correct the discrepancy in leg lengths after the THR;
- 18.3 failed to perform further surgery to correct the discrepancy in the leg length;
- 18.4 caused permanent damage to the sciatic nerve in the lower left limb;
- 18.5 failed adequately to investigate the cause of the sciatic nerve fallout in the left lower limb prior to the plaintiff being discharged on 23 October 2019;¹⁸
- 18.6 failed to consider the possibility that the leg lengthening had caused the sciatic nerve fallout in the left lower limb;
- 18.7 failed to investigate the plaintiff's condition and consider possible alternative treatment options after six months had elapsed after the operation;
- 18.8 failed to prevent permanent damage to the sciatic nerve in the left lower limb by administering timeous corrective surgery or treatment;

¹⁸

Subparagraphs 5 to 7 were included by way of an amendment to the particulars of claim after evidence had been led, and in preparation for argument. The amendment was not opposed, and the defendant effected consequential amendments to the plea.

and

18.9 failed to act with due care.

19. For the plaintiff to be successful in her claim she must therefore prove, on an assessment of the probabilities, that the “lengthening” of her left leg (by correcting the centre of rotation of the hip from a pathological position to an anatomically correct one) was the cause of the sciatic nerve injury and, had revision surgery (or alternative treatment) taken place, she would not have suffered any ongoing motor or sensory fallout.

The defendant’s plea

20. In her plea, the defendant admits that the THR took place on 15 October 2019, after which partial sciatic nerve fall-out was noted. She pleads that the employees at the hospital did not act negligently, and that the plaintiff’s partial nerve injury was treated correctly in the circumstances, in that, *inter alia*:

20.1 The plaintiff had been at high risk of sciatic nerve fallout, given that she had suffered from bilateral developmental hip dysplasia (“DDH”),¹⁹ upon which she received extensive counselling.

20.2 No problems were experienced during the surgery. The injury to the nerve (which presented after the surgery) was partial, and there was no indication that the defendant should further investigate the cause of the injury, nor was there any indication that the surgery should be revised.

20.3 The plaintiff remained in hospital until 23 October 2019 for monitoring.

¹⁹ Hip dysplasia, as explained in the course of the evidence, means that a hip socket does not fully cover the ball portion of the upper thighbone. This allows the hip joint to become partially or completely dislocated, sometimes resulting in an “unevenness” in the level of the hips and the perceived length of the person’s legs.

20.4 The plaintiff showed improvement before her discharge on 23 October 2019, and further improvement thereafter, which justified adopting a conservative approach.

21. A replication was delivered, but it has no bearing on the issues to be determined by this court.
22. The defendant contends that on a consideration of the evidence, including expert evidence, the plaintiff has failed to prove her claim on a balance of probabilities. To assess the legal questions posed, one has to focus on two legal aspects, namely how the “*but for*” test is applied in delictual claims based on alleged medical negligence; and how to deal with conflicting expert opinions.

The evidence presented

23. I refer to the central aspects of the evidence that was furnished, prior to turning to the application of the relevant principles to the facts.
24. Three witnesses gave evidence at the trial. Dr Gerald Versfeld, orthopaedic surgeon, was called as an expert witness on the plaintiff’s behalf. The defendant called two witnesses, namely Dr Jordaan as a factual witness, and Dr Thane Munting as an expert witness. These witnesses are both orthopaedic surgeons.
25. The plaintiff did not testify. She relies on Dr Versfeld’s (and in part Dr Munting’s) interpretation of the medical records as the factual basis for her claim.

Factual evidence for the defendant: Dr Jordaan

26. Dr Jordaan is an 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.

27. Dr Jordaan performed the plaintiff's THR surgery. As the plaintiff herself did not testify, the relevant facts are mainly to be gleaned from the evidence that he presented on the defendant's behalf, in conjunction with the medical records to which he referred.²⁰ He was at the scene, so to speak. Dr Jordaan's evidence dealt in detail with how the plaintiff first presented to the hospital, her treatment upon admission in October 2019, the surgery, the treatment she received thereafter, and the interactions he had with her throughout this period.
28. Dr Jordaan stated that he recalled the matter well. He had independent memory of his interactions with the plaintiff because he had a good relationship with her. Her case was an interesting and complex one. The plaintiff presented with severe bilateral DDH, and a complication post-surgery – the sciatic nerve injury at the heart of this case.
29. The plaintiff's planned second surgery for a THR for the right hip was cancelled in December 2020 due to a breakdown in the air-conditioning in the theatre at the time. Covid-19 caused a further delay in the surgery to the right hip. In March 2021 the surgery was again deferred, as it clashed with an Islamic religious event. Finally, in May 2021, after being notified of the pending litigation, Dr Jordaan was told by the hospital authorities that he should not perform the second surgery.
30. The plaintiff was unhappy about the fact that the litigation affected her relationship with him, as she had been under the impression that the claim against the hospital would not affect her second THR. On this note, the medical records show that she requested a right THR, complaining of pain in

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No express agreement was reached between the parties about the status of the discovered documentation. The defendant's counsel prepared a useful timeline in relation to the relevant documents, with which no issue was taken in the course of argument. A copy thereof is attached to this judgment as "A".

that hip, and consenting to the surgery despite the warning of the real possibility that she would again experience nerve fall-out. The defendant argues that the reasonable deduction to be made is that the plaintiff did not have any complaint with the surgery which took place on her left hip.

Prior to the surgery

31. In any event, Dr Jordaan explained that the plaintiff was assessed at the hospital in July 2018, scoring a prioritisation rating of 55/100. She had severely dysplastic hips (denoted by what is known as a Crowe III rating), and was morbidly obese (she had a high body-mass index (BMI)). The plaintiff presented with equal leg lengths (there was no significant difference apparent radiologically), and there was also no significant differentiation in the alignment of her hips. In May 2019 the plaintiff presented and was scored again, this time reaching a prioritisation score of 95/100. She was seriously disabled, with a pain score of 8/10 at rest and 10/10 when active. She was accordingly a candidate for surgery at the hospital.
32. Dr Jordaan warned the plaintiff of the risks involved with a THR, especially considering her dysplastic hips. The various risks attached to, amongst other factors, the implants to be used, the administration of general anaesthetic, and the implications of the plaintiff being a smoker for the healing of the wound.²¹ Dr Jordaan testified that the plaintiff would also have been handed a physiotherapy booklet, which did (and still does) not include any warning about sciatic nerve fallout, as this is not a common risk in standard hip replacement surgeries. He did, however, warn the plaintiff about these possibilities. Given the severity of her condition, there was extensive pre-operative planning involved.

The surgery

33. The plaintiff's surgery took place on 15 October 2019. It proceeded without

²¹ It was common cause that the plaintiff was a smoker.

problems, and in hindsight Dr Jordaan would not have changed anything about the surgery if he had to redo it. Dr Jordaan explained that he positioned the acetabulum²² and femoral head to be as close as possible to the normal anatomical position, but that it was slightly shorter (by about 13mm) when compared to normal anatomy (that is, the placement of the hip had the plaintiff developed normally, without DDH). He estimated that he brought the centre of rotation of the hip down by roughly 38mm. In cross-examination he stated that he used the shortest femoral prosthesis.

34. Dr Jordaan was concerned about the risk of sciatic nerve throughout the surgery. He therefore palpated the nerve on three occasions, assessed that there was normal tension once the implant had been inserted, and assessed the amount of bleeding. He found that there was no need for a drain, which would have been placed if there was a concern about the formation of a haematoma.

Post-surgery, up to 23 October 2019

35. The plaintiff remained in hospital until 23 October 2019. On 16 October 2019 it was noted that she had a “flickering” of the left foot. Dr Jordaan confirmed that there was a discrepancy between the doctor’s and physiotherapist’s notes on 16 October 2019, as far as the “flickering” is concerned. He ascribed it to the physiotherapist being a student at the time, and not a qualified physiotherapist.
36. On 17 October 2019 one of the doctors on duty, Dr Basson, recorded that the plaintiff had a drop foot, that there was no sensation in the first and second toe, that she had no power in the foot and could not dorsiflex,²³ and that she was experiencing pins and needles.
37. The medical notes for 18 to 21 October 2019 continue to record the drop foot.

²² A concave (that is, curling inwards) surface of the pelvis. The head of the femur meets with the pelvis at the acetabulum, forming the hip joint.

²³ That is, she could not move her foot upwards towards her shin.

Dr Jordaan testified, however, that when he examined the plaintiff clinically on 21 October 2019, he noted an improvement in her condition, specifically in relation to the drop foot. He explained how he would have tested the plaintiff's motor function, which included considering the muscle strength in her ankle. He stated that the injury was partial²⁴ (this was common cause at the trial), and the implications of the sensory and motor fallout at the time were that the plaintiff could flex her foot downwards. It was only the big toe that could not extend upwards, and she could not pull her ankle upwards from a 90-degree position.

38. According to Dr Jordaan, he considered various possibilities in relation to the cause of the injury, amongst them whether there could have been a haematoma. He therefore examined the dressing at the surgery site: there was no indication of atypical swelling. The leg was soft, and there was no hard swelling or masses in the leg. He also ensured that the knee was moving well, with the normal range of motion, and no stiffness in the hip joint. He discarded the possibility of injury to the sciatic nerve during surgery, especially as cement was not used and there was no force on the sciatic nerve during surgery (it is common cause that the surgery took place without incident).
39. The plaintiff argues that the reason that Dr Jordaan did not investigate the cause of plaintiff's nerve injury was because he believed that the fallout was caused by surgical swelling. This was his evidence: he testified that he attributed the injury to surgical swelling and that he believed that once the swelling went down there would be no further damage. There was thus no reason to investigate further. On a consideration of his evidence as a whole, however, it is clear that this view was formed on the basis of Dr Jordaan's observations in relation to a variety of relevant aspects. Dr Jordaan testified that he discussed the plaintiff's condition with colleagues and students in the department, and given that the injury was partial with no clinical indication of

atypical swelling, he decided that the plaintiff should be closely monitored. If her condition worsened, the position would be reconsidered.

40. Dr Jordaan saw the plaintiff on various occasions post-operatively, prior to her discharge. She seemed to be improving each day, and he therefore decided upon a conservative management of the situation. Dr Jordaan added that he had a lengthy discussion with the plaintiff prior to her discharge on 23 October 2019 about what had occurred, and what the plan for future management was. He testified that it was natural that she was in pain post-surgery. Prior to the surgery her pain was 10/10 when she was active, so purely on that basis she had already improved. As she was actively "*getting better*" he thought that a possible reason for the initial fallout was surgical swelling. In cross-examination he stated that surgical swelling (internal swelling around the wound site) would generally go down after approximately two weeks. In the plaintiff's case, given her status as a smoker and of more advanced age, the process could take longer.
41. He explained, however, that he remained unaware of the cause for the nerve injury, and that the plaintiff therefore fell in the percentage of cases where the aetiology of sciatic nerve injury remains unknown.
42. Dr Jordaan stated that there was no indication for further investigation as suggested on behalf of the plaintiff during the trial. Even if there had been, an ultrasound would not have been useful, given the plaintiff's high body mass index, and a CT scan is most helpful to assess bone (which had already been considered by way of X-ray to assess the correct placement of the prosthesis). There was no indication for an MRI. There was also no reason for revision surgery, as there was no indication of a haematoma, and the injury was partial.
43. In cross-examination Dr Jordaan was asked if he considered the injury to the sciatic nerve to have been caused by traction (or lengthening of the leg). He answered that he had not. He added that there was never any concern about traction, given the pre-operative planning, the measurements taken

intra-operatively, and the fact that there was no overlengthening of the leg, since the hip was merely restored to approximately (or slightly higher than) the correct anatomical position from the pathological position. He explained that a lengthening of less than 4cm is generally acceptable, and that the pelvis can accommodate a 2cm difference. He had calculated the lengthening intra-operatively, and was at no time concerned that he had lengthened the leg beyond what is acceptable. The plaintiff's leg length discrepancy (which was less than 4cm) was therefore not significant.

44. Dr Jordaan stated that he used his experience and clinical skills, and weighed up what was the best course of action in the circumstances. He discussed the case with other registrars, a fellow, and with students. The decision was therefore made by drawing on a pool of knowledge and experience.

Post-discharge: 3 November 2019

45. According to the medical notes, the plaintiff came to the hospital on 3 November 2019, complaining of increased pain in her foot. Dr Jordaan testified that he did not see her on that occasion, and that he could not say much about the visit or the notes taken then. He was merely told, the next day, that the plaintiff had been satisfied to take additional pain-killers prior to returning home. On the notes, he added that no evolving nerve lesion was mentioned, and there was still no indication for further investigation. In cross-examination, Dr Jordaan pointed out that upon the plaintiff's arrival at the hospital she was examined by an intern in the casualty unit, and triaged. He added that an intern's understanding of pathology will not be as good as a specialist such as Dr Wiese, who was the orthopaedic registrar who later attended upon the plaintiff.
46. Upon being asked why Dr Jordaan did not further investigate the cause of the plaintiff's pain at that stage, he testified that what needed to be considered was if there was disproportionate pain. He added that the pain-killers (paracetamol) given to the plaintiff seemed to have had the desired effect, and that there was nothing more that required investigation. In fact, the

prescribed medication (amitriptyline) also given to her was of a low dosage, and was probably given because Dr Wiese wanted to give the plaintiff something to stop “*nerve irritation*”. He reiterated that, before the surgery, the plaintiff’s pain score was 10/10 when she was active. Her pain had been managed well post-surgery. The only analgesic which she received on 3 November 2019 was paracetamol.

47. Dr Jordaan reiterated further that he considered that the injury was partial, and that there was nothing that the MRI would have noted, as there was clearly no haematoma. A nerve conduction test would only be of clinical value after six months.

Follow-up consultation on 29 November 2019

48. A further note dated 29 November 2019 is contained in the medical records. Dr Jordaan stated that there was no worsening of the plaintiff’s condition. The fact that she experienced paraesthesia indicated that there was some sensation. By that time the plaintiff was on crutches. Her pain had improved and that she was wearing an ankle-foot orthosis (AFO) to assist with her drop foot.
49. In cross-examination, Dr Jordaan explained that even if her condition remained static, there was not enough evidence to indicate further investigation. It was put to him that the plaintiff was unable to dorsiflex shortly after the surgery. She had reduced sensation, and could not extend her big toe. By November 2019 (six weeks later), she still had limited motor function, and her condition remained “unchanged”.
50. Dr Jordaan explained, however, that the limited motor function experienced in November 2019 was not the same as no motor function, which was the case on 17 October 2019. The medical note taken on 29 November 2019 stated that there was “*nerve function recovery*”, and the doctor who assessed the plaintiff must have found that the nerve was recovering clinically. It was put to him that he should nevertheless have ordered an MRI when she

presented at the hospital after six weeks. Dr Jordaan repeated that there had been some recovery, and the injury was partial. One only investigates if one is planning to perform further surgery, and there was no reason in the circumstances to subject the plaintiff to further surgery.

Further assessment on 12 December 2019

51. Dr Jordaan testified that the medical record of 12 December 2019 showed further improvement in the plaintiff's condition, and in her activities of daily living.

Preparing for the second THR: November 2020 to May 2021

52. Dr Jordaan saw the plaintiff again in November 2020 when she came to the hospital in contemplation of a THR on the right. He stated that despite warning the plaintiff of the likelihood of nerve injury occurring again (as the cause of the previous injury was unknown and, according to Dr Jordaan, he could not have done anything differently), the plaintiff felt that regardless of the limitation of her big toe and ankle flexion on the left, she was happy with the functional outcome of the left THR, and she wanted to proceed with the right hip surgery.
53. It was noted in cross-examination that the plaintiff could at that stage dorsiflex to a neutral position, and Dr Jordaan therefore stated that that would be characterised as motor power ranking at 3/5. Upon it being put to him that she was walking with a crutch, he stated that the plaintiff was in pain from the right hip, which was progressively getting worse. This was supported by the relevant medical records.
54. It was again put to him that he should have further investigated the plaintiff's condition, as any residual swelling from the left THR would by that stage have gone down. Dr Jordaan stated that nerve regeneration can be as slow as 1mm per month, and take as long as two years for the end point of recovery. There was thus still no need for further investigation.

55. In December 2020 the plaintiff was admitted to hospital to attend to the right THR. She was admitted early (as had been the case prior to her left THR) to ensure proper pre-operative planning. The medical notes record that the plaintiff was at that stage pain free in the left hip, and that she was very happy with the outcome of the left THR. At that stage the plaintiff was able to walk unaided in sandals, and her motor function was therefore considered normal.²⁵
56. The surgery was unfortunately cancelled due to the failure of the air conditioning in the theatre, when the plaintiff was already under anaesthetic.
57. On 22 April 2021 the plaintiff again came to hospital for the THR of the right hip. She was able to walk unaided and in normal shoes, and had altered sensation in the first web space of the foot. Her foot drop was said to be more or less resolved, although she presented with pins and needles. He added in cross-examination that there was clearly nerve regeneration, and that her motor function would have been 3/5, and only if it were 0 or 1 out of 5 would that have warranted further investigation and potentially a tendon transfer.
58. This time the surgery did not proceed because of the intervention of Eid-al-Fitr.
59. In May 2021 Dr Jordaan had a meeting with the plaintiff. He explained that he was compromised because of an internal investigation into the plaintiff's surgery, and the possibility of litigation (this action was instituted in June 2022). He therefore referred the plaintiff to the Groote Schuur Hospital. The plaintiff was upset that Dr Jordaan could not perform the surgery. She told him that she had lost her employment during Covid-19, and that the litigation was nothing personal. In cross-examination, it was put to him that the

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The plaintiff's tibialis anterior muscle (at the front of the lower leg) had recovered completely, and the condition of the extensor hallucis longus muscle (the main action of which is the extension of the big toe) was recorded as 4+/5.

plaintiff's admission sheet in 2019 recorded that she was unemployed at that stage already. Dr Jordaan responded that he remembered was that she had said that she had lost her employment as a seamstress due to Covid-19.

60. I have mentioned that the plaintiff did not give evidence. Her version of what she told Dr Jordaan at the interaction in May 2021 is unknown, and his evidence in this respect stands uncontested, for what it is worth.
61. Dr Jordaan's conclusion, based on his experiences in relation to the plaintiff's case after her surgery, was that he could not find the cause for the sciatic nerve injury. He could only postulate that it was possibly due to post-operative swelling, but in about 50% of cases a cause is never found.
62. I shall return to the plaintiff's criticism of Dr Jordaan's evidence, which was provided as factual, not expert, evidence. At this juncture, I set out the expert evidence given on each party's behalf, after a statement of the principles underlying the evaluation of expert evidence.

The expert evidence

63. It is trite that an expert's opinion is relevant and admissible when, by reason of his or her special knowledge and skill, such expert is better qualified to draw inference than the court and. The expert is, on account of his or her attributes or qualities, able to provide significant benefits to the court in determining legal disputes.²⁶ An expert's opinion must be properly reasoned in order for it to be of assistance:²⁷

"[A]n 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

²⁶ *SARS v Stepney Investments (Pty) Ltd* 2016 (2) SA 608 (SCA) para 16; *PriceWaterhouseCoopers Inc and others v National Potato Co-operative Ltd and another* [2015] 2 All SA 403 (SCA) para 98.

²⁷ *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371.

expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert."

64. In *Den Hartog NO obo NAH v Road Accident Fund*²⁸ the court held as that *"while experts are entitled to make assumptions, they should avoid basing their opinions on conjecture or speculation for once they do so they place their evidence at risk of being disallowed. Expert witnesses ought to confine their testimony to their respective disciplines but at times and under suitable conditions may venture outside their area of expertise. If it becomes necessary to step out, they should then and there declare."*

65. In *Michael and another v Linksfield Park Clinic (Pty) Ltd and another*²⁹ the Supreme Court of Appeal considered the evidence of five expert witnesses concerning the conduct of anaesthetists. In relation to the preferred approach to conflicting expert opinions, the court stated:

"... it is perhaps as well to re-emphasise 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.

...

*That being so, 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."*³⁰

66. In *Life Healthcare Group (Pty) Ltd v Suliman*³¹ the Supreme Court of Appeal

²⁸ [2024] ZAGPJHC 1196 (18 November 2024) para 33.

²⁹ 2001 (3) SA 1188 (SCA) paras 34 and 36.

³⁰ See also *Van Wyk v Duze and another* [2025] ZANHC 2 (17 January 2025), which involved a THR. Incidentally, the court in *Van Wyk* accepted (at para 69) the view expressed by the experts involved there (and as stated by Dr Jordaan in the present matter) that the cause in 50% of nerve injuries remains unknown.

³¹ 2019 (2) SA 185 (SCA) para 15.

reiterated that, in assessing conflicting expert evidence, one must determine whether the expert opinion is founded on logical reasoning. The court warned against readily accepting isolated statements by experts, especially in a field where there is no medical certainty. It is for the court to weigh the evidence as a whole and make a finding based on what was presented.

67. A 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. 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. 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.³²
68. Expert evidence is only as sound as the factual evidence on which it is based. The less fixed the assumption and the fewer hard facts available to the expert, the greater the scope for alternative conclusions.³³
69. I consider the expert evidence furnished in this matter against this background. The experts were questioned at length, especially in cross-examination, and the evidence is wide-ranging. I focus on what I regard as the salient aspects.
70. A joint minute was prepared between Dr Versfeld and Dr Munting. They agreed that the plaintiff had a diagnosis of osteoarthritis of the left hip, secondary to developmental dysplasia of the hip. She also had developmental dysplasia of the right hip. A left THR was done on 15 October

³² *Michael and another v Linksfield Park Clinic (Pty) Ltd and another supra* paras 37 to 39.
³³ *Harrington NO v Transnet Ltd t/a Metrorail* 2010 (2) SA 90 (SCA) at 107 F-G.

2019. As a result of the hip replacement surgery, there was a lengthening of the left leg at the hip joint. After the surgery, it was noted that the left leg had altered sensation around the foot, and that there was an inability to dorsiflex the foot. There was motor as well as sensory nerve fallout emanating from the sciatic nerve following the injury.

71. The experts diverged on the cause of the injury, and on the reasonable follow-up measures that could, or should have been undertaken.

Expert evidence on the plaintiff's behalf: Dr Versfeld

72. Dr Versfeld is an orthopaedic surgeon of many years' standing. He qualified in 1968, and has been in private practice since 1977.
73. Dr Versfeld's opinion is concise: where, after a hip replacement procedure, any overlengthening of the leg exceeds 2cm and there is evidence of sciatic nerve damage, as in the present case, then the procedure that ought to have been followed post-surgery was to perform revision surgery to rectify the overlengthening as soon as possible. This is because failure to do that was likely to result in permanent disability. Dr Jordaan should thus have re-operated on the femoral stem and corrected the overlengthening of the plaintiff's leg. Dr Versfeld does not mention, in his report, that further investigation was necessary prior to the plaintiff's discharge, although this aspect came up during the course of his evidence.
74. Dr Versfeld's opinion, as set out in his report, is that the THR was performed negligently as there was overlengthening. Both expert witnesses agreed that leg lengthening means the difference between the length of the leg before and after the operation, although (as the experts agreed) this was in fact a perceived lengthening because of the repositioning of femoral head during the THR surgery.
75. If the leg measures longer after the operation, because the head of the femur has been moved down from its previous raised position, the leg has been

lengthened. This lengthening is an inevitable consequence of surgery of this nature. Dr Versfeld was of the view that such overlengthening caused damage to the plaintiff's sciatic nerve and *"the surgeon failed to take Plaintiff back to theatre as soon as possible in order to correct the deformity so as to avoid permanent disability"*. Dr Versfeld does not venture a cut-off time by when it would be too late for revision surgery to be effective, and he was unable to state by when the damage would become permanent. He did indicate that, unless he had no doubt that overlengthening had caused the injury, he would not rush in without performing further investigations like an MRI or ultrasound.

76. In Dr Versfeld's view, a THR was the most appropriate treatment in the plaintiff's case. He accepted the opinions expressed in the academic literature to which he was referred,³⁴ in relation to the applicability and risks inherent in the procedure. The THR in the present case was difficult and highly specialised, given the gravity of the plaintiff's condition. Nothing untoward occurred during the surgery.
77. He was further of the view that one can only consider the extent of the lengthening of the leg after the surgery. The centre of rotation and hip socket was, post-operatively, in the correct anatomical position, with the correct angle of the acetabulum to the femoral stem. The acetabulum was placed slightly higher in the socket than what you would see in an anatomically correct hip joint, and therefore the leg was slightly shorter than if the plaintiff had grown up without DDH. Ideally, in his view, the leg should not be more than 1cm longer than its original length. In the present case, he calculated that the lengthening was approximately 4.18cm, and that the leg length discrepancy was approximately 5 centimetres. He suggested that the prosthesis used by Dr Jordaan may have been too long.
78. Dr Versfeld agreed with the relevant literature that the cause of sciatic nerve injury remains unknown in about 50% of cases, but stated that in the plaintiff's

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Hasija *et al* "Nerve injuries associated with total hip replacement" *Journal of Clinical Orthopaedics and Trauma* 9 (2018) at 81-86.

case the “*significant overlengthening*” was the “*probable cause*” of the injury to the nerve. He said that he could not, however, with absolute certainty rule out the possibility that the injury was caused by compression. He testified that once the possibility of intra-operative damage to the nerve has been excluded, one is left with two possible causes for the sciatic nerve damage, namely compression of the nerve by a haematoma, or stretching of the nerve as a result of overlengthening. This evidence was not contradicted by Dr Munting, who testified that leg lengthening could have been a cause of the nerve injury but that he could not definitively say that it was, and one would need to investigate on the basis of the symptoms displayed as a result of the injury.

79. Dr Versfeld agreed, in cross-examination, that performing revision surgery could have damaged the nerve, further, and could have done more harm than good. In any event, given the nature and extent of the THR surgery, one would have expected the plaintiff to have experienced pain afterwards. He conceded, further, that improvement was shown after the surgery, and by the time of the plaintiff’s insistence of a THR of the right hip, there was marked improvement of her functioning as well as her experience of pain. According to the medical notes, by April 2021 the foot drop had more or less recovered. She had good hip function and no hip pain, although still experiencing pins and needles. As there was improvement, this could have indicated that the nerve was starting to recover.
80. His opinion nevertheless remained that the defendant was remiss in failing to investigate the cause of the injury by way of revision surgery.
81. Dr Versfeld testified that he has never performed a THR on a patient with bilateral DDH, such as the plaintiff. He had also asked a colleague “*who did hip replacements*”. Over his career, he performed thirty-five THRs, and he acknowledged that a THR for a patient with DDH is complex. He has never performed a revision surgery. In my view he was therefore not confidently able – as expert witness - to assist in explaining the method which should have been adopted to address the plaintiff’s condition post-surgery. At best

he could suggest that the plaintiff's leg would need to be shortened by shortening the femoral stem.

82. Given his relatively limited (as opposed to Dr Munting's) experience in the context of the present case, Dr Versfeld's inability to state what the outcome of revision surgery or of further investigations would have been, creates difficulties for the plaintiff in proving that, had further intervention taken place, she would be entirely without complaint.
83. Dr Versfeld based his opinion that there was excessive overlengthening of the plaintiff's leg on the assumption that, if a leg is lengthened more than 2cm, it is overlengthened. According to his measurement the leg was lengthened by 4.18 centimetres. This is not supported by the medical records which indicate the leg length discrepancy as 3cm and 2,9cm.
84. As will appear from the discussion below, Dr Munting explained that in measuring the leg length according to the X-rays, Dr Versfeld must have "upscaled" instead of "downscaled", in other words, he confused the nature of the measurements. This is borne out by the medical records which do not support the notion that there was a leg length discrepancy of almost 5cm, as estimated by Dr Versfeld. Dr Versfeld's opinion is therefore based on the incorrect presumption that there was an overlengthening of the plaintiff's leg.
85. When Dr Versfeld was asked what he based his opinion on whether, if a leg is lengthened by more than 2cm and nerve injury presents, revision surgery should take place, he stated that he read about the issue, and sought the advice of a colleague who specialises in hip replacements. Upon being asked where the figure of 2cm came from, he stated that he remembered it being taught to him. These are not reliable sources upon which to base an expert opinion.
86. Dr Versfeld testified, in answering a question about the plaintiff's condition after her discharge from hospital, upon the medical note of an intern of one

isolated incident on 3 November 2019 when the plaintiff returned to hospital with pain and loss of sensation in her whole foot, that the nerve injury was progressing. This is doubtful - as stated below, Dr Munting explained that the whole leg and not just the foot would be compromised in the event of further injury to the nerve. It appears from the note that the plaintiff was treated with paracetamol and a low dose of amitriptyline, and that she was ready to return home in the morning. The medication accordingly had the desired effect. She attended at the hospital again for her scheduled appointment for 29 November 2019.

87. In evaluating the evidence given by both Dr Versfeld and Dr Munting (whose evidence is set out below), I tend to agree with the submission by counsel for the defendant that Dr Versfeld's opinion is, in the particular circumstances of the present matter, not based on logical reasoning. He came across as fixated on the notion that the plaintiff's injury had been caused by what he regarded as the overlengthening of her leg. He also does not have as much practical experience as Dr Munting in the particular field of surgery, and therefore unable to guide the court in deciding what the reasonable follow-up steps would be in the plaintiff's particular circumstances, the probable cause of the plaintiff's nerve injury, what difference further investigations or scans would have made, and what the probable outcome of such further investigations or revision surgery would have been.

Expert evidence on the defendant's behalf: Dr Munting

88. Dr Munting is a practising orthopaedic surgeon with extensive knowledge and experience in the field of hip replacements, which includes performing THRs to patients with DDH, and revision surgeries. Hip replacement is his speciality. He remarked that very few people are trained and experienced in the performance of these types of surgeries, which are complicated.
89. In his opinion, a patient with a classification of Crowe III (such as the plaintiff), would not require femoral shortening. He contrasted this with a

patient who presents with a Crowe IV rating, in whose case the migration of the femoral head would be so high that the correction and placement in the anatomically correct position would require femoral shortening.

90. The movement of the femur dictates how much stretching is involved during a THR. Pre-operative planning is therefore imperative. With regard to the medical notes in relation to the plaintiff's THR, Dr Munting agreed that the correct prosthesis was used for her. He added that the surgery seemed to have taken place without any misadventure.
91. There is a material difference in opinions of Dr Munting and Dr Versfeld in respect of the lengthening of the plaintiff's left leg. Dr Munting emphasised that lengthening is to be understood as the perception of length. As pointed out by Dr Jordaan, the femoral head had to be repositioned from a pathological state to an anatomically correct position, and was about 13mm shorter than what it probably would have been had the plaintiff developed normally.
92. Dr Munting measured that the lengthening in the present case was approximately 2cm, and he was thus in disagreement with Dr Versfeld's measurement. He thought that Dr Versfeld must have upscaled the measurement to have arrived at 4.18cm.
93. Dr Munting explained that there was, historically, a school of thought that held that lengthening caused harm to the sciatic nerve. He stated that the rule of thumb³⁵ has always been 4cm, and as a registrar he had been taught that more than 2.5cm attracted increased risk. There is, however, no direct correlation between an amount of lengthening and sciatic nerve injury. Some patients can have no nerve injury after a lengthening of 5cm, and some can have nerve injury with a lengthening of only 1 cm. The variables are endless.

94. Dr Munting testified that the usual course in the case of nerve injury is to wait and see if there is a trend of improvement. If there is no improvement, or if there is worsening (which could suggest ongoing trauma like a suture through the sciatic nerve), then one would consider revision surgery. If there is an improvement, there would be no need to investigate further.
95. In cross-examination, Dr Munting stated that patients who have congenital dysplasia (such as the plaintiff) are at higher risk, because of the complexity of the surgery which is required, and the consequent lengthening of the leg. In the case of the latter, he added that the risk is heightened because the sciatic nerve had never fully grown. Given the variables, there can be many reasons for a nerve fallout. In Dr Munting's view, a lengthening 2cm or 2.5cm is not unreasonable. Even if the measurement of the lengthening was 3cm, that would still be within the acceptable norms, and would not be considered overlengthening. In any event, clinical assessment of a patient for leg lengths is the most inaccurate way of assessing. He said that the only accurate way of measuring leg lengthening is by considering a mechanical axis X-ray view.
96. The plaintiff argues that Dr Jordaan's evidence in relation to what would constitute overlengthening was inconsistent with Dr Munting's evidence that there is no fixed length at which overstretching can occur – each patient is different and responds differently to trauma, with the result that an overlengthening of 1cm could result in nerve injury in one patient whilst an overlengthening of 5 cm in another patient could cause no damage at all.
97. Dr Jordaan failed to measure the plaintiff's leg length post-operatively, which, so the plaintiff argues, was a fundamental error. If limb lengthening is an inevitable consequence of this surgery and if there is a known risk of sciatic nerve injury in patients with DDH arising from the limb lengthening, as Munting testified, then the first thing that Dr Jordaan should have done on becoming aware of the nerve palsy was to measure plaintiff's leg to determine the degree of lengthening. This is what Dr Munting would have done. Thus, had Dr Jordaan done this measurement immediately post-

operatively, he would have been aware that plaintiff's leg had been overlengthened. In the context of sciatic nerve palsy, which has been positively linked to leg lengthening in the literature, this would have pointed to the need for further investigation and possibly revision surgery, particularly after the elimination of a haematoma as a potential cause of the injury. However, this was not done because Dr Jordaan, who was aware of the risk that the sciatic nerve could be stretched by overlengthening of the leg, testified that he did not consider this possibility.

98. The argument does not take account, however, of Dr Munting's evidence that there are many variables in relation to the cause of a sciatic nerve injury. This is coupled with what Dr Jordaan testified as to his observations when the injury presented itself. Dr Munting stated that if there is any improvement in a patient's condition in the early post-surgery period, the consensus amongst medical practitioners is that one does no more than observe. One would expect changes over a six-month period post-surgery. On the necessity for revision surgery, Dr Munting stated that factors which would have been taken into consideration included that the plaintiff had a high BMI, that the initial surgery was complex, that she was at high risk of infection during revision surgery, and that there was a chance of further injuries during such surgery. He added that the revision surgery usually entails the freeing up of the nerve, if there is a constriction, alternatively a shortening osteotomy. It is not an easy operation - there are substantial risks and no guarantees.
99. Dr Munting pointed out that doctors should live by the standard of "*first do no harm*". The proper reaction in the case of complications is case-specific. One would reflect on the surgery, consider if the fallout was substantial, and whether it was complete or partial. He added that Dr Jordaan is a senior and experienced surgeon, and that it was his call to adopt a conservative approach. He did not view such call as unreasonable in the circumstances.
100. As regards the plaintiff's visit to the hospital with seemingly increased pain on 3 November 2019, Dr Munting explained the difference between

expected and unexpected pain. An altered sensation is not too important, but one would concentrate on the pain. In cross-examination Dr Munting stated that there could be increased pain two or three weeks after surgery because of the increased blood flow to the area. He said that this could include extreme pain. Swelling to the left foot would not be unexpected at such time. He also said that if the nerve injury had progressed to include the whole tibial nerve, then not just her foot would have been affected, but the entire lower leg. He stated that pain must be “associated” pain. Therefore, if the plaintiff had presented with motor and neurological fallout and excessive pain directly after the surgery, then you would need to take active steps.

101. If, as in the present case, the plaintiff is discharged with some improvement in her condition, and she presents with pain three weeks later, he would expect that there had been some sort of trauma, and he could not comment on where the pain might have come from.
102. Upon it being put to Dr Munting in cross-examination that on 3 November 2019, when she presented to the hospital in pain, further investigation should have taken place, he stated that it was not necessarily the case, and that such a decision relies heavily on the consultant in charge. If you were to have a team of surgeons answer that question, half would agree and half would disagree. It depended on the particular circumstances of the matter.
103. A variety of investigation options was put to him. He was of the view that ultrasound would not be useful, given the plaintiff’s high BMI. MRI scans were difficult to access in the public sector, and CT scans would not be of much assistance as they show mostly bone. He added that if you require an MRI you would need to schedule it immediately, and that you would need to make a decision more quickly than in a week (which is when Dr Jordaan stated it would be available by). Whilst an MRI would be able indicate to a blood clot, such a possibility was remote in the present case, because the plaintiff did not show the relevant changes in her condition.
104. It was put to Dr Munting in cross-examination that the medical notes taken

on 28 November 2019 do not indicate any improvement in the plaintiff's condition. Dr Munting pointed out that there is reference to "*nerve function recovery*". He said that he was unsure what the starting point was. He could only presume that she must have been better than before, as the note mentioned limited motor function, not no motor function. Therefore, according to his interpretation of the note, there was some improvement. As to the note taken on 12 December 2019, he observed that it stated that the plaintiff appeared to be doing well, and there was no report of pain.

105. On 5 November 2020, a year after the surgery, he noted that there was no worsening in her condition, and that she stated that she was pain free in the left hip, that she had good range of motion, and that she was happy with the outcome. In cross-examination it was put to him that she could dorsiflex to neutral, and that there is a weak dorsiflexion in the big toe, in other words, there had not been not much of an improvement. Dr Munting agreed that the improvement was not much, but there was improvement nonetheless. One expected small improvements over an extended period, but a deterioration would raise a red flag.
106. The note taken in April 2021 specifies that the plaintiff had more or less recovered from the foot drop, and that she had some pins and needles. It was put to Dr Munting that this was almost twenty months after the surgery (the defendant argued that the period was closer to eighteen months, or nineteen at most). He replied that one usually considered a two-year period as the end point of recovery. The progress over a six-month period would be observed, and if one adopts a conservative approach, one would monitor the improvement over the course of two years. Muscle function would be assessed if it was dire.
107. He explained that one wanted to see a trend over six months to two years, even if it was gradual. If there was no improvement, then one would consider electromyographic studies. Dr Munting was of the view that to ascertain whether the correct treatment was administered, he would need to consult with her in her present condition. The plaintiff's counsel stated that

she could not tell him what the plaintiff's current condition was.

108. Dr Munting's opinion in relation to the cause of the injury was that the sciatic nerve fallout was due to the complexity of the surgery. Unlike Dr Versfeld, he could not state that the leg lengthening was the cause. He could also not state that plaintiff would have recovered if revision surgery had taken place. He was of the view that the correct decision had been made given how much the plaintiff had improved, and given the shortcomings and risks involved in revision surgeries.
109. Given the extensive nature of the respective experts' evidence, both in chief and in cross-examination, it is important to remind oneself that what needs to be assessed is whether, had the defendant done something differently post-surgery (in other words, had Dr Jordaan taken a different approach), the outcome would have been different for the plaintiff. This is to be decided on a balance of probabilities.
110. As the plaintiff did not testify, it is not known what her current condition is, or what her condition was two years after the THR. One is therefore reliant on what Dr Jordaan testified in relation to his final interaction with her in May 2021, which was nineteen months after the surgery. What are the inferences to be drawn from the evidence? The expert evidence is crucial.
111. The expert opinions of Drs Versfeld and Munting differ materially. I have already indicated that I prefer the evidence of Dr Munting, who is up to date with the current practical and academic views on the subject. The plaintiff argued that Dr Munitng's evidence is to be doubted because he knows Dr Jordaan well, and thus have a benevolent attitude towards him. He also made positive statements about Dr Jordaan's character, such as that the latter is a "straight arrow" and that he is not lazy. The plaintiff argued that it is clear from these statements that Dr Munting is predisposed to believe that Dr Jordaan's treatment was adequate, and that this has skewed his testimony in favour of defendant.

112. I could pick up no attempt in Dr Munitng's evidence of a biased attempt to influence the court in finding in Dr Jordaan's favour. Viewed holistically, his evidence remained focused on a consideration of the plaintiff's history and the circumstances prevailing when the injury presented itself (as well as it could be considered without having consulted with the plaintiff), and a frank explanation that the nerve injury could have been caused by a variety of factors.
113. Dr Munting emphasised that this type of surgery is complex. The manner in which it is dealt with should be determined on a case-by-case basis, and depends very largely on the clinician who extensively consulted with the patient, and who can therefore appreciate the progression (or regression) of their condition. There is no absolute rule to follow. Given the plaintiff's gradual improvement, he thought that Dr Jordaan's approach was appropriate.

Discussion

114. The plaintiff argues that Dr Jordaan's evidence must be discounted in its totality, on the basis that there were various discrepancies in his version. Her criticism of his evidence is trenchant. I agree with the defendant's submission, however, that despite the internal and external contradictions identified by the plaintiff, the crux of his evidence remained steadfast. On material aspects, for example the manner in which the surgery was conducted, and whether there was a general albeit gradual improvement in the plaintiff's condition, Dr Jordaan's version cannot be disputed. As indicated, the plaintiff did not testify. There is thus no contradictory version as regards her level of pain after the surgery, why she returned to the hospital on 3 November 2019, or how she steadily improved until being "*more or less*" recovered eighteen months later. There is no evidence as to her current condition.
115. One must remember, too, particularly in the context of what the plaintiff points out as contradictions between his evidence and that of Dr Munting, that Dr

Jordaan's evidence was furnished as factual, not expert, evidence. Where Dr Jordaan strayed into expert territory because of the nature of his involvement in the matter, it is Dr Munting's expert evidence that is to be considered in relation to the fundamental questions that need to be addressed, namely the likely cause of the injury, and whether Dr Jordaan should have approached the situation differently in the circumstances.

116. The plaintiff criticises, too, what she regards as the inadequacy of the note-keeping in relation to the plaintiff's aftercare. She pointed out that the need to keep and protect medical records is prescribed in the National Health Act, 2003. The Health Professions Council's Guidelines (2008) on the keeping of patient records, which applies to all health care practitioners stipulate that it is compulsory to record, amongst other details, the time, date and place of every consultation; the assessment of the patient's condition and the proposed clinical management of the patient. The courts have made adverse findings against medical practitioners and hospitals in cases where medical notes have disappeared or have been made available in a piecemeal manner or are inadequate.³⁶
5. Dr Jordaan, an experienced medical practitioner, was aware of and acknowledged the importance of taking notes. He was also aware of the legal obligation on medical practitioners to keep notes, and agreed that one of the reasons stated for the need to keep notes is in anticipation of potential litigation. Although he personally does not keep notes, he testified that he very rarely saw the plaintiff alone and further that the intern or registrar accompanying him would keep notes. In light of this acknowledged obligation to keep adequate medical records, the plaintiff contended that the court cannot accept Dr Jordaan's evidence that a consultation was held prior to the surgery, that the integrity of the sciatic nerve was checked intra-operatively, or an assessment was done, if there is no recordal of this happening in the medical notes.

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See, for example, *Khoza v MEC for Health and Social Development* 2015 (3) SA 266 (GJ) para 47.

117. The adequacy of the note-keeping is, however, not an issue which needs to be considered because it was not pleaded as a ground of negligence. Dr Jordaan's alleged lack of properly recording his interactions with the plaintiff takes the matter no further, because the plaintiff has not given evidence to the effect that her version of the events differs from Dr Jordaan's version as to his communications with her. There was also no disagreement between the parties that the integrity of the sciatic nerve was checked intra-operatively. On the contrary, they were in agreement that the surgery took place without misadventure.
118. I did not regard Dr Jordaan's evidence as being undermined by the lack of notes to such an extent that he was an unreliable witness whose evidence had to be disregarded. He testified that he remembered the plaintiff's case well, because it was an interesting and complicated matter. He did not have to rely on hearsay evidence in relation to the plaintiff's condition, as he – as he testified – himself observed an improvement as time went by. He regarded the notes as a guideline.
119. It would in any event be illogical to disregard Dr Jordaan's evidence or discredit him on the basis that he gave evidence that went outside of the available notes. He was the surgeon who performed the THR, and who interacted with the plaintiff since 2018 and on regular occasions after the surgery. Where he had lapses in memory, or was uncertain about certain aspects posed to him, those were natural given the time that have since elapsed.³⁷ He nevertheless retained a good recall of the salient aspects. I did not form the impression, as the plaintiff urges me to do, that his evidence amounted to a narrative was constructed after the event.
120. Dr Jordaan's evidence, which is supported by the content of the available medical notes over the months post-surgery (even if it is accepted that they do not contain all that he testified to), is that although the plaintiff's improvement was slow, it was steady. She was able. within nineteen

months after the THR, to regain almost full motor power in her left foot. The sensory fallout was ultimately insignificant to the extent that she looked forward to a THR to the right hip, despite Dr Jordaan warning that a similar nerve injury was a risk yet again. The plaintiff's contention that there was no improvement from the time of the surgery until more than one year later in November 2020, is not what appears from the notes. They have to be considered holistically – it is not helpful, as the plaintiff has done, to focus on specific entries that might be ambivalent. When considered in context, the notes indicate a steady nerve function improvement, with references to the regaining of motor power and the presence of sensation in the foot.

121. In cross-examination, Dr Jordaan was asked whether the plaintiff's eagerness for the second THR could have been caused by her concerns about the leg length discrepancy, or whether the pain in her right hip spurred her on. This could have been resolved by evidence from the plaintiff directly. It is not clear why she was not called. Dr Jordaan's evidence to the effect that the plaintiff was happy with the left THR (and whatever her reason was for instituting the action), therefore remains uncontested.
122. I accept, further, Dr Munting's evidence that a partial sciatic nerve injury such as the plaintiff's could be caused by many variables. This is undisputed, despite the plaintiff's criticism of a shift in his evidence as opposed to what is set out in his expert summary. The experts were in agreement that in 50% of these types of cases the cause of the injury remains unknown. It is, in the particular context of the plaintiff's case not possible to pinpoint the origin of the injury, and therefore the manner in which it could be dealt with depended largely on what Dr Jordaan considered prudent in the circumstances. Dr Jordaan observed a gradual improvement in the plaintiff's condition, and he was satisfied with the adoption of a conservative approach, which accord Dr Munting's view that he would have dealt with the matter in a similar manner.
123. One cannot, from the available evidence, infer that further investigation as suggested by the plaintiff, or revision surgery as recommended by Dr Versfeld, would have revealed the cause of the injury, and would have

prevented further damage to the nerve. This was a nagging gap in the evidence throughout the trial, and poses an insurmountable hurdle in the plaintiff's ability to prove the required factual causation in this matter.

124. The matter of *Van Wyk v Duze and another*,³⁸ which involved a THR, is instructive. In that case, the THR was an uncomplicated procedure, other than in the present plaintiff's case. In relation to the cause of the injury in that case it was fairly similar to the present one.
125. The plaintiff in *Van Wyk* suffered a permanent sciatic nerve injury during or as a result of the surgery which took place in 2015. The injury resulted in, amongst other issues, a permanent drop foot. The issue to be determined was whether intra-operative damage done to the sciatic nerve was as a result of the negligence of the defendant, and the nature of the negligence alleged by the plaintiff was the incorrect and careless placement of a retractor during the THR procedure.³⁹ By 2017, the plaintiff still had to wear the drop foot splint and had a limp on the left side. There was disagreement between the parties' respective experts about the cause of the injury, and whether the defendant had been negligent.⁴⁰
126. In discussing the evidence, the court pointed out that the plaintiff's expert agreed that the cause of 50% of sciatic nerve injuries associated with hip replacements is unknown.⁴¹ The expert nevertheless maintained that a retractor most likely caused the damage to the plaintiff's sciatic nerve, as retractor is always used during such an operation, close to the nerve. It has sharp edges, is a dangerous instrument, and is the usual cause of such an injury.⁴²
127. The defendant's expert witness was of the opinion that indirect compression of the sciatic nerve was likely the cause of the complication. He was also of

³⁸ [2025] ZANCHC 2 (17 January 2025).

³⁹ See paras 1-4.

⁴⁰ See paras 7-9.

⁴¹ At para 21.

⁴² At para 25.

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. He could, however, not pinpoint the cause of the compression injury.⁴³

128. The court referred to relevant authorities⁴⁴ in relation to the approach to expert evidence, and discussed each of the parties' criticisms of the other party's expert witness.⁴⁵ The court remarked, in relation to the plaintiff's expert, that his attempts at explaining the cause of drop foot cases with which he was familiar, despite him taking the utmost care in those instances, did not assist the plaintiff. Neither did his proposition that because the plaintiff presented with a drop foot after the operation, the defendant must have been negligent in the manner identified by the expert as the likely cause of the injury.⁴⁶
129. As to the evidence of the defendant's expert witness, the court commented that the matter was not one where "*one would be tempted to assess the evidence in terms of scientific certainty*". An analysis of the cogency and underlying reasoning for the opinions of the experts sufficed:

"[69] ... 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

⁴³ See paras 39-47.

⁴⁴ I have referred to some of these authorities earlier in this judgment.

⁴⁵ See the discussion from para 51 and further.

⁴⁶ At para 58.

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".⁴⁷

130. The plaintiff's claim in *Van Wyk* was dismissed. Similar criticisms may be levelled against Dr Versfeld's evidence in the present matter, as opposed to Dr Munting's. I have already dealt with the bases for their respective opinions.
131. The court in *Van Wyk* referred to the case of *Van Vollenhoven v v Dr JCM Venter*,⁴⁸ 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. In that case the court reiterated what was referred to as "the golden rule" which applies to THR procedures, namely 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.
132. (I pause to point out that, in the present case, there was no dispute that there had been palpitation of the patient's sciatic nerve in the course of the surgery.)
133. As the court in *Van Wyk* explained,⁴⁹ in *Van Vollenhoven* the court held on the probabilities that the placement of the retractor caused the injury to the plaintiff's sciatic nerve:

"[66] 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

⁴⁷ At paras 69-70. My emphasis.
⁴⁸ [2015] ZAGPPHC 39 (2 February 2015).
⁴⁹ *Van Wyk supra* paras 66-67. My emphasis.

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.”

134. As regards foreseeability of the harm, the plaintiff points out that it was accepted by both expert witnesses and Dr Jordaan that patients with congenital DDH have a much higher risk of sciatic nerve damage following a hip replacement procedure and that extra care is required in these cases. It is further common cause between these practitioners that leg lengthening is an inevitable consequence of moving the femoral head down from its pathologically displaced position to the pathologically normal position and that an overlengthening of the limb could, by stretching the sciatic nerve, cause damage to it. In other words, the potential harm to plaintiff arising from the lengthening of her leg was foreseeable.
135. It was clear from the literature and the evidence that there is no precise figure at which lengthening will necessarily give rise to a stretching of the sciatic nerve, as patients vary and respond differently to treatment. However, given the increased risk of sciatic nerve damage in congenital patients and the evidence of the experts that one should not lengthen the limb in these patients by more than 2cm or 2.5cm, the plaintiff contends that Dr Jordaan, who was aware of the potential risk of nerve damage, acted unreasonably by lengthening plaintiff's leg by 3cm. The degree of lengthening was, according to his evidence, in accordance with the pre-operative surgical plan which was followed in surgery. The only conclusion that can be drawn from this evidence is either that Dr Jordaan deliberately lengthened plaintiff's leg by 3cm, which

is longer than the conventional accepted safety norm, or that the planning for this surgery was inadequate.

136. One must keep in mind, however, Dr Munting's evidence that, even if the measurement of the lengthening was 3cm, that would still be within the acceptable norms, and would not be considered overlengthening. A number of variables are at play and there is, as the plaintiff acknowledges, no precise figure at which lengthening will necessarily give rise to a stretching of the sciatic nerve.
137. The plaintiff also submits that, once the nerve damage was observed after the surgery, Dr Jordaan could still have avoided the harm to plaintiff by investigating the potential cause of the sciatic nerve injury by, *inter alia*, determining the degree to which plaintiff's left leg had been lengthened and ordering imaging of the leg; performing revision surgery if the investigations supported it, investigating or reconsidering plaintiff's condition when she returned to the hospital in extreme pain three weeks after the surgery; or investigating or reconsidering plaintiff's condition after the lapse of six months without improvement, alternatively, after twelve months without normalisation of the foot.
138. In the present matter (unlike in the case in *Van Vollenhoven*) there is no agreement on the mechanism of the plaintiff's injury, and there is expert evidence to the effect that there may have been a variety of causes therefor. It is by no means – and certainly not on a balance of probabilities – clear that the injury was caused by overlengthening, and that revision surgery or further investigation into the injury would have prevented such damages as the plaintiff had suffered. It is any event not clear what such damages entail at present.
139. I cannot, on these facts and on a balance of probabilities, find that the conservative approach taken by Dr Jordaan was unreasonable.

Conclusion, and costs

140. I conclude that the plaintiff has failed to prove on a balance of probabilities that she has suffered harm because of the defendant's decision not to perform revision surgery on the left hip, or to undertake further investigations into the cause of the sciatic nerve injury.
141. There is no reason why costs should not follow the result. The matter was moderately complex, and counsel's fees on Scale B are warranted.

Order

142. In the premises, the plaintiff's claim is dismissed, with costs, including counsel's fees taxed on Scale B. All costs that stood over for later determination are costs in the cause.

P. S. VAN ZYL
Judge of the High Court

Appearances:

For the plaintiff:

Instructed by:

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Malcolm Lyons & Brivik Attorneys

For the defendant:

Instructed by:

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The State Attorney