

Medical malpractice: The extent, consequences and causes of the problem

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OPSOMMING

Mediese wanpraktyke: Die omvang, gevolge en oorsake van die probleem

Hoewel daar bitter min empiriese inligting beskikbaar is oor die presiese omvang van mediese wanpraktyke en die daaropvolgende eise, dui die beskikbare inligting daarop dat die situasie in Suid-Afrika uiters dringend is. Die openbare gesondheidstelsel ly aan 'n verskeidenheid sistemiese swakhede wat 'n uitwerking op die gehalte van sorg het en is dus veral vatbaar vir litigasie. Die aansienlike bedrae wat gespandeer word op eise kan nie bestee word op die verbetering van infrastruktuur en gesondheidsdienste nie. Dit verswak verder die sorg wat voorsien word en lei weer tot verdere wanpraktyke en nog meer eise. Die koste van eise in die private sektor het vrywaringversekeringspremies drasties verhoog en die manier waarop medisyne beoefen word verander. Ongelukkig sal pasiënte moet worstel met al die gevolge van wanpraktyke en ook die gevolge van toenemende litigasie. Dit sal moeiliker wees om toegang te verkry tot gesondheidsdienste en gesondheidsorg kan duurder raak, soos wat die koste van litigasie en versekering oorgedra word aan die verbruiker. Versoeke om die aanspreeklikheid en vergoedingstelsel te hervorm is geregverdig, maar sal slegs effektief wees indien die oorsake van wanpraktyke en die verwante eise behoorlik geïdentifiseer en verstaan word. Dit sou ideaal wees as eise en kostes voorkom kon word deur wanpraktyke te verminder. Dit sal egter slegs kan gebeur as die gehalte van sorg verbeter en pasiëntveiligheid bevorder word. Daar moet ondersoek ingestel word om te bepaal hoe die aanspreeklikheid en vergoedingstelsel aangepas kan word om 'n meer effektiewe rol te speel in die verband.

1 INTRODUCTION

In recent years, South Africa has seen a sharp increase in medical malpractice litigation. A number of factors have contributed to this increase and doctors as well as other healthcare providers have been profoundly affected thereby. It seems as though the proliferation of claims for the adverse consequences of medical intervention, which has been a rising global trend, has eventually reached our shores.¹ Not only has there been an increase in the frequency of claims, but the amounts that have been awarded have also risen significantly.

¹ Pepper and Slabbert "Is South Africa on the verge of a medical malpractice litigation storm?" 2011 *SA J of Bioethics and Law* 29; Malherbe "Counting the cost: the consequences of increased medical malpractice litigation in South Africa" 2013 (103) *SA Medical J* 83.

It is near impossible to find any empirical data on medical malpractice in South Africa.² In June 2013, the Minister of Health, in response to a parliamentary question on the number of claims instituted against the department, declined to give exact figures. The Minister did indicate that the escalation of medico-legal claims and associated legal costs is a top priority of the Department and that it poses a serious threat to the survival of both the public and private health system.³ The Minister has previously blamed the high costs of medical litigation on the legal profession, stating that doctors are ‘unmercifully’ being targeted by attorneys.⁴ Stakeholders in the medical fraternity have called for urgent action to be taken in order to address the issue. They share the view of the Minister that the increase in medical litigation poses a serious threat to the entire health system and have suggested that government intervenes by implementing tort reform measures.⁵ A Medico Legal Task Team has been set up by the Minister to investigate the increase in malpractice claims and the causes thereof. Their recommendations will inform policy on the issue.⁶

2 EXTENT OF CURRENT MEDICAL MALPRACTICE SITUATION

The lack of information on the extent of medical malpractice is problematic, the causes and prevalence of medical errors would be much easier to assess and address if the data was readily available. Media and other reports do however provide a general idea of the current medical malpractice situation.

2.1 Health Professions Council of South Africa: Increased incidence of unprofessional conduct cases

Medical practitioners do not only have to contend with civil claims, they are also held accountable for unprofessional conduct by the HPCSA.⁷ The objective of a disciplinary inquiry of this nature differs from that of a civil claim, in that the focus is not on compensation for damages suffered by the patient, but rather on upholding the standards of the profession and protecting the interests of the public.⁸ This fact is also reflected in the disciplinary powers of the professional boards and the penalties that may be imposed by it.⁹

The HPCSA has indicated that more than 200 medical practitioners were found guilty in 306 cases of malpractice between 2008 and 2012.¹⁰ The council

2 Coetzee and Carstens “Medical malpractice and compensation in South Africa” 2011 *Chicago-Kent LR* 1295.

3 Parliamentary Question 2013/25A Question Number 627: <http://bit.ly/1tWR4uQ> (accessed on 30 April 2014).

4 “Motsoaledi wages war against lawyers” *Medical Chronicle* (2011-10-10) <http://bit.ly/1r3IISn> (accessed on 30 April 2014).

5 “Medical litigation: A national health crisis requiring urgent solutions” *Medical Chronicle* (2011-11-07) <http://bit.ly/1DvRKve> (accessed on 30 April 2014).

6 Parliamentary Question 2013/25A Question Number 627.

7 S 41 Health Professions Act 56 of 1974.

8 *Veriava v President, SA Medical and Dental Council* 1985 2 SA 293 (T) where the court stated that: “The council is thus truly a statutory *custos morum* of the medical profession, the guardian of the prestige, status and dignity of the profession and the public interest in so far as members of the public are affected by the conduct of members of the profession to whom they had stood in a professional relationship.”

9 S 42(1) Health Professions Act 56 of 1974.

10 “248 doctors found guilty of incompetence” *Times Live* (2012-10-19) <http://bit.ly/1r3IRoS> (accessed on 30 April 2014).

issued 283 fines and 137 suspensions to doctors for misconduct during the same period.¹¹ Insufficient care and mismanagement of patients roughly doubled, while cases of incompetence also increased in the past year.¹² According to figures published by the HPCSA, 53 practitioners have been struck from the roll since 2005 due to unprofessional conduct.¹³

The Registrar and Chief Executive Officer of the HPCSA, Dr Mjamba-Matshoba, is reported to have said that the increase of medical errors was a big concern and that her office and the health department were investigating the situation.¹⁴ In March 2012, the HPCSA launched an awareness campaign to educate the public and practitioners on their rights and responsibilities.¹⁵ This initiative was launched in response to some of the aforementioned developments.¹⁶ The acting CEO of the HPCSA, Dr Letlape, said a decline in levels of professionalism among healthcare practitioners and the increasing costs of medical negligence necessitated the need for greater public awareness of patients' rights and responsibilities when accessing healthcare.¹⁷ These statements have been criticised by the South African Private Practitioners Forum and the South African Medical Association who have indicated that the awareness campaign would encourage litigation and lead to an increase in the practice of defensive medicine.¹⁸ The Medical Protection Society has also strongly refuted the claim that a decrease in the levels of professionalism is to blame for the current situation, although they agree that patients should be better educated about their rights and responsibilities.¹⁹

The Council has come under severe criticism from both doctors and patients. These criticisms have cast doubt on the Council's ability to protect the public and guide the profession.²⁰ There are allegations that the Council has been politicised and that management failures have had detrimental consequences.²¹ Practitioners have raised concerns about the poor service they receive, often having to wait months before they even obtain a response from the Council.²² Patients are also *dissatisfied with their dealings with the Council*.²³ *Many feel that*

11 HPCSA Annual Report 2010/2011 (2010) 27; HPCSA Annual Report 2011/2012 (2011) 33.

12 HPCSA (2011) 34. When compared to the 2010/2011 report, discrepancies in the tables become apparent. This is more than likely due to a typing error in the latest report.

13 HPCSA Annual Report 2008/2009 (2008), read together with the more recent reports.

14 "248 doctors found guilty of incompetence" *Times Live* (2012-10-19).

15 HPCSA Media Statement: HPCSA embarks on health and human rights awareness campaign. (2012-03-19).

16 *Ibid.*

17 "Patients 'need educating on rights, responsibilities'" *Business Day* (2012-08-08).

18 "HPCSA's 'Report a doc' campaign likely to hike medical costs" *Medical Chronicle* (2012-05-07) <http://bit.ly/1mqsAsJ> (accessed on 30 April 2014).

19 Howarth, Brown and Whitehouse "The importance of comprehensive protection in today's healthcare environment" 2013 *SA Medical J* 453.

20 "Health Professions Council tried to stop exposure of Eastern Cape health crisis" *Daily Maverick* (2013-11-05) <http://bit.ly/ZbR6DY> (accessed on 30 April 2014).

21 Van Niekerk "HPCSA: A mess in the Health Department's pocket" 2009 *SA Medical J* 203. See also the reply to this editorial comment by the CEO of the HPCSA, Mkhize "HPCSA: A mess in the Health Department's pocket" 2009 *SA Medical J* 484.

22 "HPCSA and Docs – A relationship on the rocks?" *Medical Chronicle* (2012-09-03) <http://bit.ly/ZbRjyq> (accessed on 30 April 2014).

23 De Villiers "Protecting the public, the HPCSA or the Profession?" 2000 *SA Family Practice* 2.

the regulatory body unfairly protects members of the medical profession.²⁴ These feelings are exacerbated by the apparent inefficiencies with regard to professional conduct inquiries.²⁵ Inquiries often take years to be resolved.²⁶ This not only affects patients who may have valid complaints, but most certainly the doctors involved as well. Potential claimants often lodge complaints with the HPCSA with the purpose of determining their chances of success in a civil suit. The disciplinary proceedings and their outcome are used to test the waters for further prospective litigation. Patients want someone to be held accountable in the event of unprofessional conduct and are adversely affected by the delays. Practitioners also have valid grievances about the time-consuming processes and the stress caused thereby. The Supreme Court of Appeal addressed the disturbing state of affairs, noting that it reflects badly on the HPCSA and will affect the public confidence in the regulatory body.²⁷ The concerns are troubling, especially if one has regard for the immense importance of the HPCSA in its dual role as protector of the public and guardian of the profession.

2.2 Civil claims

Malpractice liability encompasses a wide range of causes. Patients can institute claims against healthcare providers if they have suffered damages due to the conduct of the medical practitioners or hospital staff involved in their treatment. As the relationship between the parties is governed by the law of obligations, a claim may be based on either contract or delict. However, a breach of a duty of care and negligence may underlie both a breach of contract and delict, in which case the conduct will result in liability for both.²⁸ Medical practitioners and hospital staff may thus incur liability for: Professional negligence; assault due to the absence of informed consent; an invasion of privacy as a result of an unwarranted disclosure of details concerning the patient; the performance of an unnecessary procedure; and breach of contract if they failed to perform an operation agreed upon.²⁹

2.2.1 Public sector

In 2010, it was reported that nearly 2 000 doctors in the public and private sectors were facing negligence claims.³⁰ Of those claims, 80% stemmed from incidents which occurred in the public sector.³¹ The institutional weaknesses and systemic challenges present in the public sector have made it especially susceptible to malpractice litigation. As a result, the respective provincial health departments have had to deal with ever escalating medical malpractice costs. The threat posed

24 "HPCSA 'protecting' hypocritical oafs" *Mail & Guardian* (2013-08-02) <http://bit.ly/1v3Zdgi> (accessed on 30 April 2014); "Health professionals smacked on the wrist" *Mail & Guardian* (2014-01-03) <http://bit.ly/1risvvr> (accessed on 30 April 2014).

25 Redelinghuys *A preliminary investigative system to professional conduct committees of the Health Professions Council Of South Africa, with specific reference to maxillo-facial and oral surgery* (Unpublished PhD thesis, 2005 University of Pretoria) 147. The author makes a few proposals after a detailed analysis of the preliminary investigative system.

26 *Roux v Health Professions Council of South Africa* 2012 1 All SA 49 (SCA) [34].

27 *Ibid.*

28 Slabbert "South Africa" in *International encyclopaedia of laws: Medical law* (2011) 69.

29 Strauss *Doctor, patient and the law* (1991) 243.

30 "Thousands of doctors 'negligent'" *Sunday Times* (2010-06-06).

31 *Ibid.*

by the financial implications of medical malpractice are emphasised by the figures presented below.³²

2 2 1 1 Provincial health departments and the cost of malpractice

Gauteng

The Gauteng health department is facing negligence claims amounting to R1.28 billion for the 2012/2013 financial year.³³ This is a significant increase from the R665 million and R876 million worth of claims the department faced in the past two respective financial years.³⁴ There are currently 306 negligence claims in total, of which 155 relate to injuries sustained at birth.³⁵ The Chris Hani Baragwanath hospital, by itself, is facing 86 medical malpractice claims equaling roughly R420 million.³⁶ These figures are even more troubling when one considers that the department has lost all medical negligence cases in the last three years.³⁷

KwaZulu-Natal

The KwaZulu-Natal health department is similarly facing negligence related claims exceeding R1.1 billion.³⁸ There are currently 515 medical malpractice claims against the department, some of which date back to 2004.³⁹ The department had to spend R376 million on lawsuits in 2008/2009 and R547 million in 2009/2010.⁴⁰

Eastern Cape

The Eastern Cape health department faced claims of R447 million in the 2009/2010 financial year.⁴¹ The amount increased to R715 million in the 2010/2011 financial year, as the department faced R284 million in additional

32 The figures presented were obtained from the latest available annual reports and media coverage related to the increase in claimed amounts.

33 "Bara facing 86 medical negligence claims – Jack Bloom" *Politicsweb* (2014-01-16) <http://bit.ly/1ofU67Z> (accessed on 30 April 2014). These figures were revealed by Gauteng Health MEC, Hope Papo in a written response to questions posed in the Gauteng Legislature; Gauteng Department of Health Annual Report 2012/2013 (2012) 322. The closing balance of all medico-legal claims up until 31 March 2013 is R2.53 billion.

34 "248 doctors found guilty of incompetence" *Times Live* (2012-10-19).

35 *Ibid.*

36 *Ibid.* This amount is the highest for all public hospitals in Gauteng.

37 "Gauteng DoH faces R3.7bn in legal claims – Jack Bloom" *Politicsweb* (2013-11-17) <http://bit.ly/ZFK36c> (accessed on 30 April 2014). It was reported that the Gauteng health department is facing 1002 medico-legal cases amounting to R3.415 billion. These figures were given to the Public Accounts Committee of the Gauteng Legislature.

38 "KZN health dept sued for R1.1bn" *The Times* (2013-05-10); KwaZulu-Natal Department of Health Annual Report 2012/2013 (2012) 350. The closing balance of all medico-legal claims up until 31 March 2013 is R1.78 billion.

39 "KZN health faces 1 356 legal claims" *CityPress* (2013-09-05) <http://bit.ly/1risfHq> (accessed on 30 April 2014).

40 "Botched operations blight SA" *The Sunday Independent* (2010-05-02) <http://bit.ly/1uUY6Am> (accessed on 30 April 2014).

41 Eastern Cape Department of Health Annual Report 2009/2010 (2009) 415. The amount encompasses all legal claims against the department and does not indicate the amount of claims specifically related to medico-legal matters.

claims.⁴² Most recent reports indicate that the Eastern Cape health department is currently facing R876 million worth of claims.⁴³

Limpopo

Reports indicate that the Limpopo health department is dealing with more than 300 malpractice cases, with claims amounting to more than R320 million.⁴⁴

Mpumalanga

In 2010/2011 the Mpumalanga health department spent R21 million on medical negligence claims.⁴⁵ This is up from the R19 million it spent in 2009/2010, and the R666 643 it spent in 2008/2009.⁴⁶ In 2011/2012 the department was facing R160 million worth of claims related to medical negligence and unpaid services.⁴⁷

Western Cape

The Western Cape department of health faced R87 million in medico-legal claims in the 2011/2012 financial year.⁴⁸ In 2012/2013 the amount increased to R118 million.⁴⁹

Free State

In the 2007/2008 financial year the Free State department of health was facing R19 million in medico-legal claims, which increased to R25 million in 2008/2009.⁵⁰ In 2010/2011 the department faced claims totalling R40 million. After incurring almost double that amount in liabilities during the following year, the closing balance for 2011/2012 stood at R106 million.⁵¹

North West

The North West department of health faced medical negligence claims amounting to R12.4 million in 2009/2010, which increased marginally to R13 million in 2010/2011.⁵² However, in November 2013 the department had to pay out R13.3 million in damages in a single case, after negligent conduct resulted in an infant being blinded.⁵³

42 Eastern Cape Department of Health Annual Report 2010/2011 (2010). This amount, again, includes all legal claims against the department, not only medico-legal claims. Also see "EC pays R50m in health claims" *Daily Dispatch* (2011-09-02).

43 "Hospital horrors costing SA plenty" *The Times* (2014-01-17).

44 "How Limpopo was looted – the inside story" *CityPress* (2012-07-14) <http://bit.ly/1wJd-SxE> (accessed on 30 April 2014).

45 "Province pays for negligence" *CityPress* (2011-08-17) <http://bit.ly/1B3b2nQ> (accessed on 30 April 2014).

46 "Botched operations blight SA" *The Sunday Independent* (2010-05-02).

47 "Province pays for negligence" *CityPress* (2011-08-17).

48 Western Cape Department of Health Annual Report 2011/2012 (2011) 342.

49 Western Cape Department of Health Annual Report 2012/2013 (2012) 474.

50 Free State Department of Health Annual Report 2008/2009 (2008) 239.

51 Free State Department of Health Annual Report 2011/2012 (2011) 168.

52 North West Department of Health Annual Report 2010/2011 (2010) 145.

53 "Hospital horrors costing SA plenty" *The Times* (2014-01-17).

Northern Cape

In 2005/2006 the Northern Cape health department faced medico-legal claims amounting to R17.7 million.⁵⁴ This figure has almost certainly increased since then, but information on the state of affairs in the Northern Cape is hard to come by. It was reported that the department has spent more than R23 million on legal fees since 2007.⁵⁵

2 2 1 2 Systemic problems in the public health system have contributed to poor health outcomes and increased malpractice litigation

Medical malpractice litigation has a devastating effect on the public health sector and this could be exacerbated by the implementation of a National Health Insurance mechanism that does not adequately address the underlying problems. A number of factors contribute to the dire state of public health care. Management problems persist and are aggravated by a lack of accountability. The failure to get primary health care and the district health system to function effectively has had a grave impact. Severe human resource constraints caused by poor policy and budget decisions have led to increased workloads, with many functions often performed by inexperienced personnel who are unable to be assisted by more senior practitioners.⁵⁶ Infrastructure and equipment are in a desperate condition and frequent shortages in supplies lead to a reduced standard of care. In addition, a huge number of patients rely on public services, a number which will increase if the NHI is implemented.

All these factors compromise the standard of care patients receive in the public sector and could potentially lead to more litigation. There has even been judicial recognition that substandard medical treatment could be expected in the public sector.⁵⁷ Seeing that provincial health departments have fixed annual budgets, these claims and the legal costs associated therewith have a direct impact on the ability to finance healthcare.⁵⁸ Money spent on medical malpractice claims, cannot be spent on improving the provincial health system.⁵⁹ This could lead to a further decline in the quality of care provided, which would inevitably lead to even more malpractice litigation.

2 2 2 Private sector

The private sector has also been severely affected by the increase in malpractice claims and awards. In 2010, it was reported that the Medical Protection Society was assisting 895 members with active negligence claims and had a 1 000 potential

54 Northern Cape Department of Health Annual Report 2005/2006 (2005) 14. This is unfortunately the only information that could be obtained from the Northern Cape Department of Health.

55 "Botched operations blight SA" *The Sunday Independent* (2010-05-02).

56 Seggie 2013 *SA Medical J* 433.

57 *S v Tembani* 2007 1 SACR 355 (SCA) 367. Also see Carstens 2008 *SA Public Law* 173 where the author welcomes the concrete judicial recognition of the compromised reality of public health care services in the country, but notes that a principled approach should have been followed in adjudicating the matter.

58 Coetzee 2010 *Obstetrics and Gynaecology Forum* 111; Pepper and Slabbert 2011 *SA J of Bioethics and Law* 29.

59 Malherbe 2013 103 *SA Medical J* 84.

claims awaiting assessment.⁶⁰ Outstanding claims in excess of R1 million, were 1 in 5, an increase of nearly 550% compared to ten years ago, while claims over R5 million surged by 900%, in the past five years.⁶¹ In the four years leading up to 2011 the Medical Protection Society experienced a 30% increase in the frequency of medical negligence claims reported in South Africa.⁶² During the period of 2008-2010 the cost of reported negligence claims rose by 132%.⁶³ There are serious concerns about this development, especially if one considers that the cost of an average claim has virtually doubled every five years.⁶⁴ In June 2013, the highest ever medical malpractice pay-out was awarded to an 11 year old patient who suffered brain damage as a result of a series of unsuccessful operations. The matter was settled out of court after the MPS conceded liability and agreed to pay R25 million.⁶⁵ Roughly 70% of all claims are settled out of court.⁶⁶ Most claims relate to adverse consequences of cosmetic surgery, children born with brain damage, birth defects not diagnosed in a timely manner and unnecessary Caesarean sections.⁶⁷

2 2 2 1 Cost of indemnity insurance

The increase in medical malpractice litigation has had a significant effect on the indemnity insurance premiums of healthcare practitioners. Statistically, obstetricians, spinal surgeons and paediatricians doing neonatal work, are more likely to face the most expensive claims.⁶⁸ These are thus also the specialities with the highest subscription rates. Neurosurgeons and spinal surgeons fall in the 'super high risk' category and have an annual subscription rate of R318 190.⁶⁹ Obstetricians have the highest subscription rate and have to pay the MPS an annual subscription rate of R330 000 for indemnity insurance.⁷⁰ Concerns have been raised about the escalating costs of insurance premiums.⁷¹ In 2012, UK-based insurer Lloyd's stopped providing indemnity cover for obstetricians in South Africa as a result of the immense costs involved with claims relating to infants.⁷²

Not only is it becoming unaffordable to provide indemnity cover, it is becoming unaffordable to purchase indemnity cover.⁷³ Obstetricians starting out in private practice will not be able to generate enough income initially to be able

60 Correspondence between the Medical Protection Society and their members, regarding membership renewal and subscription rates 2010.

61 *Ibid.*

62 Bown "Counting the cost of litigation" 2012 *Casebook* 9.

63 Bateman "Medical negligence pay-outs soar by 132% – subs follow" 2011 *SA Medical J* 216.

64 Whitehouse "Counting the costs of GP claims" 2013 *Practice Matters* 8.

65 "Brain damage leads to SA's highest-ever medical payout" *Sunday Times* (2013-06-16).

66 "Thousands of doctors 'negligent'" *Sunday Times* (2010-06-06).

67 *Ibid.*

68 Bateman 2011 *SA Medical J* 216.

69 MPS Subscription Rates 1 January – 31 December 2014. <http://bit.ly/XTAMGi> (accessed on 30 April 2014).

70 *Ibid.* In 2010 the subscription rate was R139 000.

71 Coetzee "The spectre of litigation - a dark cloud on the obstetric horizon" 2010 *Obstetrics and Gynaecology Forum* 109.

72 "Litigation: A killer epidemic with no cure?" *Medical Chronicle* (2012-08-06) <http://bit.ly/1yoxzsn> (accessed on 30 April 2014).

73 Howarth "The threat of litigation: private obstetric care - *quo vadis?*" 2011 *SA J of Bioethics and Law* 86.

to afford the subscription rates,⁷⁴ whereas experienced practitioners who perform fewer deliveries will also not be able to afford the higher premiums and may instead stop practicing obstetrics entirely.⁷⁵ With the potential liabilities the high risk specialities could incur they cannot afford not to have indemnity cover and continue practicing in those high risk areas either, as one successful claim and the resulting legal costs could be financially devastating.⁷⁶

The escalating costs of necessary insurance cover for high risk specialities may bring about even more unwanted consequences. Practitioners, especially the ones in rural and low-population urban areas, may not be able to treat enough patients or perform enough operations to be able to afford the expensive premiums.⁷⁷ It may not be financially viable to continue their practice or they may relocate to more populated areas. This, in turn will deprive those communities of access to already scarce specialist care.⁷⁸ Medical students and doctors at the start of their careers may even be deterred from practicing in certain specialities due to the costs and the potential threat of litigation.⁷⁹

2 2 2 2 Patients pay the price

Patients stand to lose the most.⁸⁰ They are the ones who have to contend with the direct effects of malpractice and may ultimately, in a cruel twist, end up having to face the indirect consequences of increased malpractice litigation as well. Healthcare costs may increase and there may be a diminution in their access to care. It is understandable that practitioners complain about the increases in indemnity insurance and malpractice awards, as from their point of view it directly affects their take-home earnings.⁸¹ However, these increased liability costs are eventually passed on to the patient in the form of more expensive healthcare services.⁸² Of course there will be practitioners who will not be able to

74 Howarth "The rising cost of litigation; a threat to private obstetric care?" 2013 *Obstetrics and Gynaecology Forum* 35.

75 *Ibid.*

76 Howarth 2011 *SA J of Bioethics and Law* 86; Howarth, Bown and Whitehouse 2013 *SA Medical J* 453.

77 Malherbe 2013 *SA Medical J* 83.

78 *Ibid.*

79 Lambert *et al* "Doctors' reasons for rejecting initial choices of specialties as long-term careers" 2003 *Medical Education* 316; Mello and Kelly "Effects of a professional liability crisis on residents' practice decisions" 2005 *Obstetrics & Gynecology* 1287.

80 Seggie "The 'boom' in medical malpractice claims – patients could be the losers" 2013 *SA Medical J* 433.

81 As mentioned above, some practitioners may even have to discontinue or relocate their practice. This is bad for the practitioner involved and worse for the patients, who will be deprived of his or her expertise and care.

82 Strauss "Geneesheer, pasiënt en die reg: 'n Delikate driehoek" 1987 *TSAR* 7; Weiler "The case for no-fault medical liability" 1993 *Maryland LR* 915; Mello *et al* "Who pays for medical errors? An analysis of adverse event costs, the medical liability system, and incentives for patient safety improvement" 2007 *J of Empirical Legal Studies* 852. With regard to hospitals bearing the costs of injuries due to medical management, the authors found that more than 70% of the costs are externalised to other parties, including the insured patients, their families and health insurers. The authors also stated that the percentage could be even higher, as they could not measure whether the hospitals raised prices as a means of passing the externalised costs on to consumers and insurers. The authors concluded that "the direct costs of adverse events do not fall on hospitals to a significant enough extent to create strong economic incentives for safety improvement".

pass on the costs and as a consequence will not be able to continue their practices. Obstetricians are particularly vulnerable in this regard, as they have seen dramatic increases in premiums over the past few years.⁸³ If the trend continues, many obstetricians in private practice may be forced to stop practicing or change specialities.⁸⁴ With no one in the private sector to deliver their babies, expectant mothers will have to turn to public facilities.⁸⁵ With the public sector already under strain, the consequences could be disastrous.⁸⁶ The resource limitations in the public sector could affect the quality of care the patients receive, which would in turn lead to an increase in malpractice claims against the state.⁸⁷

3 ADDITIONAL CONSEQUENCES OF INCREASED LITIGATION

3.1 Defensive medicine

There is evidence to suggest that an increased litigation risk has an effect on how medicine is practiced. Practitioners are more likely to practice defensively in order to avoid complaints or malpractice claims. A survey conducted by the MPS found that 76% of private general practitioners in South Africa were aware of the growth in medical negligence claims and complaints, and as a result thereof 58% indicated that they have changed the way in which they practice.⁸⁸ Compassion-centred care is being substituted with defensive medicine.⁸⁹ Defensive medicine has been described as “a deviation from sound medical practice that is induced primarily by a threat of liability”.⁹⁰ This threat of liability is avoided by engaging in assurance or avoidance behaviour.⁹¹ Assurance behaviour includes the over-ordering of diagnostic tests, unnecessary patient referrals and the prescription of more medication than medically indicated.⁹² Apart from being wasteful and expensive, this behaviour may either reduce or improve quality.⁹³ Additional care may have some benefits; however it could also expose patients to other risks.⁹⁴ It may also raise the expected legal standard of care.⁹⁵ Avoidance behaviour has a negative effect on patient care, high risk patients and interventions are avoided by doctors either restricting or stopping their practice altogether.⁹⁶ This behaviour reduces access to care.⁹⁷

83 “Litigation: A killer epidemic with no cure?” *Medical Chronicle* (2012-08-06).

84 MacLennan *et al* “Who will deliver our grandchildren?: Implications of cerebral palsy litigation” 2005 *JAMA* 1688; Mello *et al* “Effects of a malpractice crisis on specialist supply and patient access to care” 2005 *Annals of Surgery* 621; Howarth “Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade?” 2013 *SA Medical J* 513.

85 Howarth (2011) 4 *SA J of Bioethics and Law* 86.

86 Howarth (2013) 23 *Obstetrics and Gynaecology Forum* 35.

87 Malherbe (2013) 103 *SA Medical J* 83.

88 Whitehouse “Counting the costs of GP claims” 2013 *Practice Matters* 8.

89 Pepper and Slabbert 2011 *SA J of Bioethics and Law* 32.

90 Studdert *et al* 2005 *JAMA* 2609.

91 *Idem* 2612.

92 *Ibid.*

93 *Idem* 2616.

94 *Ibid.*

95 *Ibid.*

96 *Idem* 2613.

97 *Idem* 2617.

We are seeing the effects of defensive medicine locally. A study conducted by the MPS revealed that 86% of practitioners now keep more detailed medical records, which is no doubt a positive development.⁹⁸ However, it was also revealed that 65% of practitioners acknowledged that they conduct more investigations and 67% indicated that they now refer more patients for a second opinion as a result of increased litigation risks.⁹⁹ A further concern is the fact that 61% of practitioners indicated that they have chosen to stop treating certain conditions or performing certain procedures and 29% said they had a lower threshold for removing patients from the practice list.¹⁰⁰ The implications of defensive medicine in the South African healthcare context are evident. As a result thereof, healthcare may become more expensive, health-resources would unnecessarily be expended, and access to care would be diminished.

3 2 Professional and emotional impact on the practitioner

The threat of medical malpractice litigation affects practitioners both professionally and personally.¹⁰¹ Practitioners who have faced litigation are more likely to report emotional symptoms, many indicating that they suffer from depressed moods, inner tension, anger, and frustration.¹⁰² Some groups of symptoms reported correspond with depressive disorders and stress syndromes.¹⁰³ The emotional well-being of practitioners is especially affected if they were more personally involved with the patient prior to the malpractice claim.¹⁰⁴ It is common for practitioners to feel personally attacked in the event of litigation.¹⁰⁵ Especially, if they feel that they have performed in the patient's best interest and in accordance with the medically indicated standard of care.¹⁰⁶ Many practitioners may consider early retirement and discourage others from entering medicine, which may impact on the availability of healthcare.¹⁰⁷

3 3 Reluctance to disclose errors

The fear of litigation may also negatively impact on the reporting of errors. Practitioners will not be forthcoming with information if it could result in an expensive and arduous civil claim.¹⁰⁸ However, if errors and adverse events are not reported, nothing can be done to prevent their reoccurrence.¹⁰⁹

98 Whitehouse 2013 *Practice Matters* 9.

99 *Ibid.* This falls into the assurance behaviour category.

100 *Ibid.* This can be classified as avoidance behaviour.

101 Charles *et al* "Sued and nonsued physicians' self-reported reactions to malpractice litigation" 1985 *American J of Psychiatry* 437; Forster, Schwartz and DeRenzo "Reducing legal risk by practicing patient-centered medicine" 2002 *Archives of Internal Medicine* 1217; Aasland and Førde "Impact of feeling responsible for adverse events on doctors' personal and professional lives: the importance of being open to criticism from colleagues" 2005 *Quality & Safety in Healthcare* 11.

102 Charles *et al* 1985 *American J of Psychiatry* 438.

103 *Id* 439.

104 Shapiro *et al* "A survey of sued and non-sued physicians and suing patients" 1989 *Archives of Internal Medicine* 2190.

105 Bark *et al* "Impact of litigation on senior clinicians: implications for risk management" 1997 *Quality in Healthcare* 9.

106 Merenstein "Winners and losers" 2004 *JAMA* 16.

107 Charles *et al* 1985 *American J of Psychiatry* 440.

108 Gallagher *et al* "Patients' and physicians' attitudes regarding the disclosure of medical errors" 2003 *JAMA* 1001.

109 Kohn, Corrigan and Donaldson (eds) *To err is human: Building a safer health system* (2000) 86.

Medical errors are an unfortunate but inescapable reality, which is why expectations should be properly managed at the start of any treatment. Informed consent plays a vital role in this regard, as patients should be made aware of the risks involved. The actions taken once an adverse event has occurred are just as important.¹¹⁰ The absence of adequate communication could lead to and reinforce a decision to litigate.¹¹¹ The doctor-patient relationship is one of trust and that relationship suffers when doctors view their patients as nothing more than potential lawsuits, or if patients view their practitioners as unsympathetic, indifferent commercialised health service providers. There is evidence to suggest that a breakdown in this compassion-centred relationship and associated communication, can contribute to the filing of malpractice claims.¹¹² When it comes to the patient's decision to litigate, what happened during the preceding and subsequent consultations in the doctor's office may be just as important as what happened during treatment.¹¹³

Disclosing errors in a sympathetic and honest manner may not only be beneficial to the safety of the health system as a whole. It may even result in a less adversarial, more trusting doctor-patient relationship and consequently, less litigation.¹¹⁴ The complex nature of the healthcare environment needs to be considered when approaching the problem; a number of organisational and systemic factors could contribute to an error, the focus often unfairly falls upon the individual, as he or she is merely the most identifiable cog in an intricate system.¹¹⁵

4 CAUSES OF INCREASED MALPRACTICE LITIGATION

A number of factors have possibly contributed to increased malpractice litigation and the associated costs. These contributing factors will be arranged into four categories for the purposes of this discussion.

4.1 Healthcare system

Many adverse events can be attributed to systemic factors, rather than purely individual negligence.¹¹⁶ Errors often occur despite the best intentions and behaviour of the medical personnel involved.¹¹⁷ The environment in which these

110 Kachalia *et al* "Liability claims and costs before and after implementation of a medical error disclosure program" 2010 *Annals of Internal Medicine* 213. The University of Michigan Health System implemented a program of full disclosure of medical errors with offers of compensation and saw a decrease in the number of lawsuits; lower liability costs; and shorter resolution times.

111 Beckman *et al* "The doctor-patient relationship and malpractice: lessons from plaintiff depositions" 1994 *Archives of Internal Medicine* 1368.

112 Levinson *et al* "Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons" 1997 *JAMA* 557.

113 Levinson *et al* 1997 *JAMA* 557.

114 Vincent, Phillips and Young "Why do people sue doctors? A study of patients and relatives taking legal action" 1994 *Lancet* 1609; Kraman and Hamm "Risk management: Extreme honesty may be the best policy" 1999 *Annals of Internal Medicine* 963; Vincent "Understanding and responding to adverse events" 2003 *New England J of Medicine* 1051.

115 Kohn, Corrigan and Donaldson eds. (2000) 5, 43, 49.

116 *Idem* 49.

117 Reason "Human error: models and management" 2000 *BMJ* 768. For a more in depth discussion of the human and organisational factors that cause accidents in complex systems and the tools and techniques available for the management of the associated risks, see Reason *Managing the risks of organizational accidents* (1997).

practitioners often find themselves and the medical realities they have to contend with need to be considered.¹¹⁸ The institutional weaknesses within the public health system may contribute to the rising number of claims, since the quality of care provided is compromised thereby, thus resulting in more and worse injuries. While it is true that practitioners have to perform their duties in accordance with the degree of care and skill expected from them, they are often hindered by factors that are out of their control. Decisions made by administrators have a direct impact on the quality of services practitioners can provide to their patients.¹¹⁹ The administrators are responsible for ensuring that there are adequate resources available to enable the provision of suitable health services. Liability can be incurred by these individuals, as well as health departments and hospital bodies vicariously, if negligent maladministration or mismanagement resulted in harm being suffered.¹²⁰

4.1.1 "Person" versus "systems" approach

Adverse events occur and it may be more emotionally satisfying to blame individuals rather than institutions or organisations.¹²¹ The 'person approach' focuses on the unsafe acts of the practitioners and medical personnel who provide health-care services; it attributes errors to the aberrant mental processes of these individuals and attempts to manage the occurrence of errors by attributing blame, instituting disciplinary measures, or deterring certain behaviour with the threat of litigation.¹²² Human behaviour is thus the main focus and error management resources are directed at making individuals less fallible.¹²³ This person approach may be inappropriate in the complex healthcare environment. A 'systems approach' may be better suited to medicine, as human error and fallibility are regarded as consequences rather than causes, originating not from human nature alone, but rather systemic factors.¹²⁴ Errors are managed, not by targeting the individual, but by implementing programmes which target several different components of the system, which includes the person, the team, the task, the workplace and the institution as a whole.¹²⁵ Such an approach could reduce errors. However, our current liability system, which is focussed on individual accountability, may not be conducive to such an approach as it may deter individual behaviour, but does little to address the systemic factors.¹²⁶

118 Carstens and Pearmain *Foundational principles of SA medical law* (2007) 638.

119 Vincent "Research into medical accidents: a case of negligence?" 1989 *BMJ* 1152.

120 McQuoid-Mason "Establishing liability for harm caused to patients in a resource-deficient environment" 2010 *SA Medical J* 574. The author discusses liability in a resource-deficient environment, indicating that a number of different parties may be held liable if harm is suffered in such circumstances. Decisions to ration services need to be reasonable and justifiable, especially where constitutional rights are affected. Also see Pieterse "Health care rights, resources and rationing" 2007 *SALJ* 514. For an international legal perspective on the legal liability of hospitals in the USA, Canada, the United Kingdom, Australia, and South Africa see Cronjé-Retief *The legal liability of hospitals* (2000).

121 Reason 2000 *BMJ* 768.

122 *Ibid.*

123 *Idem* 769.

124 *Idem* 768.

125 *Idem* 769.

126 Leape *et al* "The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II" 1991 *New England J of Medicine* 383.

4 2 Medical profession

Some have suggested that the increase in claims has been brought on by a decline in professionalism and the standard of care.¹²⁷ The HPCSA has also raised concerns about the increased number of complaints they have received.¹²⁸ Practitioners have criticised these views and have blamed the increase in litigation on other factors. However, if there was no malpractice there would be no claims.¹²⁹ Lapses in judgement do occur and even the most vigilant practitioners make mistakes.¹³⁰ The focus should perhaps rather be on putting systems in place to avoid preventable mistakes.¹³¹ Nevertheless, practitioners need to make sure that they adhere to the standard of care expected from their particular branch of the profession. Failure to meet the expected standard may be alleviated by an increased emphasis on education and the enforcement of practice guidelines.¹³² Improving the detection of negligent behaviour and instituting appropriate corrective or disciplinary processes would also be constructive.¹³³

Some studies have, however, found that the quality of care provided and the technical expertise of the practitioner may not be determining factors when it comes to malpractice litigation.¹³⁴ Instead it seems that patients' dissatisfaction may be critical.¹³⁵ A perceived lack of caring and a breakdown in communication often precedes the decision to litigate.¹³⁶ Merely obtaining money may not be the only objective of injured patients; the reasons for filing suit may be due to the manner in which the practitioner subsequently managed the situation after the occurrence of the adverse event.¹³⁷ Practitioners would thus be wise to adjust their behaviour accordingly. Communication is essential. Practitioners need to build a rapport with their patients and, in the case of an adverse event, they need to manage the situation sympathetically, whilst keeping in mind that patients may be immensely affected by such an unfortunate outcome.¹³⁸

4 3 Legal profession

It is easy to vilify lawyers when the issue of malpractice litigation arises. As mentioned above, the Minister of Health has done so by accusing greedy lawyers of 'unmercifully' targeting doctors.¹³⁹ It is likely that many members of the

127 "Patients 'need educating on rights, responsibilities'" *Business Day* (2012-08-08).

128 "HPCSA responds to campaign criticism" *Medical Chronicle* (2012-06-04) <http://bit.ly/ZFNbit> (accessed on 30 April 2014).

129 Coetzee 2010 *Obstetrics and Gynaecology Forum* 111.

130 Ncayiyana "Compensation for injury from medical treatment is a social justice obligation" 2004 *SA Medical J* 304; Gallagher, Studdert and Levinson "Disclosing harmful medical errors to patients" 2007 *New England J of Medicine* 2713.

131 Reason 2000 *BMJ* 768.

132 Leape *et al* 1991 *New England J of Medicine* 383.

133 *Ibid.*

134 Entman *et al* "The relationship between malpractice claims history and subsequent obstetric care" 1994 *JAMA* 1588.

135 Levinson *et al* 1997 *JAMA* 553.

136 Beckman *et al* 1994 *Archives of Internal Medicine* 1365; Hickson *et al* "Patient complaints and malpractice risk" 2002 *JAMA* 2951.

137 Hickson *et al* "Factors that prompted families to file medical malpractice claims following perinatal injuries" 1992 *JAMA* 1359.

138 Vincent, Phillips and Young 1994 *Lancet* 1609; Vincent 2003 *New England J of Medicine* 1054.

139 "Motsoaledi wages war against lawyers" *Medical Chronicle* (2011-10-10).

medical profession share his sentiments. While it may be true that lawyers are not acting entirely altruistically when taking on malpractice cases, patients who have suffered injuries as a result of a practitioner's negligence have a right to compensation and lawyers provide the only avenue for obtaining the necessary financial redress. Whether they are driven by sympathy or the money involved, is probably of no concern to the injured patient who requires assistance in obtaining compensation for medical and other damages incurred as a result of a practitioner's negligent care. It is in the injured patient's best interest to have an attorney who will try and get the best possible settlement or award. Again, if there was no malpractice there would be no need for malpractice litigation. The threat of an adverse order of costs does serve to deter meritless claims.¹⁴⁰ It may be unfair to criticise attorneys, as their practices are determined by the liability and compensation system in which they function. Criticism should perhaps be directed at the system, rather than the individuals who are merely a part thereof. That being said, certain factors relating to the legal profession may contribute to the increase in medical malpractice litigation.

Some commentators have noted that medical malpractice attorneys are purposely targeting the public, often encouraging patients to seek legal assistance if they have suffered adverse consequences due to medical care.¹⁴¹ Others have indicated that amendments to the Road Accident Fund legislation may have driven attorneys to other types of personal injury litigation, such as medical malpractice, since it may be more financially lucrative than Road Accident Fund claims.¹⁴² The Contingency Fees Act has opened up the possibility of litigation to patients who could previously not have afforded to institute claims.¹⁴³ Although this "no win, no fee" arrangement allows greater access to justice, especially for indigent public sector patients, it has led to some questionable practices.¹⁴⁴ The incentive to inflate claims has no doubt fostered the often justified perception that lawyers are selfish and greedy.¹⁴⁵ The legal profession and the public should take cognisance of the fact that lawyers are bound by a range of ethical duties to both their clients and the court. These duties may well come into conflict with their own financial interest in the proceedings where contingency fee agreements are involved.¹⁴⁶

140 Strauss (1991) 245. The author describes the threat of an adverse order of costs as the "most powerful deterrent" against litigation in South Africa.

141 Pepper and Slabbert 2011 *SA J of Bioethics and Law* 30.

142 Road Accident Fund Amendment Act 19 of 2005; *Law Society of South Africa v Minister for Transport* 2011 1 SA 400 (CC); Malherbe 2013 *SA Medical J* 83.

143 Contingency Fees Act 66 of 1997.

144 Coetzee 2010 *Obstetrics and Gynaecology Forum* 109; Howarth 2011 *SA J of Bioethics and Law* 85.

145 Howarth 2013 *Obstetrics and Gynaecology Forum* 33; "Health MEC attacks lawyers" *The Mercury* (2014-02-07).

146 *Ronald Bobroff & Partners Inc v De La Guerre; South African Association of Personal Injury Lawyers v Minister of Justice and Constitutional Development* (CCT 122/13, CCT 123/13) 2014 ZACC 2 [10]. The appellants challenged the constitutionality of the Contingency Fees Act. In terms of the Act, provision is made for fees to be charged in regulated instances and at set percentages. However, some law firms charged more than what was allowed for in the Act. The Act was found to be constitutional and leave to appeal was dismissed by the court. Common law contingency fees are unlawful.

4 4 Increased patient awareness

Stakeholders in the medical profession have indicated that the proliferation of complaints and litigation is not due to a decline in standards and care, but rather due to the fact that patients are more aware of their rights.¹⁴⁷ This is a development that should be welcomed, as patients who have legitimate claims must be compensated.¹⁴⁸

5 CONCLUSION

Although there is little empirical information available on the incidence of medical malpractice and the subsequent claims, the available information suggests that the extent of the situation is dire. The public health system suffers from a range of systemic weaknesses that have had an effect on the quality of care provided and have made it especially vulnerable to litigation. The substantial amounts spent on claims cannot be spent on improving healthcare infrastructure and services. This compounds the problem and may result in more malpractice and further claims. In the private sector the costs of claims have raised indemnity insurance premiums and changed the way in which medicine is practiced. However, in the end patients will have to contend with all the effects of malpractice and increased litigation. It could become more difficult to access health services and healthcare may become more expensive, as costs are passed on to the consumer. Calls for reform are justified, but will only be effective if the causes of malpractice and the related claims are properly identified and understood. Ideally, one would want to prevent claims and costs by reducing malpractice. For this to happen, the quality of care provided must improve and patient safety should be promoted. Research on how the liability and compensation system could be aligned with such an objective, whilst being more effective at preventing malpractice, is required.

147 "HPCSA's 'Report a doc' campaign likely to hike medical costs" *Medical Chronicle* (2012-05-07).

148 Ncayiyana 2004 *SA Medical J* 303.